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**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 2, 2016**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to submit this statement for the record of today's hearing. As you know, DAV is a Congressionally chartered national veterans organization of 1.3 million wartime veterans, all of whom were injured or made ill due to military service.

Your invitation letter indicated the focus of today's hearing is to examine plans of the Department of Veterans Affairs (VA) with regard to eligibility for non-VA care under the proposed New Veterans Choice Program (VCP), as mandated in Public Law 114-41, and to assess whether they are sufficient to increase access to care among veteran patients. We appreciate the opportunity to share our views and recommendations in this regard.

When it comes to our nation keeping its promises, perhaps none are as important as the promise to care for injuries and illnesses suffered by the men and women who served. VA's capacity to meet its needs is limited by its annual appropriations allocated to VA by Congress. Thus, VA's health care mission involves, among other things, keeping expenditures under a resource ceiling. The inherent limitation impacting veterans' access to care is what type of service they may need, where it is available and the availability of resources to purchase the care in the community.

Indeed, the findings of a presidential task force reported in 2003 and the Independent Assessment report issued by MITRE Corp., Rand Corp. and others last September confirm what DAV and our *Independent Budget* (IB) partners (Paralyzed Veterans of America and Veterans of Foreign Wars) have said for more than a decade: the resources provided to VA health care have been inadequate to meet the mission to care for veterans. In fact, we have repeatedly testified to Congress about this "mismatch" and "misalignment" of resources and demand.

To be clear, DAV does not believe that simply increasing funding by itself—without making some significant reforms to the underlying VA health care system—will lead to better health outcomes for veterans over the next 20 years. However, no VA reform plan

has any chance of success unless sufficient resources are consistently provided to meet the true need and demand for services by veterans, when and where they need them.

Our members have unfortunately experienced the adverse consequences of this mismatch first-hand when VA policy for purchasing certain care is inconsistent, unclear, and/or comes without commensurate resources. Funding uncertainty compels some facilities to develop local policies, procedures, or dicta which generally limit veterans' access to community care paid for by VA.

Unless tensions between resources, demand and authorities are addressed with a clear understanding of the circumstances in which care is purchased in the community, and how this policy fits into VA's broader health care mission, the probability is quite high that even the best intended policies and procedures will continue to undermine the veterans' perception and experience of the coordination, quality and value of health services provided or paid for by VA.

In reviewing the eligibility for non-VA care under Choice consolidation, as mandated in Public Law 114-41, and whether they are sufficient to increase access to care among veteran patients, we believe it offers the potential for expanding and improving access to care. According to VA, its entire plan will increase access to non-VA care and "require additional annual resources between \$1.5 and \$2.5 billion in the first year and are likely to increase thereafter."

The eligibility for non-VA care under Choice consolidation is laid out in four parts: hospital care and medical services; emergency and urgent care; and outpatient medication and durable medical equipment. DAV's statement will review each of these parts including grievances, disputes, and appeals, and provide our views and recommendations where warranted.

Hospital Care and Medical Services:

VA's plan: "The eligibility criteria for Hospital Care and Medical Services, including Dentistry services, in the community will continue to be focused broadly on wait-times for care, geographic access/distance, and availability of services. The criteria will be streamlined into a single set of rules applied across the VA health care system."

Geographic and temporal eligibility criteria

The plan proposes to continue the existing geographic and temporal eligibility criteria of the Veterans Choice program as authorized by the Veterans Access, Choice, and Accountability Act of 2014. We note the choice program criteria remains underdevelopment having been amended from its original form, and veterans today remain frustrated by the current criteria not being sensitive to their medical care needs and preferences.

We believe VA's proposed geographic and temporal criteria for community care eligibility in the New Veterans Choice Program (NVCP), while simple in concept—are arbitrary.

It continues to administratively separate NVCP from the VA health care system, does not foster full integration, and limits performance to the detriment of veteran patients.

Under this separated construct, because DAV was founded on the principle that this nation's first duty to veterans is the rehabilitation and welfare of its wartime disabled, because VA's capacity to provide for "the rehabilitation and welfare of its wartime disabled" is limited by its annual appropriations allocated to VA by Congress, and because of the natural tension between demand, resources, and authorities, we recommend consideration that the eligibility to use the NVCP should mirror the eligibility for VA health care, giving the highest priority to service-connected veterans.

Notably, the independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry best practices focus on clinical need and the interaction between clinicians and their patients. We could not agree more.

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. Thus, DAV, along with the co-authors of the IB, believes 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.

From the veteran patient's perspective, the decision-making process can be more than a clinical decision—and it can often be a complicated one. Many veterans who use the VA health care system present complex health and social challenges requiring more than simple coordination of care, often including coordination of supports and other services. A decision on where, when and with whom to obtain care may need to involve the veteran's social support network such as caregivers, family members and friends to address factors and limitations such as the time required to complete a visit, procedure, or treatment plan, availability of appropriate transportation when needed, and various financial considerations.

This is why DAV, as part of the IB, proposed creating local Veteran-Centered Integrated Health Care Networks to seamlessly integrate community care into the VA system and to provide a full continuum of care through such networks. The future VA health care system with an integrated NVCP should be responsive to the decision made between veterans and their providers. Veterans should be able to choose among the options within VA and the NVCP network and schedule appointments that are most convenient for them.

Availability of service eligibility criteria

In addition to geographic and temporal criteria, VA's plan also proposes an eligibility criterion for hospital care and medical services, including dentistry services, in the community that focused on "availability of service." Specifically, when a VA facility cannot directly provide a particular service or when a VA facility determines there is a compelling reason a veteran needs to receive care from a community provider, then outside care would be authorized.

We believe the “compelling reason” criterion may inappropriately limit access to community care through NVCP. We have received reports about treatments, procedures or tests available in the private sector, which the veteran’s VA health care team has determined “is not necessary.” These complaints are more pronounced when a veteran’s non-VA provider recommends a service that is neither cosmetic nor experimental, but which VA has determined “is not necessary.”

Veterans-centric care means including veterans participation in their care. This means providing veterans options, whether that be a second option or describing all the different treatments that are endorsed by clinical literature and even though the veteran's doctor may favor one over another, the final decision ultimately stops—or should stop—with the patient. When these options are not presented particularly for preference-sensitive conditions and treatment options, disagreements between the veteran and their provider can and does occur.

Grievances, Disputes, and Appeals

We agree with VA’s plan that “[T]o ensure VA meets the unique needs of Veterans...the process also will include clear appeal and grievance mechanisms for Veterans to dispute eligibility determinations.” We also support VA’s plan for “[a] formal, timely appeals process will provide Veterans a clear point of contact for concerns about the status of their authorization.” When authorization questions arise, there is a clear path for appeals through the call center.

Congress and VA should consider an appeal mechanism that covers all decision and determination points, not just eligibility determinations for the NVCP. To this end, DAV stands committed to working with VA in developing mechanism(s) designed to address grievances, disputes, and appeals.

As part of the IB, we envision the Veterans Experience Office playing a role in this regard. VA Secretary McDonald has made improving veterans experience a main pillar of the MyVA transformation. To ensure VA leaders are aware of the issues veterans face when they obtain their earned benefits and health care, the MyVA taskforce has established the Veterans Experience Office, with a Chief Veterans Experience Officer who reports directly to the Office of the Secretary. VA plans to have veterans experience officers throughout the country who collect and disseminate best practices for improving customer service, coordinate community outreach efforts, and serve as subject matter experts on the benefits and services VA provides to veterans.

The Veterans Experience Office should be strengthened by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code, a veteran’s right to seek redress through clinical and administrative appeals, claims under section 1151 of title 38, United States Code, the Federal Tort Claims Act, and the right to free representation by accredited veterans service organizations are fully applied and complied with

by all providers who participate in Veteran-Centered Integrated Health Care Networks, both in the public and private sector.

The Plan for Emergency and Urgent Care:

VA's plan: "Eligibility criteria will increase access to these services and simplify access rules to prevent the denial of claims for the appropriate use of these services."

During our engagements with VA in the development of its plan, DAV specifically urged the inclusion of urgent care into VA's medical benefits package and to better integrate emergency care with the overall health care delivery system.

VA's plan also indicates it will focus on a more consistent application of the "prudent layperson" definition of emergency treatment across claims to reduce the administrative burden on VA to conduct a nuanced review of each emergency treatment claim.

Presumably, the more consistent application of the prudent layperson standard will rely in part on "Develop[ing] business rules to trigger audit of emergency treatment and urgent care claims to identify potential overuse or fraud, waste, and abuse of these services."

VA believes its plan will "encourage Veterans to use these services appropriately and not as a substitute for primary care...by requiring cost-sharing for emergency treatment" unless the veteran is admitted to an inpatient status, or if it [causes] an undue financial burden to the veteran. In addition, it will "limit cases where Veterans are held responsible for a bill for emergency treatment or urgent care because they did not fully understand the criteria for VA coverage."

We applaud VA for including in its plan expanded access to, and simplification of the eligibility requirements for, emergency and urgent care coverage.

Prudent Layperson

DAV has received a resolution from our membership regarding urgent and emergency care as they pertain to the VA health care system. Specifically, our members believe urgent and emergency care should be integral to VA's medical benefits package.

Our resolution regarding emergency care also urges the VA to provide for a more liberal interpretation of its policy governing reimbursement to veterans who have received emergency care at non-VA facilities. VA readily admits that "[M]any 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."

We recommend VA's plan use a national prudent layperson emergency care standard that provides coverage based on a patient's presenting symptoms and relative urgency of need, rather than the final diagnosis, VA's current standard.

24-Month Requirement

The VA plan proposes the eligibility for reimbursement of costs associated with emergency treatment be limited to those enrolled in VA health care and who are active VA health care patients (i.e., sought care from VA within the past 24 months).

As opposed to VA, DAV believes the 24-month requirement does not “incentiviz[e] appropriate health behaviors,” as claimed in VA's plan. DAV has testified on a number of occasions in support of legislation to eliminate the current law provision that requires enrolled veterans to have received care from VA within the 24-month period prior to date of the emergency care, as a precursor to reimbursement.

Absent a change in law, veterans who are fortunate enough to not need VA or VA-authorized care at least once every 24 months would need to make an unnecessary VA medical appointment in order to remain eligible for emergency and urgent care reimbursement under the NVCP. DAV continues to recommend to Congress that this artificial limitation on use of emergency care be lifted.

Copayment

DAV has received a resolution from our membership calling for the elimination or reduction of VA health care out-of-pocket costs for service-connected disabled veterans.

Premiums, health care cost sharing, and deductibles are a feature of health care systems in which some costs are shared by the insured and the insurer in a contractual relationship between the patient, payer and provider. In DAV's view service-connected disabled veterans have already paid the price of any health care copayment or cost-sharing scheme imposed the federal government.

Notwithstanding the imposition of copayments to all veterans seeking emergency and urgent care, the plan fails to consider those instances where an emergency department or urgent care clinic would be the most appropriate setting for the care veterans need.

DAV recommends, in addition to those situations where copayments would be waived under the plan, including similar relief when an emergency department or urgent care clinic is the most appropriate setting.

From the veteran patient's perspective, not all VA primary care clinics or teams are capable of providing fast, life-or-limb-saving care. Moreover, veterans need urgent care when VA primary care appointments are unavailable or treatment is needed outside of office hours. If the VA health care system and the integrated NVCP are unresponsive to these needs, the proposed co-payments should not apply.

We appreciate VA's desire to incentivize appropriate health behavior; however, we insist VA provide positive rather than punitive incentives. As part of the IB, VA should consider establishing a national nurse advice line to help reduce overreliance on emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance of emergency room care without having to increase cost-shares for veterans.

Define Emergency Condition

Moreover, in the interest of parity in VA's legislative proposal to address its existing authorities to reimburse the cost of emergency treatment, we recommend "emergency condition" be defined. We urge serious consideration be given to reliance on the Emergency Medical Treatment and Labor Act (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 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."

Outpatient Medication and Durable Medical Equipment; Extended Care Services:

VA's plan: "Eligibility criteria will not be altered in this report, as any adjustment would constitute a fundamental change to the VA health benefit."

VA's plan is to leverage its rates for outpatient medical and durable medical equipment (DME) by requiring veterans to receive these services through VA facilities with limited exceptions, including urgent prescription medications, allowing veterans to pay out of pocket and seek reimbursement from VA.

Limitations of Plan and Approach

We understand the scope of VA's plan being limited to those "non-Department provider programs" prescribed by Congress in P.L. 114-41; however, we caution Congress and the Administration on this fragmented approach to provide timely access to care in the community, which may produce adverse consequences.

VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics, and mental health; gender-specific care, long-term care in both institutional and non-institutional settings. The limits of the plan is identified by some health care benefits such as dental care that carry additional statutory eligibility requirements, and extended care, which VA indicates is "out of the scope of this effort to adjust the eligibility criteria." The VA plan for the NVCP also does not propose changes to the VA health benefit or to other eligibility requirements for care purchased through other authorities not contemplated in Section 4002 of PL 114-41.

If Congress intends to increase veterans' access to care, including care in the community, it should recognize that by not addressing gaps and inconsistencies in VA's plan (*all* of VA's purchased care authorities—including cost controls through differing eligibility requirements and other stipulations), VA's medical benefits package, and the full range of health services available in the community, VA will assuredly continue certain fragmentation of care veterans experience today into the future. Veterans could be left unassisted across different providers and care settings, fostering frustrating and unsafe patient experiences, leading to medical errors, waste, and duplication that foster poor overall quality of care.

Mr. Chairman and Members of the Committee, thank you for the opportunity to present this testimony. DAV will be pleased to respond to any questions on the topics discussed in this statement that need additional information or clarification.