DRAFT LEGISLATION: To Establish A Permanent Veterans Choice Program; Draft Legislation To Modify VA's Authority To Enter Into Agreements With State Homes To Provide Nursing Home Care To Veterans, To Direct The Secretary To Carry Out A Program To Increase The Number Of Graduate Medical Education Residency Positions, And For Other Purposes; DRAFT LEGISLATION: To Direct VA To Conduct A Study Of The Veterans Crisis Line; DRAFT LEGISLATION: To Direct VA To Furnish Mental Health Care To Veterans At Community Or Non–Profit Mental Health Providers Participating In The Veterans Choice Program; The Department Of Veterans Affairs (VA's) Legislative Proposal, The Veteran Coordinated Access And Rewarding Experiences (CARE) Act; H.R. 1133; H.R. 2123; H.R. 2601; And, H.R. 3642

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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FIRST SESSION

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Tuesday, October 24, 2017

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Radewagen, Bost, Poliquin, Dunn, Arrington, Rutherford, Higgins, Bergman, Banks, Walz, Takano, Brownley, Kuster, O'Rourke, Rice, Correa, Esty, and Peters.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

Welcome and thank you for all joining us today, the Full Committee legislative hearing.

Today we will begin discussing several pieces of important legislation, including draft legislation that I have been working on to establish a permanent, improved Department of Veterans Affairs Care in the Community Program, draft legislation that Ranking Member Walz has been working on to address VA's agreements with state veteran homes; graduate medical education residency positions, community care obligations, and telemedicine licensing issues; and a legislative proposal Secretary Shulkin has been working on, the Veteran Coordinated Access and Rewarding Experiences, or CARE Act.

We will also consider legislation this morning that would affect how veterans are able to access life-saving transplant and mental health care, and how VA is able to use telemedicine to treat veterans in rural areas.

Needless to say, we have a very full docket this morning. I am grateful to Ranking Member Walz, to Secretary Shulkin, and all the sponsors of the bills on today's agenda for being here this morning and for their hard work on behalf of our veterans.

I look forward to hearing the testimony of my colleagues and of the Secretary on various proposals, and, for brevity's sake, will limit my comments to my draft bill addressing community care. So let's get started.

Earlier this month, the Committee hosted a roundtable discussion with VA and numerous Veterans Service Organizations to discuss community care reform. At that roundtable, we had a robust discussion surrounding an earlier version of my community care reform bill. I am immensely grateful to all the VSOs, members, and other roundtable participants for their support of the earlier draft, their thoughtful suggestions for how it could be improved, and their willingness to meet with me and my staff over the last few weeks to discuss these issues and my language in depth.

It is important to note that the written testimony that was submitted for today's hearing is based on an earlier draft of the bill that is before us today. On Friday, a revised version of the bill was circulated that incorporates the feedback that I have received over the last few weeks from VSOs, members, VA, and other stakeholders.

Once again, I want to thank all of those who agreed to sit down with me and my staff, for being so generous with their time and for their commitment to ensuring that all viewpoints and concerns are heard and considered in the Committee's final work product. I made every effort, every step of the way, to be transparent and keep all stakeholders informed about our work and intentions with regard to this bill.

To that end, I believe it is important to state yet again that this effort is in no way, shape, or form intended to create a pipeline to privatize the VA health care system. I want to be completely clear about that. Everyone who participated in the roundtable earlier this morning and contributed to the development of this legislation to be completely clear on that. Everyone listening today should also be completely clear on that.

Supplemental care sources from within the community has been a part of the VA health care system since the 1940s, and services to expand VA's reach and strengthen and support the care that VA

provides. Rhetoric aside, strengthening and supporting VA is what this conversation is about.

It should go without saying that VA cannot be everywhere, providing everything to every veteran. Expecting VA to perform like that sets up the VA to fail. That is why my draft bill preserves VA's role as the central coordinator of care for enrolled veteran patients.

In addition to consolidating VA's menu of existing community care programs into one cohesive program, my bill would create a seamless, integrated VA system of care that incorporates VA providers and VA medical facilities where and when they are available to provide care a veteran seeks in a network of VA providers in the community who can step up when needed.

Under my draft bill, the VA generally retains the right of first refusal, meaning that if VA medical facilities can reasonably provide a needed service to a veteran, that care will be provided in that facility. But when the VA can't do that, my bill would ensure that veterans aren't left out to dry.

My bill would also modernize VA's medical claims processing system to ensure that community providers can be expected to be paid on time, every time, and for the care they provide to veterans on VA's behalf.

My bill would further require VA to consolidate periodic capacity and market assessments to identify how gaps in care can be addressed through improvements to both internal and external capacity, standardize the rates VA pays to community providers, and authorize VA to enter into provider agreements for needed care when contracts are not available or achievable.

That said, my bill remains a work in progress and we still have work to do together. For example, we still need to figure out how to pay for all these improvements, which will be no easy or pleasant feat for any of us, I can assure you.

I am committed to remaining as transparent and open as possible moving forward, and I want everyone here to know the doors of this Committee are open to anyone who is honestly interested in working with us to resolve this issue once and for all before the year runs out and the Choice funds, once again, run dry.

With that, I look forward to hearing what all of our witnesses have to say this morning and thank them for being here.

The CHAIRMAN. I will now yield to Ranking Member Walz for any opening statement that he might have.

OPENING STATEMENT OF TIM WALZ, RANKING MEMBER

Mr. WALZ. Well, thank you, Mr. Chairman.

Earlier this summer, the New York Times did a story and the headline in it was, "If You Want to Know How Congress is Supposed to Work, Look at the VA Committee." That is a testament to Chairman Roe's leadership, it is a testament to what is basically the who's who of those who care for veterans who are in this room today. For those veterans that will be watching and following this closely, they expect nothing less of us; they expect nothing less than bipartisanship aimed at common values and outcomes, and for that I am grateful.

Secretary Shulkin and your team, thank you. It is not a rare occurrence to have you in this room. You are accessible. We pick up the phone, we talk often, and you are always proactive in that and I think that changes the conversation.

To the VSOs that are here, we will talk a little bit about your input that is absolutely invaluable.

We have even been joined by a neighbor to the east of me from Wisconsin, Mr. Leinenkugel. I wanted to thank you for taking the time to come down. I know you are a busy man, so you may have missed the Vikings and the Packers did play, just by the way. Okay, I thought we would share that. Passive-aggressiveness runs deep in Minnesotans—

[Laughter.]

Mr. WALZ [continued]. —but thank you for that.

Over 3 years ago, the Committee worked together under significant public pressure and time constraints to establish the Veterans Choice Program, in response to the immediate access to care crisis. At that time, I think we all understood Veterans Choice would be a temporary fix. Aside from using the time to improve VA internal capacity, it also allowed the Committee to assess a long-term strategy for consolidating VA's multiple community care programs into one streamlined, easy-to-use program, based on all the lessons learned from Veterans Choice.

During this period, the Chairman is absolutely right, we have held countless hearings on the topic, and today we have the opportunity to discuss the product of these hearings: draft legislation to replace the Veterans Choice Program and consolidated community care.

I want to begin by thanking the Chairman again and his incredible staff for the hard work on this issue. When you look at their willingness to consider and incorporate stakeholder feedback into their draft, it is evident this is not a partisan issue, it is a veteran issue. And this Committee continues to prove that veterans, not politics, come first.

In preparation for this hearing, I had the opportunity to go with Congressman Nolan up to International Falls in Koochiching County, Minnesota. They are famous for lots of things and not just being the coldest place in America. And they told me this to be very clear about it is, is that International Falls is not the end of the road, it is the beginning of the road when you come from Canada. And the room was filled with about a hundred veterans from all of this Nation's conflicts and, just like so many of you and the Members who are here hold these hearings all over, we were talking about what it is going to take to deliver that care. And the Chairman is right, it is very difficult. There is no VA hospital in International Falls. The nearest community-based outpatient clinic is miles away. Community care in hospitals are even spread out some, but the willingness of that community hospital there, a small rural hospital willingly taking Choice, willingly taking TRICARE, willingly taking CHAMPVA, to try and serve their people.

And out of that meeting, and we will get a chance to talk about it, is some of the things that they want to know we hear about. They love the care they get in the VA, but they don't want to drive to Minneapolis or, more importantly, fly to Minneapolis every time

they need it. They want to try and figure out how we can best deliver that care. So today, the county veterans service officer in the VFW, they are holding a watch party today in the VFW out in International Falls. They wanted to hear what we had to say and ask them, and they are curious about this, just like all of your veterans are.

So I thank the VSOs for that engagement. Your members are listening, they are paying attention, and they care deeply about this. And to the VA for their support. Each has continued to provide a level of insight and expertise necessary to make this program work.

I am pleased that we are as close as we are to settling on policy underlying a Choice replacement program. I am concerned with how we fund it, as the Chairman said. I continue to believe that veterans do not benefit when we scrape the barrel for money by skimming from some veteran's benefits or health programs to pay for others. That is something that came out of that meeting. I asked them, if we could deliver everything you are asking for on CARE, would you be willing to do it with round-down and other things, and that cause's great consternation amongst that group.

We need to have that open, honest dialogue, which we have always had. A program of this magnitude will require more than round-downs, and I look forward to learning more about how we plan to pay for this legislation and bring in those stakeholders.

A critical component of consolidating community care is improving VA's ability to enter into provider agreements with state veteran's homes. That is why I have included language in the minority draft to do just that. Without the modification to VA's authority, veterans' access to high quality nursing homes will decrease. I hope my colleagues will support this legislation as it advances through the Committee. We must ensure the needs of our aging veteran's population are met and future demand on these services will rise.

Today, this Committee will also discuss legislation to improve the current Veterans Choice Program. These improvements include changes to organ transplant authorizations and eligibility. Also some changes I am concerned with, such as changes to the eligibility of veterans to seek mental health from VA and in certain locations the eligibility of veterans to seek treatment for military sexual assault. I am concerned these changes to eligibility could lead to VA ultimately losing its role as the coordinator and the guarantor of one of the most important responsibilities: to provide high-quality mental health care.

I believe that by concentrating our efforts within the VA we can better treat veterans with mental health concerns or that are suffering from military sexual trauma. I look forward to hearing from our witnesses. We can do more on this.

With that, I would once again thank you, Chairman, for your leadership, thank you for once again proving that Congress can work in tackling the toughest issues on those shared values. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding and his comments.

And I am honored today to be joined by a number of colleagues who have sponsored the bills on our agenda and will be joining us on the first panel.

With us is Representative Jim Banks from Indiana, who will be testifying from his seat here on the dais; Representative Mike Gallagher of Wisconsin. Welcome.

Judge John Carter from Texas; G.T. Thompson from Pennsylvania. And Representative Dr. Neal Dunn from Florida will also be testifying from the dais. And Representative Andy Barr, my friend from the north in Lexington, from Kentucky.

Representative Banks, you are now represented for 5 minutes.

STATEMENT OF HONORABLE JIM BANKS

Mr. BANKS. Chairman Roe, Ranking Member Walz, thank you for holding the hearing today and for including my bill on the agenda,

Our gratitude for our servicemembers demands that we address the personal impact of their service. Suicide is our Nation's tenth leading cause of death, claiming over 40,000 lives a year. That is almost five times as many people as my entire hometown Columbia City, Indiana. This rate has increased by over 32 percent since 2001. Veterans account for 18 percent of those deaths, even though they are only 8.5 percent of the Nation's population.

Every day, as we know, 20 veterans die from suicide. Veterans are 22 percent more likely to commit suicide and our female veterans are two and a half times more likely than civilian women. The invisible wounds of PTSD are a large contributing factor, afflicting 11 to 20 percent of those who have served in war zones.

Our veterans were vigilant in fighting for our freedoms, we must be vigilant in addressing their needs.

In recognizing the increase from 2001 to 2014, the VA has focused many resources to tackle this issue. One resource is the 24/7 Veterans Crisis Line, or the VCL, which was created in 2007. As of May 2016, the line answered over 2.3 million calls and over 55,000 texts. Emergency services were dispatched over 61,000 times and there were over 376,000 referrals to VA suicide prevention coordinators, ensuring veterans reach further care options.

The VCL, as you can see, is a critical tool. My draft bill seeks to enable it to be even more effective. In this information age, the power of data analytics can greatly help.

An Inspector General report from March of 2017 indicated room for improvement regarding data analysis and performance measures. Currently, there is still no overarching approach to ensure the VA knows the efficacy of the VCL in preventing future suicide attempts after the initial one is prevented, or in how well it is integrated into the entirety of VA's mental health services.

My bill would require the VA to give us quantitative insight regarding the following. First, the VCL is a conduit for veterans to be connected to opportunities for sustained mental health treatment through the VA. Next, it would look for the visibility of the VCL to veterans who have never used VA care, and VA health care's effectiveness at ensuring that those receiving physical care find help for any mental needs; and VA mental health care decreasing the chance of a veteran needing to contact the VCL again; if the amount of times a veteran contacts the VCL changes outcomes; and, lastly, what is mental health care's effectiveness at decreasing suicide risk. These answers will further empower the VA in this fight.

We must ensure that our veterans know that they are not alone after the phone call. Suicide attempts usually result from mental health concerns that require further care to find complete resolution.

Through talks with Veterans Service Organizations, I have learned of their concern for veterans' information privacy. I share this belief in privacy and seek to maintain it. That is why this bill will not change the nature of the phone conversations. Veterans who wish to are still able to maintain anonymity.

Additionally, the bill provides for a study of data from January 1, 2014 through the end of 2018, almost 80 percent of which has already been collected. The last year of data for 2018 would be acquired no differently or extensively. This bill has no data-acquisition purpose at all, it serves solely for data analysis.

Another concern raised is the privacy of the information during analysis. This bill does not intend to jeopardize that either. I intend to work with the Committee and veterans organizations to ensure that there is no ambiguity allowing for the possibility of any such interpretations.

With the quantitative insight this bill would provide, the goal all of us share could be accomplished, which is saving more veterans' lives.

With that, I urge my colleagues to support this bill. With the loss of 20 veterans each day, we must do everything that we can, it is our duty.

Thank you, Mr. Chairman. I yield back.

[THE PREPARED STATEMENT OF MR. BANKS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Banks.

Mr. Gallagher, you are now recognized for 5 minutes.

STATEMENT OF HONORABLE MIKE GALLAGHER

Mr. GALLAGHER. Thank you, Chairman Roe, Ranking Member Walz—although I represent the Packers in Congress, that was tough to hear—and distinguished Members of the Committee, thank you for inviting me to join you here today.

My draft legislation before you seeks to address the unmet suicide-prevention needs of America's military veterans. As my colleague Mr. Banks laid out, 20 veterans take their own lives on average each day and, on average, 14 of the 20 veterans who commit suicide each day did not receive care within the VA.

In May 2017, Secretary Shulkin stated the following: "Nothing is more important to me than making sure that we don't lose any veterans to suicide. As you know, 20 veterans a day are dying by suicide. That should be unacceptable to all of us. This is a national public health crisis, and it requires solutions that not only the VA will work on, but all of government and other partnerships in the private sector, nonprofit organizations."

As a veteran myself, I could not agree more with Dr. Shulkin. That is why my colleague Seth Moulton, a fellow Marine, and I have been working on legislation to address this crisis.

Simply stated, our bipartisan legislation would improve veterans' access to evidence-based mental health care services at community

or nonprofit mental health providers participating in the Veterans Choice Program. Our bill would allow eligible veterans in need of mental health services to access the care they need on a same-day basis in the community without a referral. This narrow provision would apply only to mental health services in order to address the suicide crisis affecting the men and women who have served our Nation.

We believe this legislation is sorely needed. In 2016, the VA Center for Innovation published a report titled "Veteran Access to Mental Health Services." The report, which is a compilation of interviews with veterans from across the country, is absolutely remarkable. I believe the candor of these findings is truly a testament to the VA's commitment to transparency and I commend the Department for recognizing that some veterans need mental health care choices outside the VA.

For example, the report states, "For many veterans, private providers and non-profits that offer confidential, bureaucracy-free access to timely care feel like a positive and desirable alternative to VA processes."

The report also states, "Many veterans are dismayed and left feeling like the VA wants to fob them with drugs when they are offered psychotropic medication before exploring non-medicated treatment options."

Further, in discussing proposed solutions, the report finds: "Many veterans don't want to use VA services for mental health care even if the red tape is cleared, so how can we enable other avenues for care that benefit both veterans and non-VA providers?"

These findings exemplify why Congressman Moulton and I are teaming up to find a bipartisan, commonsense solution to this crisis. It is my belief that by allowing eligible veterans access to same-day, evidence-based mental health care services at community and nonprofit providers that are credentialed under the Choice Program's care delivery network, veterans in crisis will be able to get the help they need when and where they need it.

The United States has now lost more veterans to suicide than the Nation has lost in Iraq or Afghanistan, and we believe our Nation has a continuing obligation to the men and women who have served to help address their mental health needs.

Tragically, only this past Friday a 33-year-old veteran committed suicide in the parking lot of the Phoenix VA. I would simply say, and I know everyone on the Committee feels the same way, that this can't continue. And I believe community-based and nonprofit mental health care providers stand ready to help fill the gap in addressing the unmet need in veterans' mental health care.

This legislation would give Dr. Shulkin and his team the ability to allow such providers to meet these urgent needs in order to continue to address what the Secretary has described as his number one clinical priority.

I hope every Member of the Committee will support this effort. I thank you for your time and I look forward to working with all of you to move this forward.

Thank you.

[THE PREPARED STATEMENT OF MR. GALLAGHER APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

Now I would like to recognize Representative Carter, Judge Carter. And I understand you have some special guests with you today, Judge.

STATEMENT OF HONORABLE JOHN R. CARTER

Mr. CARTER. Thank you very much, Mr. Chairman. And, yes, I do, and I'll introduce them in a moment.

Chairman Roe, Ranking Member Walz, and other Members of this Committee, it is an honor to speak here before you this morning.

Mr. Chairman, thank you for including our bill, H.R. 1133, Veteran Transplant Coverage Act of 2017, in today's hearing.

I am here this morning on behalf of thousands of American veterans who find themselves in need of transplant care. Under current law, a veteran in critical need of a live donor transplant can't, with their VA coverage, receive a donation from a non-veteran. This excludes children, siblings, and other non-veteran family members, the people a veteran would be most likely and willing to enter into a successful organ match. This is unacceptable.

My legislation, the Veterans Transplant Coverage Act of 2017, removes unnecessary barriers that prevent veterans from receiving the care they deserve. H.R. 1133 will allow veterans to receive donations from a live donor, regardless if the donor is a veteran or a non-veteran, and allows them to have the procedure done in a non-VA facility if that makes more sense for the patient.

This is a commonsense, live-saving policy, and I am proud that it has received robust and bipartisan support as a stand-alone bill.

This legislation is a good fit for the Veteran Coordinated Access and Rewarding Experiences, CARE Act, because it seeks to give veterans more options when it comes to their health care, both in donors and providers. This is especially beneficial for veterans who live in rural areas, far away from the closest VA medical center, to say nothing of the closest VA transplant facility.

Mr. Chairman, I want to take the time to pause and recognize my constituents, the inspiration for this bill, Mr. and Mrs. Charles Nelson and their son Coty, who are here from Leander, Texas, a city in my district.

The CHAIRMAN. Please stand, if you would.

Mr. CARTER. Mr. Nelson is a 100-percent disabled service-connected veteran, who served his country and ran into this roadblock. That is why we are here today.

They brought up what I thought was a commonsense, crazy thing that should be changed. I want to thank them for coming out here and doing this. And they care enough about it to come all the way here from Texas to let you know they care.

[Applause.]

Mr. CARTER. Mr. Nelson, a 100-percent disabled service-connected veteran, served his country and did everything his grateful Nation asked him to.

Unfortunately, while serving in Korea, he developed kidney disease, which further led to a need of a kidney transplant. His then 28-year-old son Coty was a willing donor and a match. Initially, Mr. Nelson was told the surgery would be covered under the VA

Choice Program of 2014 and able to be performed at the University Hospital in San Antonio. However, because his son was not a veteran, the VA central office denied coverage and costs.

The Nelsons were forced to use Medicare and private donations, and their own savings to cover the surgery costs. Mr. Nelson deserves better, our veterans deserve better.

VA health should be there to address the health care needs of those who have served our country in uniform. For Mr. Nelson, who served our Nation bravely, to be forced to solicit donations to cover life-saving medical treatment was a failure of the VA system and an insult to his service.

I am proud to represent Mr. Nelson and the more than 84,000 veterans in my congressional district. Each of them, along with the 22 million nationwide, deserve access to life-saving transplant procedures, regardless of donor, in a facility that makes sense for them and their family.

I hope that with the passage of H.R. 1133, Veterans Transplant Coverage Act of 2017, and of the entire Veteran Coordinated Access and Rewarding Experiences, CARE Act, our veterans can access the care they need in the best facility through their VA coverage. Our veterans deserve nothing less and the very best, and the best we can offer them for their service.

Mr. Chairman, Ranking Member Walz, I want to thank you again for the opportunity to speak here today. I want to thank all the Members of this Committee for their service to our country and to our veterans.

With that, I yield back.

[THE PREPARED STATEMENT OF MR. CARTER APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

And, Mr. and Mrs. Nelson, thank you and your son Coty for being here today, and thank you for bringing this up to Judge Carter. It is that you can see that your particular situation will benefit many, many veterans in the future and their families. And I want to thank you personally for you being here and coming all the way from Texas up here. And just remind you, there wouldn't be a Texas if it weren't for Tennessee, I want to point that out.

[Laughter.]

The CHAIRMAN. But I too served in Korea, I appreciate your service. And, once again, we very much appreciate what you have done for veterans for this country and your service.

Judge, thank you.

And now my friend G.T. Thompson, you are recognized for 5 minutes.

STATEMENT OF HONORABLE GLENN THOMPSON

Mr. THOMPSON. Well, Chairman Roe, Ranking Member Walz, thank you so much for inviting me to testify before the House Veterans' Affairs Committee, with regards to H.R. 2123, the Veterans E–Health and Telemedicine Support Act, also known as the VETS Act.

The issues before this Committee are critically important to ensure that those who have selflessly served our Nation receive the

care and support that they rightfully deserve. With this in mind, a constituent approached me a few years ago to discuss the barriers to care that his fellow veterans were experiencing through the VA system.

As an active duty soldier, he told me the stories of his friends coming home from deployments and fall through the cracks in our systems. Some were suffering post-traumatic stress disease, some traumatic brain injury, and depression, and required the care of specialists. Others had difficulty traveling from their rural communities to VA medical centers because of the injuries sustained during combat.

It broke my heart to hear the stories of this soldier's friends not receiving the care that they deserve and, quite frankly, many of them wound up taking their own lives. What made it more difficult was the fact that this constituent, this soldier, was my son.

After numerous conversations about how we can help our servicemembers when they return home, we determined that expanding access to telehealth would be a great start. Many of our veterans live in rural areas and are unable to travel far distances. Allowing them to see their health care provider in the comfort of their home would increase their access to care.

As a result, I introduced the Servicemembers Telemedicine and E–Health Portability Act of 2011, or the STEP Act. Now, this bill allowed the Department of Defense health care professionals and contractors to provide telehealth care to members of our Armed Forces anywhere in the country, even across state lines, and that bill was included in the fiscal year 2012 NDAA, which was subsequently signed into law.

The STEP Act has allowed more than 32,000 servicemen and women to gain access to telehealth and has been the basis for a number of telehealth expansions throughout the years. The DoD recently decided to expand telehealth care for recipients of TRICARE based on the success of that legislation.

The STEP Act has proven that telemedicine can be expanded safely and responsibly across state lines. And while DoD patients can receive telehealth care no matter where they are located, those who receive care through the VA are not afforded the same liberties. That is why Representative Julia Brownley, a proud Member of this Committee, and I introduced H.R. 2123, the Veterans E–Health and Telemedicine Support Act.

The VETS Act will similarly allow VA-employed health care providers to practice telehealth across state lines no matter where the doctor or the patient is located. It also commissions a study of the effectiveness of telemedicine programs utilized by the Department of Veterans Affairs.

And while the VA has made major strikes in advancing telehealth access, outdated barriers limits its growth. My bill will eliminate these barriers by giving VA-employed providers an exemption to practice telehealth across state lines.

Currently, each state has its own licensing requirements for health care providers to practice medicine within its borders. For example, if a doctor has offices in Pennsylvania and Ohio, they must hold a license from each state. VA provider licensing requirements are different. As long as the doctor is licensed and in good

standing in a single state, they can practice in-person care within the VA system in any state. This reciprocity, however, is not afforded to their practice of telehealth.

VA providers seeking to provide telehealth care to patients must also be licensed in the state where the patient is located. And while this licensing requirement can be waived if both the doctor and the patient are located in a Federal facility such as a VA medical center, this still forces a veteran to travel to a VA facility, and applies a separate, unnecessary level of regulation to VA telehealth providers.

These outdated regulations are hurting our Nation's veterans. The Department of Veterans Affairs has successfully been using telemedicine for quite some time. Since 2002, more than 2 million veterans have received telehealth care through the VA. In 2016 alone, more than 12 percent of veterans receiving VA care utilized telehealth in some capacity; 45 percent of these veterans live in rural areas.

Veterans who have access to telehealth are overwhelmingly pleased with the quality of care and access they had received. Those receiving at-home care, for example, cite an 88 percent satisfaction rate.

The VETS Act continues to expand telehealth access for veterans in a responsible manner, allows states to hold providers accountable while increasing access to quality care for veterans who need it. The VETS Act is the result of legislators, practitioners, and advocates coming together to negotiate workable language in good faith, and these efforts will result in veterans across the country gaining access to quality care in the comfort of their homes.

Our veterans should receive the best care available to them and this starts with the passage of the VETS Act.

Again, thank you, Chairman Roe and Ranking Member Walz, for inviting me to testify before the Committee, and I look forward to working with you to expand access to quality care for all our veterans.

Thank you.

[THE PREPARED STATEMENT OF MR. THOMPSON APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

Dr. Dunn, you are now recognized for 5 minutes.

STATEMENT OF HONORABLE NEAL P. DUNN

Mr. DUNN. Thank you, Chairman Roe and Ranking Member Walz, for including my bill, H.R. 2601, the Veterans Increased Choice for Transplant Organs and Recovery Act, VICTOR Act, in today's legislative hearing agenda. I also want to thank all of the witnesses here for their testimony.

It goes without saying that timely organ transplants can make the difference between life and death. It is always a race to bring the organ and the transplant team together on time. Patients have to be ready at a moment's notice, and the stakes and the risks are always high.

The Department of Veterans Affairs has participated in transplant medicine since 1962, but is a relatively small program, which

is limited both by scope and location. As a result, veterans in need of organ transplants suffer unique challenges in trying to receive transplant care.

Currently, when a veteran receives care through the VA for a transplant, they are forced to travel to one of only 14 VA transplant centers throughout the United States. This means that a veteran must be required to travel hundreds or even thousands of miles across several states for a transplant despite potentially passing many other transplant centers on the way.

To illustrate this point, in the United States there are currently 147 liver transplant centers, 141 of those are civilian and six are in the veterans system. As a veteran in Florida who needs a liver transplant, there are seven liver transplant centers in Florida, but they can't go to any of them. They have to travel to Nashville or to Pittsburgh. Similarly, a veteran in California has 13 transplant centers in their state, but cannot go to any of them. The difficulties associated with transplant care are particularly apparent with liver transplants. Given the incidence of end-stage liver disease in the veteran population, liver transplants are especially important, especially live-saving, and a common concern within the VA system.

Out of the 14 veterans centers, just six of these transplant centers are designated for liver transplants. And for those veterans who are waiting for a liver transplant at a veterans center, they face a 32-percent increase in waiting time compared to civilian centers.

The VICTOR Act addresses these challenges by simply reducing the existing barriers to care. If a veteran who needs a transplant lives more than 100 miles away from a veterans transplant center, the bill allows them to seek care at any federally approved transplant center closer to them that also treats Medicare patients.

Speaking as a surgeon, a veteran, and a former student of Tom Starzl, the father of liver transplants, this is the right thing to do. This policy change in transplant medicine builds on our larger strategy to improve the quality of health care access for those who, as Lincoln said, "shall have borne the battle."

Thank you very much, Mr. Chairman, Ranking Member Walz, for allowing me to testify today on behalf of 2601.

I yield back.

[THE PREPARED STATEMENT OF MR. DUNN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Dunn.

Congressman Barr, you are now recognized for 5 minutes.

STATEMENT OF HONORABLE ANDY BARR

Mr. BARR. Good morning. First of all, I would like to thank Chairman Roe and Ranking Member Walz for allowing me the opportunity to speak before the House Veterans' Affairs Committee and all the Members of the Committee this morning about providing access to community care for survivors of military sexual trauma, or MST, which my legislation, H.R. 3642, the Military Sexual Assault Victims Empowerment Act, also known as the Military SAVE Act, helps to improve.

According to the findings of the Department of Veterans Affairs National Screening Program, 1 in 4 women and 1 in 100 men report that they have been victims of military sexual assault during their time serving in the military. This problem was first brought to my attention by a group of very courageous and inspirational female veterans in the 6th Congressional District of Kentucky, led by MST therapist Karen Tufts. Sadly, due in part to the emotional trauma as a result of their MST experiences, two women that were part of this group were lost to suicide.

In fact, according to an independent nationwide study conducted by the National Victims Center, the Medical University of South Carolina, and Florida State University, research has found that female victims of MST are 14 times more likely to commit suicide than women who have never been assaulted.

In addition, according to the Nation's largest anti-sexual violence organization, sexual assault is also commonly associated with adverse mental health outcomes such as depression, anxiety, substance abuse, and non-suicidal self-injury, which are also commonly associated with suicidal ideation attempts and death by suicide.

While Congress has taken several actions recently to better protect survivors of MST within the military justice system, many survivors have expressed concern that services available within the Department of Veterans Affairs health care system may still not match their specific post-MST needs.

This is why I have been working closely with this Committee, Veterans Service Organizations, and my VA Pilot Program Development Task Force in the 6th District of Kentucky, to improve medical care for survivors of MST in order to help get those survivors the care that best fits their unique physical and psychological needs.

This legislation would allow survivors of MST the ability to seek treatment specifically related to their MST injuries by a private health care provider of their choice during a 3-year pilot program. MST survivors would be given a choice: to participate in this pilot program or remain in the VA health care system for treatment options. Participants in both this pilot program and those being treated within the VA health care system for MST-related injuries would participate in a pre-treatment and post-treatment survey, as well as a development survey conducted every 6 months to study individual progress.

This pilot program would study the results of the effects that direct-access care provides that the VA does not.

A certified VA researcher will be assigned as a member of the VA community care office, which will ensure the quality and integrity of collecting and analyzing data for the study, which would then be submitted to Congress for review.

As I mentioned before, this legislation was developed with the contributions of many interested parties. It has been through the dedicated support and trusted advice of MST survivors themselves, and subject matter experts who are members of the VA Pilot Program Development Task Force. And we created this task force by carefully selecting each of these outstanding and in many cases courageous individuals who helped develop and determine what best possible pilot program for MST survivors should look like.

Each of these members brought a unique experience and different skill sets to the table, which was ideal for this task force, and I thank them all for their contributions.

In conclusion, I ask that this legislation be included in the Veteran Coordinated Access and Rewarding Experiences, CARE Act, in order to provide survivors, both male and female, the proper medical care that best fits their unique medical needs, care that they have earned through the service to their country.

Again, thank you for allowing me to testify before this Committee today, and I am happy to answer any questions you may have about this legislation.

I yield back.

[THE PREPARED STATEMENT OF MR. BARR APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

And now I will just simply ask the panel, I know that the Members have other places they need to be, but I will just simply now open it up, first to my colleagues over here. Does anyone have a question of the panel?

STATEMENT OF HONORABLE JULIE BROWLEY

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thanks to all the witnesses who are here today and participating in our hearing.

We will be considering the Choice 2.0 legislation later this morning and I am looking forward to that discussion, but I would like to just briefly note my support for one of the bills that were presented this morning, H.R. 2123, the VETS Act. It has been my pleasure to work with Congressman Thompson on this bill and I thank him for all his efforts pushing the bill forward.

This bill really came out of a field hearing last year that I held with our Health Chairman, Dr. Wenstrup. During that hearing in my district in Ventura County, the VA testified about their growing and successful telemedicine program. The rapid growth of technology has created new possibilities for providing timely, quality health care that best suits veterans' needs, including care at home.

The VA has seen tremendous growth and interest in telehealth, and we should continue to find innovative ways to connect veterans with the providers that they need no matter their physical location. This will particularly help rural veterans and is a key way to expand access to specialty care from the medical centers to the CBOCs, and even into the veteran's home.

Under current law, however, VA doctors can only provide telehealth treatment across state lines if the veteran and the doctor are located in Federal facilities. The VETS Act removes those barriers and allows VA providers to offer treatment free of this restriction. After significant discussions with the relevant stakeholders, including a roundtable last month, we found widespread agreement about this fix.

I would like to enter into the record a recent letter of support for the VETS Act from a broad coalition of patient groups, provider organizations, employers, and payers. This is a targeted fix that will help strengthen the telehealth medicine program at VA.

The VA recently took steps to address this through executive action, which I think is a good step forward, and our bill will codify that action into law.

Thank you, Mr. Chairman, and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding. And, without objection, those letters are submitted for the record.

The CHAIRMAN. Anyone else have a question?

Mr. O'Rourke.

Mr. O'ROURKE. Mr. Chairman, just a quick comment.

I want to thank all of my colleagues who have brought very thoughtful legislation forward and for the fact that so much of it has been inspired by the real-life circumstances of their constituents, the veterans that they are here to serve in Congress.

And I want to especially thank Judge Carter for highlighting the Nelson family and for the example that you give, which is incredibly motivating to us. Sometimes we discuss policy in the abstract, but to actually see you here and know of your sacrifice. I agree with the Chairman that it is not going to just be better for you and others in Leander and Texas, it is really going to be good for veterans across the country. So I want to thank you for being the inspiration for this, and Judge Carter for bringing it to us and to our attention, and hope that it is successful in passing.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And before he leaves here, Coach Luce, hold on just a second before you leave. I don't know whether they caught him or not. I'll get that a little bit later.

Anyone else?

Well, if there are no further questions, the first panel is excused, and I will introduce the second panel momentarily.

Yes, the gentleman who was leaving is one of my very dear friends, who just retired, is head basketball coach where I went to college for 27 years. He is the winningest coach in Ohio Valley Conference history and has won over 500 Division 1 basketball games. So he is a great guy and his wife is here. So he sneaks out before I could introduce him.

[Pause.]

The CHAIRMAN. I am honored to be joined on our second panel by the Honorable Dr. David Shulkin, Secretary of the Department of Veterans Affairs. Secretary Shulkin is accompanied today by Dr. Carolyn Clancy, the Executive in Charge of the Veterans Health Administration, and Dr. Laurie Zephyrin, the Acting Deputy Under Secretary for Health in the Community Care.

Mr. Secretary, thank you for being with us this morning. At your request, we are going to provide a few additional minutes for you to present your testimony. You are now recognized for as much time as may consume.

STATEMENT OF HONORABLE DAVID J. SHULKIN, M.D.

Secretary SHULKIN. Great. Well, Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee, good morning to everybody.

Mr. Chairman, first let me express my deep thanks to you and the entire Committee for your hard work on community care

issues. And thanks for including the VA's Coordinated Access and Rewarding Experiences bill, what I'm going to refer to as the Veterans CARE Act from now on.

The work that all of you have done on accountability, on the GI Bill enhancements, on the PLS modernization, shows that we can work together in a bipartisan way to make dramatic improvements in VA health care and VA services.

And I would agree with you, Ranking Member Walz, that this is the example of Committees in Congress, I tell people we have the best leadership and the best Committees in both the House and the Congress anywhere, that I am very, very proud of the work that all of you do. So, thank you.

The Veterans CARE bill reflects our overarching veterans-centric effort that has been driving our transparency initiative. So you may have seen that we are now posting wait times publicly, we are posting our quality data publicly, we are posting our veterans satisfaction data publicly, and all of that is about empowering veterans with information they need to make the best health care choices. And, most importantly, it is representative of what the private sector has been doing to improve health care over the past decade.

The Veterans CARE bill leaves behind the old days when administrative needs, not the veterans' needs, governed decisions. It is about individualized care, community care, well-coordinated health care designed for a positive experience. The VA will take back customer service and treat veterans as valued customers.

Veterans CARE ensures that veterans get the right care, at the time right time, with the right provider. It is a system that is driven by good clinical decisions rather than administrative rules, where clinical assessment determines what the veteran needs, that is a VA primary care provider or VA specialist, or a primary care provider or specialist in the community, if the community care is the answer the veteran chooses from our integrated, high-performance network.

And if VA doesn't offer the necessary service, if VA can't provide timely services, if there are unusual burdens to receiving care, or if the service at the VA isn't meeting quality metrics compared to the community, we will look towards the community while working hard to improve these services within VA.

Under Veteran CARE eligibility, criteria will align closely with TRICARE and private sector criteria.

And let me just say that we are working closer and better with the Department of Defense than ever before. This plan builds off coordination with the Department of Defense, other Federal agencies, and our community partners.

Under the Veteran CARE Act, veterans will have new access to a network of walk-in clinics for occasional needs such as minor illnesses and injuries. Under Veterans CARE, we are proposing consolidating Choice and all VA's Community Care programs into a single program. Under the Veteran CARE Act, we will make sure the community providers have patient records and we will get the records from veterans back.

Veterans CARE is a new path that gives veterans more to say in their health care, and makes the program work like it should. It is a new direction for VA, where VA is accountable for its own

performance. In my opinion, that is going to mean sustained improvements and modernization in this vital resource. In short, it brings VA health care into the 21st century and in line with the industry best practices.

But the Veteran CARE bill is more than purchasing care outside of VA. Much of the bill aims to strengthen and improve VA health care with enhanced telemedicine authority, as you just discussed; better tools to recruit medical residents and other personnel enhancements; and tools to improve VA's leasing programs, and make it easier for VA to enter into shared facility arrangements with its academic partners and the Department of Defense. They all strengthen our capacity to deliver better health care. I know this Committee shares that goal.

I recognize there are going to be concerns about how we will pay for this new system of care. Over 10 years, the cost will be billions less than maintaining the Choice in Community Care Programs that we currently in place. Savings will come from buying community care smarter and spending less money on administrative processes, so we can invest more money in veterans' care.

We can achieve savings by focusing on clinically-driven care; paying Medicare rates for all community services except in areas with severe provider shortages; reducing administrative burdens; improving internal and external efficiencies in the revenue program to collect more dollars from other health insurance; and using value-based purchasing strategies already proven in the private sector.

We are committed to exploring innovative ways to achieve more efficient health care delivery and will seek authorities to test reforms for that purpose.

This program will require financial offsets and mandatory spending, and I am glad to discuss these offsets.

Mr. Chairman, there is much to commend in the House discussion draft on Community Care that you have presented. I think any bill moving forward must allow veterans greater choice in their site of care; simplify veteran eligibility by replacing administrative rules with clinical criteria; add convenient care benefits; set timely payment standards; allow VA to take back customer service; include provider agreements with flexible payment rates that streamline how we pay for care, including care in State veterans homes; allow VA to record obligations at payment for community care—without this, it is going to be very challenging for us to calculate financial projections, as we have shown—permit medical record sharing in the network when needed for veteran care; consolidate all non-VA care into a simple program; provide additional tools for VA to expand and fill residency positions; and address clinical staffing shortages by improving VA hiring and retention of staff.

We need top-quality health care professionals to deliver excellent care and it is a very competitive market. The direct-hire authority that you provided in Choice funding helped us in hiring network and medical center directors, and I would like to work with you and the Committee to find other ways to address personnel shortages in health care.

Mr. Chairman, to bring Veteran CARE to veterans in October of 2018, we need to move quickly. We need Congress to pass this leg-

islation before December, as you said, Mr. Chairman, to avoid the program running out of money in the Choice Program, and to give veterans a system that works, and that meets or exceeds the best the private sector has to offer.

This is about building a VA that veterans choose for their care. We want veterans to choose VA.

Thank you, and I look forward to your questions.

[THE PREPARED STATEMENT OF SECRETARY SHULKIN APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the gentleman for yielding.

I will now yield myself 5 minutes for questions.

And thank you very much, Mr. Secretary, for being here. Your written testimony notes that the cost of the CARE proposal are still being discussed with OMB, and what is the status of those discussions, and when do you expect to have more information regarding the bill's budgetary impact?

Secretary SHULKIN. Well, Mr. Chairman, you are correct, we still are in discussions with OMB. We have presented very detailed descriptions of where we think that these cost savings will come and what the overall cost impact will be. And as I said in my oral testimony, we believe that this program, compared to continuing Choice and Community Care Programs as they are, will actually be billions of dollars less over 10 years.

The reason for those cost savings are, we believe by recording community care obligations at the time of payment, that is going to save money. When we make it easier to share information with community providers, we are going to avoid duplicative testing and have money savings. We are going to have increased authorities to collect money, to do better in our collections. But mostly it is going to be the decreased administrative costs.

The administrative costs associated with the Choice Program in its complexity has been extremely high, 13 percent of all money goes towards administrative costs, and that is not consistent with what the private sector would do.

So we want to save on administrative costs and invest that into both the VA system and more care that veterans can receive in the community.

The CHAIRMAN. A couple things that we—the system that we have put together is really no different than what you see, what I personally have, which is a gatekeeper. I have a physician, a primary care doctor that I go to; depending on what my primary care doctor says, I am then referred if I need a specialist. That is pretty much what we are saying. If the specialty care can be provided within the VA, it is done so, and, if not, referred out.

And here is my concern, and your proposal was a little light on details, is what if there is a conflict when the veteran goes in about either specialty care and/or primary care? We know that, I visited Medford, Washington with Greg Walden, Chairman Walden about a week ago, and they are short four PACT teams there. So if a veteran calls in at Medford, they can't get in because there is no PACT team there.

So two things: What does that veteran do? And then, one, when there is a conflict, if they get in there, how do you get out of the system if you want out? That is Choice. So how is that resolved?

Secretary SHULKIN. Well, there is a lot there and we have actually worked a lot on these details. So I am not going to be able to do everything right here, but let me just comment exactly on what you said.

I completely agree. We are trying to model this after the way that you and I have practiced medicine, and the way it is practiced across America. Doctors, patients, providers, patients, make decisions on what's best for the patient. So that is clinical criteria as opposed to a bunch of rules like 40 miles in 30 days. So we want the rules to go away; we want this to be a clinical decision.

What we have learned over the past couple years in VA is, first of all, our top priority is to define the clinical urgency of a problem. That concept was missing a couple years ago in VA when we got into trouble in Phoenix with the wait time crisis. So there will be no issues when patients have clinically urgent needs.

And we are also going to add or propose to add this convenience care benefit, so that people don't have to drive in hundreds of miles just to get something simple.

When it comes to what you are talking about, which is where many people say, look, the VA can provide something within a clinically appropriate time, but I would rather not wait that long; I would rather go someplace more convenient. This is where we want to align with the TRICARE eligibility criteria and align with private sector standards.

And so we are prepared to sit down and to share some of those eligibility criteria on how we would deal with that, just like any other health system does.

The CHAIRMAN. The other thing is, if I get in there and I am seeing you as my doctor, and it is just not working out, and there is no other—how is that resolved where that veteran can then get either outside care or if they can't provide a PACT team in there? I think that is critical, because we have trapped the veteran in the same system if it didn't work. And so how is that resolved?

Secretary SHULKIN. What we are signaling in this is beginning to start doing what we should have been doing more, which is giving the veteran more choice in the say of their care. There is no doubt about that. You know, in the private sector we are seeing more consumer-driven health care and we need to be moving in the same direction.

Nobody should feel trapped in the VA system. What you are seeing here is, we are saying where the VA is not meeting community quality standards, we want to give veterans more choice. Where the capacity isn't there, like you are talking about where the PACT teams cannot handle the capacity or the demand, that is where we will give veterans more choice in the community.

The CHAIRMAN. Okay. My time has expired.

Mr. Walz, you are recognized.

Mr. WALZ. Well, thank you.

Secretary Shulkin, again, thank you. As I said, no one is more accessible, no one is more engaged in talking to folks, and I am

grateful. That changes the entire dialogue and helps us be successful.

Dr. Zephyrin, thank you for being in the work you do. And, Dr. Clancy, thank you once again.

I was just thinking in my head, I think you and I have the most seniority of the people here today. You keep stepping back into the breach and for that I am grateful.

Up in International Falls again, I bring it back, because if you want the example of rural, if you want the example of people who are committed to this, of trying to get the care. I asked them in a room of about 100 veterans and family, how many have used Choice, about 30; how many had successful experiences, two. It didn't change their concept, though, that we needed to make this work.

And I think all of us in here, the reason we have been successful is that we have tried to make sure there is not a hidden agenda, there is not—people fear VA is a choice. Being able to get into a VA hospital with a fully-staffed staff is a choice with people too. And every time we say and we all are up here, and I think we have talked about this before, every time we say it is not privatization, it is the exercise in don't think of a draft, that is exactly what they are thinking about.

So if the idea is, we have to figure this out, emergency funding for Choice cannot continue. That is what we have all talked about, we have to fund this. We have to understand what is the proper balance that is struck between a VA that, as the Chairman always said, we have always used CARE in the community, we have always tried to figure that part out.

I think getting veterans engaged in this, making sure they are very clear about what this is and where these intersect is absolutely critical, because I think most of us agree on principle that getting veterans timely access to health care as near to home as possible in a manner they want, that is what we should do. Trying to match that up, it is no small thing. As we found out when we first did Choice, you can't have the concept and not talk about the money, because when they came back from CBO with $100 billion, a lot of people stepped back and re-looked at this.

So with that being said, how does a draft VA proposal and the HVAC proposal align or not align with that request for a proposal that was issued last year? How is the alignment happening here, as you see it?

Secretary SHULKIN. With the proposal last year?

Mr. WALZ. The RFP that was issued, December, is that correct?

Secretary SHULKIN. Oh, yes, yes, yeah.

I think that these are working out very well in terms of the alignment. What we are looking for in revising the approach towards the Choice Program, what we learned is, is that VA needs to take back customer service, you can't outsource that. No successful company does that and survives. And we learned that the relationships that we have developed with our veterans over the years is very important to maintain.

So the RFP is out there. What that is going to do is to ask for external help in areas that VA does not have expertise. It is network development and maintaining the network in potentially

processing claims and in paying bills, and in some of the other administrative areas that we have put into the RFP.

We believe we are going to have to phase in that RFP over the next year, because we can't do everything at once and we want to do this well. Again, another lesson that we learned from the Choice Program when we tried to turn it on across the country all at once in 90 days.

So I think that this is a well-thought-out plan and I think we all align well.

Mr. WALZ. Okay. I think all of us are trying to get simplicity here. A lot of those failures were complexity. So you talked about consolidating into a single program. A few bills on today's agenda seek to make changes to Veterans Choice. In your opinion, based on the fact the Committee is discussing draft legislation to consolidate CARE, does it make sense to do that in best practices? Because it is well intentioned, but once again, we are talking about consolidation and streamlining, and we are proposing things to do carve outs and start different tracks.

Secretary SHULKIN. Well, there were a lot of really good ideas presented on the first panel and there is no doubt that everybody is addressing significant issues with the various bills. I think that we would have to sort of go through them one by one. Some are absolutely essential to do.

Our family from Texas, there is no reason we shouldn't be able to take an unrelated or non-veteran donor and be able to help a veteran, that is absolutely clear. Others, I think that we would want to do is to make sure that we are not making the program more complex by setting a whole bunch of different rules.

But the intents of these programs are all well designed, focusing on suicide, military sexual trauma, mental health issues, and we want to work with the Members and the Committee to make sure we can accomplish that.

Mr. WALZ. I appreciate that.

I yield back, Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Bilirakis, you are recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it very much. And thank you, Mr. Secretary, for thinking outside the box and putting our veterans first, I really appreciate that so very much, and being so open-minded when it comes to this.

Can you speak to how you envision VA assessing and monitoring the quality of care received in the community, and whether you believe community providers should be required to meet or excel the same quality standards VA providers are required to meet? And if so, how would you accomplish that? Is that something the VA can do on its own or will it require legislation?

Secretary SHULKIN. Yeah, Congressman, we have a very extensive set of metrics in which to do that, but I have to my left Dr. Clancy, one of the country's experts on this and it is her area of responsibility, so I am going to ask her to talk to that.

Dr. CLANCY. So it is a very, very important question. The issue of what you can learn about the quality of care in the community is a picture that is changing and growing rapidly, because more and more people want to know. If I am going to seek care from Dr.

Hill or Dr. Roe, how do I know that that is the right provider for me?

It is a bit spotty right now, but we are working with private sector partners, and they too are facing increased demands from the private and public sectors to be far more transparent about their care. Right now, the greatest transparency that we see is in cardiology, because their professional organization has been building this out for a while, but we will see more and more of that over time.

And that becomes a big resource for us to be able to hold ourselves accountable that we are providing care that is at least comparable, and hopefully better, than that provided in the private sector. But it is also going to be, as Dr. Shulkin just said, a key part of our decision matrix in terms of when are veterans eligible for Choice or care in the community.

Mr. BILIRAKIS. Thank you. Thank you. Please continue to communicate with us on that issue.

Mr. Secretary, Doctor, of course, please respond to concerns that the $2.1 billion Congress provided in August to supplement the Choice Act, the fund will run out before the end of the 6-month period that money was intended to cover. How much money is in the Choice Act now and do you have any concerns that the VA will over-obligate that fund before the end of the year?

So we just want a report on what is there.

Secretary SHULKIN. Yes. There were some erroneous reports earlier that we were quickly running out of money on that fund, that is not the case. We do plan on the $2.1 billion lasting until the end of the year. As you know, you authorized this again in August, so we believe we will get through the end of the calendar year.

I think as the Chairman said and I reiterated, we believe there is some urgency to get this done before the December recess so we don't fall into crisis. We are tracking the financial projections on the $2.1 billion and it is tracking according to plan; we follow it every week.

Having said that, this is a very challenging program to do financial projections on. I know it sounds like it should be easy, but when you have to record your payments before, when you have to obligate your funds before you provide the service, it is like looking into a crystal ball and trying to guess what services a veteran will use, and no other private sector company would do that.

So that it is very tough for us to do this, but we are doing the best we can and we think that we are on plan.

Mr. BILIRAKIS. Okay, very good. Thank you.

Skilled nursing care centers were not included in the Choice Program as an eligible provider, as you know. Utilizing existing resources like skilled nursing centers could help alleviate access issues for quality care, again, in our own communities.

Does the VA support provider agreements for skilled nursing centers? And can you explain potential benefits or initial concerns?

Secretary SHULKIN. Yes, we do support that.

Right now, as you know, Medicare reports on the quality of community nursing centers and many of the most popular or highest quality nursing centers won't deal with the VA because of the complexity of our Federal contracting rules and the requirements that

we put in place. Provider agreements and being able to do this directly with the skilled nursing facilities with less burdensome contracting rules would help veterans, it would allow us to have access to the best centers that are out there in the community.

So we would very much support that.

Mr. BILIRAKIS. Thank you for that input, I appreciate that. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Takano, you are recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Secretary Shulkin, my first question is about the Veterans Crisis Line. I recently came back from a codel to visit deported veterans living in Tijuana, Mexico. I traveled with my fellow Committee Members Representatives Correa and Rice, and while there we learned that veterans abroad can't access the Veterans Crisis Line. We tried calling from several different cell phones and land lines, but couldn't get through. This doesn't just affect deported veterans, it affects any veteran living or traveling abroad who may need immediate access to the VCL.

While I understand today's draft legislation to study the VCL doesn't focus on veterans abroad, has the VA looked into creating a toll-free line that veterans could call when they are out of the country?

Secretary SHULKIN. You know, I will ask the Members that are—Dr. Clancy and Dr. Zephyrin. I was not aware of that and I don't see any reason why we wouldn't want to do that. Our goal with the Veterans Crisis Line should be to help anybody who needs help and I was not aware that you couldn't call from abroad and reach the number.

So that is something that I don't think would be technically difficult to do and we should be able to do that.

Mr. TAKANO. I thank you for that answer, Mr. Secretary. And, you know, we have many deported veterans who wore the uniform of the United States, some in combat, one veteran was actually at the barracks in Lebanon that was bombed, and I believe veterans like this should be able to get access to that crisis line.

What kind of resources or support would the VA need from Congress so that veterans could access the VCL from anywhere in the world?

Secretary SHULKIN. Well, as I said, I don't see it as a technically difficult process to have. You know, on the back of your credit card you have one phone number when you are trying to reach it domestically and one internationally. So I think that we should be able to work with our telecommunications provider to set up a toll-free number.

Mr. TAKANO. Well, I certainly hope to engage with you on this issue further.

Secretary SHULKIN. Yes.

Mr. TAKANO. Secretary Shulkin, two of the draft bills before us today make changes to the VA's graduate medical school education residencies, including the VA's CARE Act. I was thrilled when the Choice Act included 1500 residency slots to help train and attract doctors to the VA.

In part, thanks to Choice, the University of California Riverside School of Medicine in my district has been able to build an academic affiliation with the VA Loma Linda Health Care System to gain residency slots and begin treating veterans in our local CBOCs.

I would like to ask unanimous consent right now to insert into the record a letter from Dr. Deborah Deas, Dean of the UCR Medical School of Medicine, commenting on the current program and the program bills we are discussing today.

The CHAIRMAN. Without objection, so ordered.

Mr. TAKANO. Thank you, Mr. Chairman.

Dean Deas raises questions about what incentives residents have to enter into the service-obligated residencies in the draft legislation. What incentive is there for veterans to apply for these residencies? And I think that is a concern about whether or not they would apply.

Secretary SHULKIN. Well, first of all, thank you for being a consistent champion on this effort.

Mr. TAKANO. Of course.

Secretary SHULKIN. I know that you have strongly supported the expansion of graduate medical education and strengthening people joining VA as a career.

This has been my private sector life, working in academic centers and running graduate medical education programs, so I have an opinion on this, and I'm sure the Dean does too and I would be glad to follow up with her.

We are now in a situation where there are more U.S. medical school graduates than residency spots. So it is becoming extremely competitive to get a graduate medical education spot. If the VA expands the number of spots available, I believe these will be highly competitive positions for highly competitive candidates.

The best asset that the VA has is its academic partners, thanks to General Bradley in 1946 and his vision of establishing these teaching relationships. So you are going to have the very best medical schools and residency programs in the country expanding spots and medical students deciding whether they want to apply for those spots or not, even if they are tied to giving back service to the VA.

So I believe it will be an experiment whether they are competitive. I believe these spots will fill. I believe our academic partners have terrific teaching programs and people will want to be in those residency spots.

Mr. TAKANO. Wonderful. I think the question is whether our most competitive medical students will want those residency spots. But I wish I could ask you a couple more questions, but my time is up and I will submit them for the record, and they are related to mainly the residencies.

But thank you so much for your testimony.

The CHAIRMAN. I thank the gentleman for yielding.

General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman and Ranking Member Walz. And Dr. Shulkin, it is always good to see you and Dr. Clancy and Dr. Zephyrin here. I know you appear before us quite regularly.

Dr. Shulkin, you mentioned earlier that VA must take back customer service. Does that mean that the VA will be moving towards, shall we say, reducing third-party contracts which naturally create, if you will, a disconnect between the VA and the veteran?

Secretary SHULKIN. Yes, I think that is exactly what it means. And, Dr. Zephyrin, maybe you want to expand on that.

Dr. ZEPHYRIN. Sure, absolutely. Thank you for your question.

So by taking back, taking back the administrative services and really connecting with the veteran directly is going to be critical. When we talked with veteran stakeholders, when we talked with community providers, when we talked with our staff at the medical centers, that was the area that was most lacking in Choice. And so with our new CCN, we will actually be taking back scheduling, taking back communication with the veteran, and really the veteran will really—and also taking back care coordination as well, so that we are interfacing with veterans directly.

Mr. BERGMAN. Thank you.

Also, I have this was a news release dated July 7th, 2016 about "VA Conducts Nation's Largest Analysis of Veteran Suicide." You know, we have talked a little bit before about those 20-some veterans a day and the breakdown of, as I look at the numbers here, the question still is a little bit unanswered in my mind of those veterans, especially in the OIF/OEF, who have actually been in the fight. Because we know that in an all-recruited force, that we have not an all-volunteer force in this country, an all-recruited force, that the demographics of those young men and women who join and, you swear an oath to support and defend the Constitution, that doesn't necessarily reflect a cross-section of the age-eligible people in our society.

Further take that into that subcategory of those who did sign, those who did complete training, those who did deploy, but those who deployed let's say into areas that didn't put them out on combat patrols, in combat convoys, and different things that are those natural mental stressors.

What I am still looking for is how we—we, you know, the VA, in conjunction with DoD—continue to dissect the relevant data to see where the stressors are. And I just, I mean, if you have any comments, anybody, I would like to hear them.

Secretary SHULKIN. Well, our data analysis capabilities have been limited. We are able to identify those that are deployed out of country and so we do some analyses that way, but we have not been able to do the finer analyses that you are talking about, about what type of conflict and what their duties have been. We continue to work with the Department of Defense on that.

What we do know, and I am sure you are aware, that there are clusters of suicides that come out of specific units, and they may be exactly the types of factors that you are talking about. And so we are working with particularly the Marines in some of the recent clusters of suicides to try to dissect that and understand that further.

Mr. BERGMAN. Well, it is relevant and essential that we don't create support structures that don't hit the target, if you will, because the goal is to help our veterans work through those naturally difficult and stressful times that life gives all of us, work them

through the rough spots and a, you know, one-size-fits-all, cookie-cutter approach does not work.

And thank you, thank you for continuing to lead and to make those tough decisions as only a secretary of a department gets to do. So thank you for continuing to do that.

And, with that, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for your continued service to our Nation's veterans.

I wanted to ask a question relative to telemedicine. You heard our discussion earlier and I am very, very interested in breaking down barriers, so that telemedicine certainly can be utilized for our veteran community. And Representative Thompson and I have worked on the VETS Act bill and I can assure you, it has taken almost a year to get consensus really from all of the stakeholders, internally and externally, to get consensus around this bill.

And then I have noticed that in your proposal that you have chosen different language around telemedicine. And so I was wondering if you could tell us a little bit, you know, why and for what purpose your approach is?

Secretary SHULKIN. Yes. Well, first of all, thank you for leading this and this is very important. As you know, VA is already the largest provider of telehealth services, but those barriers that you have identified are real and we want to get them addressed.

I am not aware of any meaningful differences between what you are trying to do and what we are trying to do. We very much support your bill, and I would be glad to go back and understand why there are language differences, but your bill I think hits exactly what we want to do.

The one area that I know that we were concerned with and that some of our stakeholders or outside stakeholders were concerned with is, is that we were only seeking authorities for VA employees and VA clinicians, and not trying to expand this beyond into the community providers, which I think is a whole different set of issues. But I looked at your bill and I don't see any problems with it.

Ms. BROWNLEY. Well, I am happy to hear that answer. I think, you know, our interpretation of the language in your proposal would expand the use of telemedicine, which, you know, I think in the future we want to get there. But basically, the way I understand it, it would include contracting authority or other community care options, which is, you know, taking those community clinicians and saying, yes, you can use telemedicine too. And I think, obviously, the stakeholders and so forth involved in this are very worried about liability issues and other kinds of things, and certainly liability from the VA if this was extended that way.

So I think that is where the rub is, so to speak. So I certainly would like to pursue further the conversation.

Another question are really around choke points in the system and I think back in March the GA testimony laid out a lot of different choke points, you know, the VA preparing and sending the veteran's clinical files or the contractors waiting 10 days to hear back from the veteran. So I am wondering from you and the VA

perspective on how you are going to address some of these choke points.

Secretary SHULKIN. Yes. I mean, I invite either of you to join in on this.

Many of these choke points are related to the administrative complexity of running multiple programs. As you know, we have seven different ways of choosing how we pay for community care. We don't seem to get exactly the spending rate out of each of the buckets to align all the time, which is the difficulty with our financial projections. But what we want to do is to simplify this, to take some of the red tape out, to put veterans more in control of their decision-making, in many cases take having to do unnecessary steps and multiple calls completely out of the way.

I think that will eliminate many of the choke points, probably not all of them, and we are going to continue to have to work at this system until we can get it so it is completely user-friendly, but I think what we are proposing is a big step forward.

Ms. BROWNLEY. Thank you. And just lastly, I only have a few more seconds left, I think, you know, health record interoperability is going to be, you know, a big savior to all of this, but I guess I would just like to hear your perspective on the feasibility and the timing. I mean, when do you really—and I really want an honest answer here—when do you really think we will have true interoperability?

The CHAIRMAN. Thirty seconds or less.

Secretary SHULKIN. Okay. We have given Congress a 30-day notification of our intent to negotiate a contract that would give us the true interoperability with the Department of Defense. We released last week in the Federal Register an RFI for industry to help us with interoperability for community providers. This is a total package where that is what we seek, real and full, true interoperability for veterans.

Ms. BROWNLEY. Thank you.

I apologize, I yield back.

The CHAIRMAN. I thank the gentlelady for yielding. Four and a half minutes next time around.

[Laughter.]

The CHAIRMAN. Mr. Higgins, you are recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman, and I thank the Ranking Member for your leadership in drafting this Choice legislation that would better serve our veterans.

And, Mr. Secretary, I thank you for your continued dedication towards the same cause.

The newly established coordination between the DoD and the VA is long overdue and it is just great to hear as a veteran. And I believe this will help ensure, you know, a seamless transition for our veterans. It is just a commonsense approach, which the bipartisan nature of this Committee and your own dedicated efforts certainly reflect a commonsense approach that we are all looking for.

I was pleased to see that the VA included in its draft CARE legislation provisions allowing for the certain use of urgent care walk-in medical facilities. Would you please speak to how you and the VA envision the use of urgent care facilities for our veterans?

Secretary SHULKIN. Yes. This would be an added new benefit. We think having a veteran have to drive 100 miles to get a lab test or a flu shot or something simple for a minor illness just doesn't make sense, it is not good for veterans. So we would add a benefit.

A national network of urgent care would be developed by our third party. We would allow veterans two visits a year under essentially their current structure, which would be no payment for service-connected veterans and a small copay that currently exists for non-service-connected veterans. After two visits a year, there would be an additional or a copay that would be required, so that we could control the cost of a new benefit, but still allow veterans to have access to these services in their community.

Mr. HIGGINS. And this would in its very nature expand the choice available to—

Secretary SHULKIN. Yes.

Mr. HIGGINS [continued]. —our veterans. There is a large difference between driving 5 blocks to have a sprained ankle treated or driving 50 miles or 100 miles and waiting 9 hours to get the same treatments.

Secretary SHULKIN. Exactly. Yes, this doesn't exist today, so it would be a new benefit.

Mr. HIGGINS. Yes, a reasonable copay is certainly something that most veterans would not argue about.

I was also pleased to see the VA included provisions to enable medical facility sharing with other departments, as well as expanded and enhanced use lease authority. Could you please elaborate on the VA's future vision for facility sharing and extended use leases, sir?

Secretary SHULKIN. Yes. Well, first of all, I think you are absolutely right, Congressman, that there has never been a closer relationship and better working relationship with the Department of Defense, and I have to thank Secretary Mattis for that spirit of cooperation.

We now have discussions going on all over the country about where the Department of Defense has excess capacity and where we have veterans that need care and services, and vice versa. And so we are working to figure out what makes sense for veterans, active servicemembers, and the taxpayers in coming up with a number of different plans and facilities.

And so what you are going to see, I think we are asking for some ability even in this legislation to avoid having to exchange bills. You know, we are probably spending more on administrative costs than we are on taking care of, you know, our veterans in this case. So we want to try to decrease some of the barriers and regulations to doing more of this work together.

Mr. HIGGINS. Thank you, sir, for your answers. And I again commend you and your staff for working tirelessly as we endeavor to reform the VA and provide greater service for our veterans that certainly deserve it.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman. And thank you, Secretary Shulkin, for being with us.

I want to first thank you publicly for your prompt response and support in New Hampshire to the problems that we are having at the Manchester VA and the changes that you are making to the administration there, and we look forward to continuing to work with you. And in particular the task force that is looking into how to restructure availability of access to health care for every veteran within the State of New Hampshire.

So along those lines, how will the VA consider geographic, seasonal, and other issues around eligibility? And, in particular, can you comment on the reasonable-distance standard? In New Hampshire, we don't have a full-service VA hospital and people have to travel long distances in the mountains and the snow. How will these decisions be made? Is it a case-by-case basis, is it subjective, or are there guidelines?

Secretary SHULKIN. Yes. Great, great questions, and I think the Chairman was referring to this as well where he said the details are very important in this.

The short answer is, is that we want this done on clinical criteria. So we want a provider and a patient making the best decision for the patient. When it comes to New Hampshire, neurosurgery, as long as it is not urgent or emergent, we do believe will still be referred to regional providers. Maybe in the case of New Hampshire continue to flow into Boston.

But we don't believe that you should have strict mileage criteria or wait time criteria, because there are patients that, frankly, are not able to get into VAs who may live 20 miles away where it is best for them to get care in the community. So this 40-mile standard just isn't what is best for them. There are others that may live 45 miles away, but getting into a regional medical center is not a problem.

So these are going to be individual, clinical decisions, and based on feasibility and access, and the drive time in the West may be easier to get to in a certain amount of mileage than it would be in a more congested area.

Ms. KUSTER. Okay. Thank you.

Another question about VA CARE proposal, you include innovative pilot programs, and I wanted to ask if you have ever considered—in your proposal you include them between Department of Defense and Veterans Affairs, I have legislation to establish pilot programs to coordinate health care resources with other providers, including specifically federally qualified health centers, and I just wonder if you have thought about that.

For example, in my rural district that is where the veterans frequently get their health care. It is a comprehensive health care with dental and eye care and podiatry, which I know has a big, long wait list at the VA. Have you considered that and would you consider a pilot project?

Secretary SHULKIN. Well, as Congressman Higgins said, we have included the piece about the Department of Defense, but, frankly, it just makes sense to do this with all Federal agencies. Federally qualified health centers, absolutely; Indian health service, absolutely. We have just announced the first time a relationship with the Public Health Service, so Public Health Service officers can begin to serve in the VA.

So, 100 percent we believe this is good for veterans and good for taxpayers, and we want to pursue that.

In addition, we want to pursue the things that we know the private sector has already shown makes sense. Our current system allows us to pay a Medicare fee schedule flat, that is not happening anymore in the private sector. I used to run a very large accountable care organization. We know these work, we know that value-based purchasing works, differential payments. We want those same systems for the VA, and we want that authority and flexibility to test these out.

Ms. KUSTER. Good. Thank you.

And just very briefly, at the end there is VACA, the 2014 bill had 1500 positions for graduate medical education residency, have those all been used? And why not just increase that program? Why do you start over with a new program?

Secretary SHULKIN. Thank you for this question. I wanted to try to get this with Representative Takano, but I didn't have time.

So you gave us 1500 positions, we have only used 750 of them. And the reason is, is that the program, the way it was designed, well intentioned, for all the right reasons, we learned some challenges over these last 3 years. The first is, is that we are only allowed to pay for the time the resident is in VA. So the academic partners have to come up with their own money to at least match that and they are capped out at the Medicare rate. So that is essentially one of the big problems.

So the other problem is, is that as we train more residents, they don't necessarily come back to the VA. We are training them and they are going out into the community, which is fine, it doesn't necessarily help VA.

So what we are proposing is to do this smarter: allow the VA to pay for the entire cost of the resident, that way academic programs are going to want to train more residents, because that is what they do and that is what they do well, but tie it back to a service component back into the VA.

So it is what we have learned over the last 3 years, why we have only used half the spots you gave us. We would like to suspend that program and invest that money back into a new, better-designed program.

Ms. KUSTER. Thank you, and I am well over time.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Dr. Dunn, you are recognized for 5 minutes.

Mr. DUNN. Thank you very much, Mr. Chairman.

Let me echo the comments that have been made by Ranking Member Walz and others that you have made yourself very available to this Committee and that is a breath of fresh air, and also you are a great partner, you and your professionals. Thank you so much.

So I want to address the VICTOR Act, that is one of the two organ transplant bills that are sitting before us. And I know, with your background you understand the barriers that time and distance impose, specifically on transplant medicine. How do you suggest that we can better meet the specialized needs of the transplant patients in a consolidated community care program?

Secretary SHULKIN. Right. Well, first of all, I have already indicated my strong support for allowing us to be able to access a non-veteran donor. And I think that the way that you presented your testimony today just makes a great deal of sense. You want what is best for veterans, and you know that getting organs and getting it done well is a challenging program anywhere in the country.

So what I think we want to try to come out of this with, and hopefully to work closely with you to do this, is to make sure that veterans that need access to organs have the best available access. And in particularly cases of urgent transplantation, we do want the ability to use community programs, but we also want to make sure that we maintain the strength of the transplant programs in the VA. So it is this balance between making sure that the 14 sites or 21 different transplant programs that we have are strengthened and supported, and at the same time making sure that veterans who need access to those community programs have them.

Mr. DUNN. Thank you. Can you compare the costs of delivering, just say a liver transplant in a VA transplant center as compared to a civilian center?

Secretary SHULKIN. Well, one of the—our transplant programs do many things; they care for pre-transplant

work-ups and post-transplant work-ups. So when you take a look at the entire package of these 21 different transplant programs at 14 sites, we think that they are less costly than the private sector alternative.

When we send patients out through the Choice Program for transplants, we pay the Medicare fee schedule. It is very challenging to get a private sector hospital to accept the Medicare fee schedule rate for transplantation. So that what we are seeing is, is that the costs in the private sector can be in some cases higher. Now, quality is what makes the biggest difference, because you don't want to have to re-transplant an organ, that is where it can get really costly.

Mr. DUNN. So if I could just make a comment to your answer, which is the other transplant bill, Judge Carter's bill, which was the living related donors being covered in the VA, is a great answer for keeping your VA—

Secretary SHULKIN. Yes.

Mr. DUNN [continued]. —centers busy and actually, as you say, training up to snuff. That is a beautiful dovetail there of those two.

So it is fair to say, listening sort of in between the lines here, that there is no clinical purpose that is served by requiring veterans per se to be driving past these other centers to get to VA centers?

Secretary SHULKIN. Right.

Mr. DUNN. Very good. Thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you.

Mr. Shulkin, I first want to begin by again thanking you for your service, and commending the Administration for nominating you and the Senate for confirming you. We are grateful for your responsiveness and the work that you and your team are doing.

I want to make sure, though, that I don't let you off the hook. Ms. Brownley asked you a very good question and you didn't answer it. She asked you how long it would take to get an electronic health records system going, true interoperability with Department of Defense, and much of your plan is predicated on ensuring that we confidentially and yet effectively share private patient health record information with providers in the community, how long for us to be able to implement that effectively 100 percent?

Secretary SHULKIN. Well, thank you for holding me accountable, but, you know, I was sensitive to her time that was running out.

Mr. O'ROURKE. Don't use too much of mine, because I have other questions.

[Laughter.]

Secretary SHULKIN. Okay. The answer is, once we negotiate the contract, it will be 18 months from the time that the contract is complete to the first site in VA going up.

Mr. O'ROURKE. How about, to fully answer my question, to get to 100 percent?

Secretary SHULKIN. We are thinking 7 to 8 years.

Mr. O'ROURKE. Okay. It is good for us to know and to be aware of as we think about implementing this that we are looking at 7 to 8 years. And this is not a scientific analysis, but I have yet to see a VA budget for time or cost exceeded, you know, it usually goes beyond the budgeted time, beyond the budgeted costs. So I think that is important for us to—

Secretary SHULKIN. This is a new VA, Congressman.

Mr. O'ROURKE. Well, I am encouraged by what you have done so far, but I want to make sure that we are going into this eyes wide open.

Secretary SHULKIN. Yes.

Mr. O'ROURKE. You have seen a number of proposals to reduce veteran suicide, many just here today. You know that Representative Coffman has been an exceptional leader on this Committee on this. We were able to join him on a proposal to reduce suicides from those veterans who have an other than honorable discharge.

You have told me you are doing everything you can to your administrative capacity to admit people on an emergency basis. For those OTH veterans who are precluded from getting care now, we are dependent on the bill that we passed out of this Committee and I believe has been passed in the Senate from getting to the floor, and I want to work with Chairman Roe and the Administration to make sure that it has got the political push to get that done. I think that is going to make a huge difference.

I want to ask you, using an example in El Paso, how you can both now administratively meet the crisis, and, two, how you will be able to do that through your proposed legislation.

While we have seen the number of total health care providers delivering mental health care in El Paso increase from 68 providers to 112 today, we just got the third quarter sale data and we see a drop of 222 percent in continuity of care for mental health care provision. I can only imagine what that means for the veterans who have been trying to receive that care.

I want to know you are going to meet that challenge in El Paso and in VA medical centers and clinics around the country, because

I think it is directly connected to ensuring that more veterans live and do not take their own lives. And, two, and I think this is related, how you are going to better focus on hiring and retaining the best primary care providers. We have a real crisis in El Paso and, from traveling Texas, I am hearing it in community after community, people unable to get to see a primary care provider or losing that primary care provider and not having a replacement.

So I asked you a bunch, we have got about a minute and a half left, I will let you answer.

Secretary SHULKIN. And you are going to make sure I answer them all.

Mr. O'ROURKE. Okay, thanks.

Secretary SHULKIN. Very quickly. Look, our top clinical priority is suicide. We also are very grateful to Representative Coffman for his leadership on other than honorable. We took some initial steps, we think that, working with you, we need to go much further. You are going to hear some announcements from us in the month of November. We are going to take some additional, very big, bold steps to address the transition problem, addressing suicide with active servicemembers coming out of the Department of Defense. We are working with the Department of Defense on that now.

We are working on new, innovative ways to address the mental health issue. We are looking at new ways of using telehealth to get more access for mental health, some ideas that we haven't yet shared with you, but we are working on right now. We need your help on hiring and retention.

As you know, I am not very happy that our retention and recruitment dollars were cut in half to pay for the CARE Act. I have asked for the authority to spend more on retention and recruitment without any additional dollars to the budget. I want the flexibility to put money towards paying our providers more and providing retention and recruitment bonuses where we are needed.

We need greater direct hire authority on those mental health workers that are now Title 5 or Title 38 hybrids, such as psychologists and licensed social workers. It is too hard to get them hired and we need that. We need it from you. Just put it into the bill, direct hire authority for mental health professionals, and that would be a great help to us.

We essentially are trying to hire 1,000 more mental health professionals. Over this past year, we went backwards by 45. We hired 900, but we lost 945. So we need to do more. And primary care doctors are challenging as well.

So we would love to work with you on additional help.

Mr. O'ROURKE. Thank you.

Thank you, Chairman, for the additional time.

The CHAIRMAN. I think that is something we can put in the bill. I have no objection to that at all.

Dr. Wenstrup.

Mr. WENSTRUP. I think it goes to Mrs. Radewagen.

The CHAIRMAN. Mrs. Radewagen, you are recognized.

Mrs. RADEWAGEN. Thank you, Mr. Chairman and Ranking Member, for holding this hearing today. And I also want to thank Secretary Shulkin and the rest of the witnesses for their testimony.

As you know, Secretary Shulkin, one of the challenges veterans in remote areas like the U.S. Territories face is a lack of access to care. Not only do they find themselves traveling ludicrous distances to receive VA care, but often the local community is also lacking sufficient health care facilities to meet their needs closer to home. Even if this very important legislation passes and veterans are able to take advantage of community care, little will change if there is no accessible care in their communities in the first place.

I have a few questions, I am going to put them all out there.

Secretary SHULKIN. Yes.

Mrs. RADEWAGEN. Mr. Secretary, your draft legislation would allow the VA to coordinate and share resources with other Federal agencies for the purposes of developing shared medical facilities. How can this be used for the benefit of our veterans in remote areas? Will this bill allow VA to develop or build upon medical facilities in the territories that meet care standards and allow our veterans to receive care close to home?

Another proposed solution to provide care for veterans in remote areas is the use of telehealth, as was mentioned, something we are addressing today with Representatives Thompson and Brownley's bill, H.R. 2123.

Mr. Secretary, VFW's written statement alleges that some VA providers are actually reluctant to provide telemedicine across state lines under the authority granted by an executive order. Similarly, AFGE's written statement for the record alleges that VA providers have serious concerns about risks to their state medical licenses even if such authority were granted via legislation, and have received no assurances that VA would offer assistance to them if state licensing boards pursue disciplinary actions against them for violating state licensing requirements.

Would you please respond—

Secretary SHULKIN. Yeah, yeah.

Mrs. RADEWAGEN [continued]. —to those allegations?

Secretary SHULKIN. Well, thank you for continuing to keep at this issue of providing our veterans in remote areas access. It is extremely important. These are not easy answers or else we would have probably done it already, but we are as committed as you are to finding solutions.

So working with the other Federal facilities, as Congressman Kuster had mentioned, absolutely, we need to do that, and we are doing that with the Department of Defense and other Federal agencies.

On telehealth, I can't give a stronger assurance to our providers that they absolutely will be protected using these telehealth authorities. We have the Department of Justice that has agreed to do that. I practice from here in Washington to Oregon. I do not have an Oregon license, I have a Pennsylvania license and a New York license. So they can see me doing it, and I want them to feel assured that they can and should be using their medical capabilities to help veterans in remote areas using telehealth.

Mrs. RADEWAGEN. Thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

We have, you know, Dr. Shulkin and I came along way before we used telephones to do health care, and we have done that for a long time. And we need to clear up, because we are going to have to clear up how Medicare compensates, that is a different discussion and I think Ms. Brownley's bill with G.T. Thompson, Congressman Thompson, really narrows the focus of the VA. And that is a great pilot program, I think, for the country to try it and see how it works. I totally agree with that.

Ms. Esty, you are recognized.

Ms. ESTY. Thank you very much, Mr. Chairman. I thank you so much, Dr. Shulkin. And I would just say on behalf of the Committee, we do want [audio difficulties] I think we have agreement on that. And so I did want to follow up on mental health issues and in particular on the issue about military suicide prevention, which remains and I think you had properly noted as your number one clinical and in fact sole clinical priority.

I was reminded of this in a conversation with a family last week who a year ago their son was in crisis and wound up with a standoff with a SWAT team. They tried calling the crisis line and found it not at all helpful. Fortunately, the situation was resolved with a friend who was a veteran, who was able to get into the house and help. But that was last year.

So we need to hear from you, I know you are committed to this, what resources you need, what training is necessary, because, frankly, we were just fortunate that a friend was able to get there in time. So please know how committed we are to providing you the resources, but it is not just numbers of people on the phone, it is the quality of what they receive, and in that crisis situation it just—you know, fortunately, we were able to get a live person there in time, but it was a reminder of that, of that challenge.

I wanted to follow up with your conversation with Congressman O'Rourke about retention and recruiting and retention of mental health professionals. I have a brother-in-law who worked a long time doing VA psychiatric work and found it very frustrating. He felt he did not have the time or support to do anything other than write scripts. And that was in Southern California and I do think his experience was unique.

So that may not only be direct hires, but that is about how their time is accounted, what directions they are given and latitude they are given to practice medicine as licensed psychiatrists. So I would ask you to work with us and provide the resources you need to do that.

Again, it is not just having the bodies, it is a special population. So when we are losing ground, you are losing talent, you are losing experience. And so, again, in looking to recruit, I think that retention is an issue. And I don't know what you are doing. Are you systematically interviewing people who are leaving to find out what their reasons are? Is it money? My guess is it probably has more to do with the conditions in which they are practicing.

Would you care to comment?

Secretary SHULKIN. Well, I am going to rely upon my 25 years of private sector experience as well.

The number one reason why people leave their jobs is usually not money, so you are correct, it is usually their relationship with their

boss, and whether they believe that they are valued and they are heard. And too often I think that we have not paid enough attention to the management structure and have the right people leading our clinicians. So that is a focus of ours.

Burnout among health care professionals in general is huge. We have had a dedicated effort to reducing burnout. We have reduced the number of alert notifications on our computers. And in fact burnout is actually better, if you can be better in burnout, than in the private sector where the billing and productivity and financial pressures are much larger than you even see in the VA.

But these are real issues. So I think your insights are right and we are trying to focus on it. We have a lot of work to do.

Ms. ESTY. You mentioned needing to have congressional direct authority to do direct hires. Are there other elements that you need us to take action on to facilitate this critical need now to recruit and retain the best mental health professionals to deal with this cherished population, who has served this country, who we owe this more than anything?

Secretary SHULKIN. I would love to see a comprehensive hiring and retention act for VA. We have met last week with OPM, we have asked them for a number of waivers. They seem willing to do this, but we haven't gotten the final responses from them.

We know that it just takes too long to hire people into the VA. We know that in many cases in Southern California—maybe it is not just Southern California, but that would be an example—our pay caps for nurses are now 20 to $30,000 below, our caps between what starting salaries are in the private sector. We have asked for some consideration of that as well.

So we would love to work with you on a comprehensive hiring and retention authorities.

Ms. ESTY. Thank you very much, I really appreciate that. And because I think we really do want to get this right, but we need guidance from you about what are the stumbling blocks that you are facing right now in doing this.

Thank you and I yield back.

Mr. O'ROURKE. Dr. Wenstrup, you are now recognized for 5 minutes.

Mr. WENSTRUP. Thank you. Thank you very much for being with us today, it is always a pleasure, and I mean that sincerely.

You know, everyone who is a veteran at one time wore the uniform. That is a given for everyone who is a veteran. And there is a transition and you mentioned some interactions with DoD, and my feeling is that we should have more interactions with DoD, which I know you are working on from the medical record on down, and I think that is important.

Post-traumatic stress to me is normal. Having served, it is a normal thing to reflect on where you have been and what you have done. Now, I deployed at 46 years old and I think that is a big difference between 19 years old. And as a doctor, I had seen trauma, et cetera, so it was a little bit different as you come back. When you come back as a Reservist, for example, they say, oh, you have 90 days before you go back to work, and I said I am going next week. And part of that is because I was in a job where I was very

necessary and the last thing I wanted to do was come home and be unnecessary. And I think that is what we face today.

We talk about suicide prevention. You know, I feel for the VA, because the VA only gets to be reactive, they don't get to be proactive, because the proactive component needs to come when you are still in uniform. And, as we know, most of the suicides don't occur when you are in uniform, and I would contend that is because you are still necessary.

And I would like you to weigh in with me on this, because I feel, serving on both Armed Services and VA, we need to do a better job in uniform that, you know what, when you sign up to serve your country, there is a success at the end of that. And we need to be more proactive on the uniform side that when you take that uniform off, you know where you are going, you are going to school, you are going to use your GI Bill, you know what you are going to major in because it leads to a job, or you are going to a job. And we need to do a better job on that end. We talk a lot about suicide prevention, I think we can do a lot more if we are proactive. And so amongst the mental health providers, I am wondering if they are coming to any kind of consensus in that arena to say, I am getting them too late.

Secretary SHULKIN. I don't think we could say it better than you did. I think you are exactly on target with that.

Mr. WENSTRUP. So, hopefully, we can engage and I will be more than happy to reach out, serving on both Committees, to try and make those connections. And we have a few Members like Mr. O'Rourke that serve in the same capacity and I know it is a point of passion for him as well.

But I would like to get some feedback from the mental health providers that you have to get their opinion on what we can do on the front end to try and be more helpful to the VA ultimately.

Secretary SHULKIN. There is no doubt that I think you have hit the most important part of why. Being in service, when you talk to veterans that are struggling the most and, you know, there is a great film coming out soon called Thank You for Your Service, which really highlights many of the things you are saying, and many people struggling say, if I could go back, I would go back, because I knew I belonged, I felt like I was contributing, and they miss that when they transition out.

Mr. WENSTRUP. Thank you. I look forward to working with you further on that.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Miss Rice, you are recognized.

Miss RICE. Thank you, Mr. Chairman.

Just to kind of continue along Dr. Wenstrup's questioning. First of all, thank you, Dr. Shulkin, for being so focused on the mental health of our veterans. From what I have heard, it sounds like there is a focus on addressing their particular needs, but the statistic that keeps coming back to me is, if you take the number of 20 servicemembers killing themselves a day, and I think the number is 16 of them were not accessing their benefits through the VA—or 14.

So I guess my question is, you can do telehealth, you can increase community care, you can do all of that, but if you can't identify these people before they separate, it is a lost cause. So in any of this plan, do you have a thought process about how we can engage veterans before they separate?

And I am glad to hear that, you know, there is a lot more coordination between the VA and DoD, because that was where a lot of people fell through the cracks during their separation process, but can you just, you know, expound on that?

Secretary SHULKIN. Well, two things, and, Dr. Clancy, I would invite if you want to add anything.

First of all, within by the end of November, we will be announcing a new plan with the DoD to work exactly on that issue of the transitioning servicemember. We know that there is a very high risk or a higher risk of suicide in the first 12 months after leaving service. So that is what we are trying to address. And we are fortunate, we now have Dr. Keita Franklin, who had headed up the Suicide Prevention Office at the Department of Defense, now detailed over to VA. So that is one of these reasons you are seeing a much closer working relationship than ever before between these two agencies to deal with this transitioning issue.

Secondly, you are also going to see this next month, a public service announcement come out with Tom Hanks talking about how do we reach out to those 14 servicemembers and what do you do as a member of the community to help identify those 14—

Miss RICE. Oh, that is great.

Secretary SHULKIN [continued]. —veterans that aren't getting access to services at all the right times. So those are two important things.

Dr. Clancy?

Dr. CLANCY. Some of the people of the 14 veterans who are not using our system now, some of them will have recently transitioned and we are very, very excited about working more closely with Defense in this area, but the largest proportion is actually in veterans over 55.

Miss RICE. Right.

Dr. CLANCY. And so we have got to figure out ways to reach out to those particular individuals, some of whom may be quite isolated, which may in fact be a big part of the underlying issue.

To that end, I serve as the public sector co-chair on a national alliance focused on suicide prevention. You know, my private sector co-chair is from the railroads, because on average they have one person a day suicide by lying on tracks and so forth. This is really a broad U.S. public health emergency.

So we are trying to exploit all of those levers as well and reach those who are not plugged into other obvious sources from our system to VSOs or what-not.

Miss RICE. Great. Thank you.

Mr. Chairman, I want to thank you so much for coming to New York and visiting our VA in Northport. I can't tell you what it did for morale there and it was a great visit, and I thank you for your time.

So my question to you, Mr. Secretary, is with the focus on doing more care in the community and putting more financial resources

there, I can tell you that whenever we ask our veterans, raise your hand if you like the service that you get at the VA Northport, the majority of the people say, yes, I like it. That is not to say that at some point they wouldn't go outside of it. But I guess my question is, how do I assure those veterans that this push to doing more care in the community, which I support and I think they want, is not going to mean taking resources away from their VA that they feel very committed to.

And I also want to thank you for your commitment to realigning a lot of the bill. I mean, Northport in some ways is falling apart and needs massive money, but that might not necessarily be—you know, it has buildings that need to be taken down, but their concern is, the VA may have problems, but it is my VA and I like the VA, and I want to make sure that it is not going to be sacrificed for more care in the community.

Secretary SHULKIN. Well, it is one of the things, finding the way to strengthen the VA, at the same time to make sure that we are meeting the current needs of veterans, is really exactly what I am focused on and I know it is one of the things that works well about both the House and the Senate.

When you take a look at the bill that was just passed, the Choice extension in August, it did exactly that. It gave resources to allow veterans to go out into the community, but it also invested more resources into the VA, 28 new leases authorized by you to allow us to do that. The President's budget, while it provides more money for community care, provides an even greater amount for investment back in the VA.

So I would assure your constituents, your veterans that that is our focus, strengthen the VA, but at the same time make sure that veterans aren't waiting while we are strengthening the VA, so that they can get care in the community.

Miss RICE. Thank you very much, Mr. Secretary.

And I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. And as my trip up there, I said, look, there are a lot of strengths here and you have five CBOCs out here that could be strengthened. And taking the care, what we are doing is taking the care, as we are everywhere, away from big hospital systems where you have got to go in and get lost, and take the care to the veteran, which is the CBOC. It puts it right in their community, it is close by, and they really like that. So I think that is one of the things you can do there.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman.

Secretary Shulkin, the draft legislation for VA Care in the Community Program broadly provides that DoD would be an eligible provider for community care.

First of all—and then I think you talk about a 2-year pilot program for that. Why is a pilot program necessary, number one, and, number two, to what extent have you worked with the Department of Defense on this?

Secretary SHULKIN. Well, the pilot program would be to avoid having to spend a lot of administrative time billing each other. And right now, I think at the end of last year the difference between what VA and DoD owed each other was like $30 million, and we

figured it cost us $40 million to bill that. You know, the DoD is not set up for billing commercial insurance, so the greater requirements are on their end. So we are trying to simplify this process.

The reason for a pilot would be to make sure it doesn't get too imbalanced, because they have an appropriation for health and we have an appropriation for health, and we don't want it to fall, the burden too much on each other.

I happen to think it is going to equal out, you know, that the amount we will use DoD and vice versa will be relatively awash, and that is why I think we could save the taxpayers money by not billing each other.

Mr. COFFMAN. Okay. So you envision then that U.S. military personnel or active duty personnel and their families would then utilize the VA system?

Secretary SHULKIN. Yes. And they do and we charge them for it and we use—we send veterans to DoD facilities and they charge us for it. And so the pilot would be, let's take down some of the administrative burdens and let's see what happens.

Mr. COFFMAN. But I think it is fairly limited right now where you are serving military personnel and their families, is it not?

Secretary SHULKIN. Yeah, and we wouldn't expand, the pilot would not be expanding the eligibility criteria; the pilot would say, Where there are areas where we are working closer together, let's make it easier to work closing together and save the taxpayers some dollars.

Mr. COFFMAN. Because I think there is no question that we have to work to make the VA better and we have done some things in this Committee like reforming the personnel system; although, I think we probably have a little further to go with that. But you really have two different very—two very different systems culturally.

The active-duty military is a solid merit-based system and you have a unionized workforce in the VA system, albeit, somewhat reformed with recent legislation.

Secretary SHULKIN. Uh-huh.

Mr. COFFMAN. So, I do—and we have had patient-safety concerns.

Secretary SHULKIN. Uh-huh.

Mr. COFFMAN. I am sure we have had them in DoD, but

we have had some fairly significant patient safety concerns in the VA and we really need to get those cleared up when you are talking about the families of our military personnel. I wouldn't want them concerned about a patient—the patientsafety issues. We have to clean them up for our veterans, but until we do, I don't want to increase the patient load there.

Secretary SHULKIN. Yes.

Mr. COFFMAN. We clearly have excess capacity on the military side simply because of the fact that our operational tempo is down right now, relative to what it has been. But it should certainly plus up again, where we have a casualty flow much greater than it is today. So that is really going to vary in terms of the military, the Department of Defense's ability to handle patients from the VA, but I think it is positive for them to do it on the DoD side because we have so many providers, quite frankly, that because of the fact

that the casualty flow is down that aren't getting expense, now we are trying to get them into the ER for trauma.

But doing surgery is doing surgery, and so if we can get VA patients, and particularly those who are service-connected first in terms of priority, I think that would be very helpful.

Secretary SHULKIN. Yes.

Mr. COFFMAN. Okay. And, again, on the mental health issue, I just want to say that I get that you are doing a lot of things administratively, but we want to set a policy that is permanently in motion, beyond this administration. And so it is important for you to have authorizing language to be able to do that and therein lies the legislation that I have done with Representative O'Rourke on allowing "other than honorable discharged" military personnel—veterans—to be able to have access to mental health care.

Secretary SHULKIN. Yes.

Mr. COFFMAN. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Poliquin, you are recognized for 5 minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman very much.

And thank you, Dr. Shulkin, for being here and your other great staff; we really appreciate it.

Mr. Secretary, you have been to Northern Maine a couple of years ago when we first met and we really appreciate that. And I just want to make sure I make this statement clear to everybody who is paying attention to this hearing, is that the Choice Act or the Choice Program or Choice 2.0, whatever you are going to be calling it going forward, Mr. Secretary, is in no way intended to replace the VA; it is just not.

Veterans love serving time with veterans. They love healing with veterans. They heal better with veterans. So, I get this and I think everybody on the Committee does; however, there are opportunities where it makes so much sense, so much made common sense to be able to receive your health care closer to home. For example, the Second District of Maine is not the Portland area, the Southern Coast area, but it is everything else in Maine. It is highly rural, the most rural district east of the Mississippi River and it is about an 8-hour drive from one point to the other.

So, where you went, Dr. Shulkin, up in Caribou, it is a little bit of a drive to Togus, our only VA hospital in the state; the first in the country, I might add, and we are very proud of that.

Secretary SHULKIN. Yeah.

Mr. POLIQUIN. So, we are very concerned that we continue to make sure in the rural part of our country—where about 40 percent of our population lives, roughly—have access to the health care they have earned and they so deserve.

Now, Dr. Shulkin, I am going to give you something that hasn't been asked here today, so I know you will be ready for it. You and I have discussed, many times, sat down personally with you and your staff—not these two nice folks, but other folks about paying your bills on time.

Now, I am not a bill collector, but I have no problem doing that on behalf of my constituents. We have had a number of hospitals in my district who have come to us and said—in our state, not only in our district—say, look, we love the VA. We serve veterans at our

hospital, we are a nonprofit property, and we are just not getting paid on time.

Now, I don't worry much, to be honest with you, Mr. Shulkin, about the big hospitals who have the wherewithal to absorb this, but when I get a call from Calais Regional Memorial Hospital in Calais, Maine—where you go all the way down, as you hit Canada, take a left; that is where Calais is—there is not a lot of opportunities out there and when you folks owe them 600 grand and I have got to show up.

By the way, Mr. Chairman, I think I am the only office in America that makes house calls now. We just got in a car and I said, where are these Health Net folks to try and straighten out this problem? We showed up at their doorstep and they were awfully nice to us. We spent about an hour. And I thank them and I thank you, if you were involved, for sending a few people up to Calais to make sure they got paid so they could make payroll.

However, my concern, Doctor, going forward is I don't mind making house calls and I will continue to do it to put pressure wherever it needs to be to get our hospitals paid. But can you assure me now and everybody else on this Committee that this new Choice Program going forward is going to be able to fix this bill-paying problem?

Secretary SHULKIN. Laurie, do you want to?

Dr. ZEPHYRIN. Sure.

Mr. POLIQUIN. I can see where you passed the buck just like that, Doctor.

Secretary SHULKIN. Yeah.

Dr. ZEPHYRIN. Well, thank you for bringing that to our attention, and as you know, we have connected with your providers. Part of what we have done is also implement training and train the providers in terms of the difference between billed charges and Medicare charges, as well.

The other training we have provided is around submission. The one thing about this legislation, it really allows us to consolidate into one program with multiple programs and multiple eligibility—

Mr. POLIQUIN. When is that going to happen?

Dr. ZEPHYRIN. It is in the CARE legislation.

Mr. POLIQUIN. Say it again.

Dr. ZEPHYRIN. It is in the CARE legislation, having one community care program.

Mr. POLIQUIN. Great.

Dr. ZEPHYRIN. So, with one program, that simplifies eligibility. We have also been improving our business processes moving from manual, because we touch a lot of our claims to more electronic processing of claims with our new community care network, as well. The TPAs will be providing claims processing and we will hold them accountable with measures so that they are processing 90 percent of claims—

Mr. POLIQUIN. So, it is going to get better. It is going to get faster. Members are—house calls, right?

Dr. ZEPHYRIN. That is correct.

Mr. POLIQUIN. Great. Thank you.

Dr. ZEPHYRIN. Thank you.

Mr. POLIQUIN. Dr. Shulkin, I have a little bit of time left here. In August, we appropriated about $2.1 billion for the next six months to make sure Choice went on. How are we doing? How much money we got left?

Secretary SHULKIN. We have, I think, when I saw it last week, we have about 1.1 billion left.

Mr. POLIQUIN. Are we going to make it through the end of—

Secretary SHULKIN. Let me make sure I am accurate.

Dr. ZEPHYRIN. A little more. We have about—when we last looked for medical care, we have for total, we have 1.4.

Secretary SHULKIN. Yeah, but we need to obligate at the very end, about 300,000—about 300 million. So you have to stop spending because of the final obligation. That is why I said it is about 1.1 billion left in the fund.

And if you—that is why we will get to the end of the year, but not much beyond that, the calendar year.

Mr. POLIQUIN. Okay. How can we make sure this is not a continuing problem, Mr. Secretary?

Secretary SHULKIN. What we are seeking in the President's budget is to permanently authorize the Choice Program, whatever we are going to call it—Choice 2.0. And that would allow us never to have to go through this exercise of, Are we running out of money? We want to permanently authorize this and that is where the issue of us identifying some final offsets to pay for this comes in, but we think that this is doable and it is the right thing to do for veterans.

Mr. POLIQUIN. Thank you, Mr. Secretary. I appreciate it.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

And thank you, panel, for your very lengthy testimony today, and I really appreciate it, Mr. Secretary.

I want to address the issue of physician-need within the VA. And I know in the VA's draft legislation around in the minority's legislation, there is a plan to increase the number of resident-trainee positions, in exchange for service at the VA. And your legislation requests an additional 1500 residency slots and the minority's legislation requires VA to increase the financial support for positions, some already authorized in the Choice Act.

And it is my understanding that under these plans, residents will not necessarily be taking care of veterans, so VA could actually be paying for care not for veterans, which is one issue and then the real concern that I have, though, is, as you know, the way residents choose their residency slots is via a matching system in which over 78 percent of medical students get their first, second, or third pick. And these slots don't come with that service or obligation to the VA.

Secretary SHULKIN. Right.

Mr. RUTHERFORD. And so my question is: Why would a medical student commit to service at the VA when they know that they have a three and four chance of getting there, three out of four chance of getting their selection?

Secretary SHULKIN. Well, two reasons. First of all, all that we are doing is borrowing from the military model where students, residents choose to go into the military in exchange for it is paid for

and it is exchanged for years of service. So, we are saying the same thing, which is, we will pay for the training of that resident in exchange for service given back.

The reason why I believe this will be a competitive slot, why students will choose this, to do the residency, because of our academic partners. We partner with the very, very best medical schools in the country and the very best residencies. And it is prestigious to get your training at major academic centers.

So, our partners are not the community hospitals that are training many of the residents, but they are the topteaching hospitals in the country; I believe they will be competitive spots.

Mr. RUTHERFORD. So, you don't fear that the VA would simply get those who don't get their match, which is going to be those folks at the bottom academically?

Secretary SHULKIN. Well, the academic centers, I will tell you, having been in charge of graduate medical education for places like the University of Pennsylvania—

Mr. RUTHERFORD. Uh-huh.

Secretary SHULKIN [continued]. —those places will leave their slots empty and not take non-competitive candidates. So, it is the academic partners who are choosing these residents, not the VA.

Mr. RUTHERFORD. Okay.

Secretary SHULKIN. I believe they are going to choose very competitive residents.

Mr. RUTHERFORD. So, it costs, roughly, 100,000 a year to train a resident. So, assuming a 4-year residency and a 4-year VA commitment, the total cost is 400,000 for—so, for the 1500, it would be 600 million; of course, that is without the administrative cost.

I actually have a bill that we have introduced—and I don't know if you are familiar with it—but it deals with a residency loan payback program that would cost you about 160,000 a year for four years for that same VA—with that same VA commitment, and that cost would be $240 million for the same number of doctors committed to VA. VA would get to choose the doctors that they want and I will tell you that they'd also be serving veterans while they are in that program.

Would that not be a better program than the graduate medical education proposals now?

Secretary SHULKIN. Dr. Clancy said the same thing to me the other day. So, these are the two ways of accomplishing what we both are trying to do.

Mr. RUTHERFORD. Right.

Secretary SHULKIN. And we very much would like to take a look at that bill and if that gets us to where we need to get to, absolutely, because I think there is—that is a very sound way to do it. We were actually trying to create some more slots for the country because, frankly, as I said, there are more U.S. graduating medical students than residency spots.

Mr. RUTHERFORD. Right.

Secretary SHULKIN. But I absolutely want to do the thing that achieves the objective at the best value for the taxpayer and we will work with you on that.

Mr. RUTHERFORD. And the best service for our veterans.

Secretary SHULKIN. Absolutely.

Mr. RUTHERFORD. And I know that is at the top of your list, as well. Thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Mr. Secretary, one final question, and I think probably, you know this well, is I have been eager for almost nine years now to take up legislation for our Blue Water Navy veterans—

Secretary SHULKIN. Yes.

The CHAIRMAN [continued]. —and place it up on a mark-up agenda. And from our discussions, I know that you share my desire to pass this Blue Water Navy bill as soon as possible. We may be adjusting some of the legislative language and I hope these changes will allow us to get this bill on the floor as soon as possible to help the remaining thousands of Vietnam veterans.

Do I have your support for moving forward on this drafting legislation language to accomplish that goal?

Secretary SHULKIN. There is no doubt, our Vietnam veterans have waited way too long for us to bring this to resolution. The problem, as you know, is this will not be guided by scientific evidence. I wish it—that is good policy for us to be able to get solid scientific evidence, so we just have to do the right thing.

And I appreciate your leadership on this and you wanting to bring this to resolution. I will be meeting this afternoon with Blue Water Navy veterans. I am absolutely committed to working with you and the rest of the Committee to bring this to resolution. They shouldn't be waiting any longer. Thank you.

The CHAIRMAN. Thank you, Mr. Secretary.

Mr. Walz, do you have any closing comments?

Mr. WALZ. Just again, thank everyone here. Mr. Secretary and your team, thank you. To the VSOs, again, it is not—it wasn't a pat on the back to say this is the way it is supposed to work; you are not supposed to get patted on the back for what you are supposed to do. But it is so rare now to bring folks together to continue to get this right and I appreciate the candid discussion and we move to draft proposal.

So thank you, and I yield back.

The CHAIRMAN. Okay. And I thank the gentleman for yielding.

And just a final comment: This is an incredibly important meeting, because it is going to shape how care is provided for the VA and we will have other changes, but basically just to outline it succinctly, it will be a primary care-oriented system, just exactly like our system is around the country now. The gatekeeper or your primary doctor will be managing your care. You will be able to get some of that care either in the VA or outside of the VA, depending on where the best care is. And we have heard many good ideas today about how care should be provided both, in and out, of the VA. So, that is one idea.

Two, consolidating seven to one makes absolute sense. It takes confusion out of administrative burdens and costs. Implementing to EHR is a huge undertaking, but that is very much a part of this, how you share back and forth.

One of the things that we have a problem now with is sharing information where a doctor is referred a patient from the VA, how

they access the VA's record currently to see what is going on with that patient.

Facilities is another issue that we will bring up later, along with a new, very innovative new way to practice health care, which is telehealth. And who knows what that is going to look like in five or ten years? We are just on the beginnings of doing that. If you need a specialist and you are at North Port and that specialist is in Denver, you might be able to access that specialist now and very quickly be provided care. So, there are huge opportunities with what we are doing.

This is a big undertaking, and Mr. Secretary, I wanted to just amplify what Mr. Walz and the rest of the Committee said: Thank you for being available and thank your team for being available and working with us, hand-in-hand, to try to get this as right as we possibly can. So, thank you all for being here.

Secretary SHULKIN. Thank you.

The CHAIRMAN. You are dismissed and we will bring our next panel in.

And now, I would like to welcome our third panel for the morning and with introductions, first, Mr. Adrian Atizado, the Deputy National Legislative Director for Disabled American Veterans, welcome; Roscoe Butler, the Deputy Director for Health Care of Veterans Affairs and Rehabilitation Division of The American Legion, welcome; and Kayda Keleher, the Associate Director for the National Legislative Service Veterans of Foreign Wars of the United States. I thank all of you all for being here and the hard work you do every day for veterans each and every day.

Mr. Atizado, you are now recognized for 5 minutes.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Committee, on behalf of our 1.3 million wartime service-disabled veteran members, I want to thank you for inviting DAV to testify at this legislative hearing.

DAV is a nonprofit veteran's service organization dedicated to a single purpose and that is to empower veterans to lead high-quality lives with respect and dignity. We are pleased to offer our views on the bills under consideration by the Committee and for the sake of brevity, I will limit my comments to just a few bills on today's agenda.

DAV support H.R. 2123, the VETS Act of 2017, which would help more veterans receive care from VA-employed providers through telehealth. We believe VA, a system designed to meet unique needs of ill and injured veterans offers certain patient protections not equally available elsewhere. The ability for a VA health care system to hold VA providers accountable through training, research, and the direct oversight, helps establish a standard of care veteran patients enjoy in this otherwise emerging field of health care delivery.

We are supportive of VA's efforts and the recent regulatory notice to support Secretary Shulkin's Anywhere to Anywhere health care initiative. We applaud VA for these efforts.

We would also like to thank Representative Banks and his staff for their commitment to work with DAV, the VA, and the VSOs to

strengthen the draft bill for a study on the crisis line. DAV Resolution 245, adopted by our members and our most recent national convention, supports improvements in data collection and reporting, relative to suicide prevention; therefore, DAV supports the intent of this bill.

We are committed to working with a sponsor and the Committee to ensure the data-collection efforts proposed in the bill does not have unintended consequences, particularly on the care being delivered as well as VA's current efforts in collecting and analyzing the effectiveness of their program.

Now, regarding the draft bills for Care agreements with the state veterans home, the draft bill for the Care Act, and a revised draft bill, making permanent, the VA Care in the Community program, we would first like to express our deep appreciation for your commitment, Mr. Chairman, Ranking Member Walz, all the Members on the Committee, particularly the staff, for their hard work, as well as VA, in their—finding a way forward to reform the VA health care system.

Evidence by many of DAV's recommendation reflected in the Committee's revised draft bill, pursuant to our resolution, calling for the strengthening, reforming and sustaining the VA health care system. DAV is pleased to support many of the provisions in these measures, which would improve access to care in the community, while preserving and enhancing the unique benefit and vital services VA provides to DAV members and all eligible veterans.

There are provisions we continue to have concerns and others which we would oppose, such as a proposal to eliminate the current practice of offsetting a veteran's to payment when VA is paid by their health insurance. We urge the Committee to stop this proposal from moving forward, as the Committee has done, with regards to the 10-year COLA round down. We believe that asking veterans to pay for their health care after they have served and sacrificed is simply not the right thing to do.

DAV and our Independent Budget partners have proposed a comprehensive framework to reform the 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 a 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.

Mr. Chairman, these structures really are guard rails that we hope Congress will take into account when they draft their legislative proposal moving forward. In those instances where VA is unable to deliver timely veteran-centric care, university affiliates, other health partners, such as DoD, service travel organizations, state organizations, such as state veterans homes, aging and disability network and community providers should be able to meet the obligation to care for our Nation's veterans.

Our goal is to strike a balance between access to care, simply access, and access to veteran-centric care. This really deals with the creation of local veteran-centric integrated networks to ensure that veterans do not fall victim to fragmented care that is rampant in the private sector.

Mr. Chairman, DAV and our members urge serious reform of the VA health care system to address access problems by preserving the strengths of the system in its unique model of care. This concludes my statement. I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF MR. ATIZADO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Mr. Butler, you are recognized.

STATEMENT OF ROSCOE G. BUTLER

Mr. BUTLER. Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee of Veterans Affairs, on behalf of our national commander, Denise H. Rohan, and The American Legion, the country's largest patriotic wartime service organization for veterans, compromised of over two million members and serving every man and woman who have worn the uniform of this country, we thank you for inviting The American Legion to testify today and share our position regarding The American Legion's position on pending legislation before this Committee.

You have my written testimony, which discusses The American Legion's views and positions in great detail; therefore, I would like to devote the majority of my time discussing the highlights of today's hearing, the Choice Program.

The 2014 wait-time scandal helped to expose what veteran's service organizations have been warning lawmakers about for years; that the VA has been systematically underfunded and was being forced to manage the budget and not budget to need. Where there is a vision, anything is possible. The draft legislation introduced by this Committee, combined with the legislative requests for VA begins to address Congress and the VA's vision for the evolution of a 21st century medicine at VA in a way that will allow the department to provide greater access and develop stronger relationships with non-VA providers, moving toward a more integrated system.

This is just the first step in a long overdue transformation and The American Legion expects greater emphasis on VA's modernization and successive legislation that is able to capitalize on VA's strengths and core competencies, while ensuring that veterans continue to have access to the best care anywhere. The American Legion is aware of criticism that suggests that this transformation moves purposefully close to increase privatization of VA's services and does not dismiss these criticisms as without merit.

Nefarious intentions can, indeed, serve to undermine modernization efforts and The American Legion will continue to be a watchdog and ensure further political interests do not diminish the capacity or value VA represents in the medical or veteran community. It is with this in mind that The American Legion asks this Committee to include a requirement in the final legislation that requires VA to ensure an annual report.

For the sake of time, I ask that you refer to our written report to review these six requirements. This effort to refine and make permanent, a consolidated community-care program begins a rede-

sign of VA's infrastructure and capabilities that will next cause a review of what services VA hospital and community-based outreach centers perform and how.

The legislation, language introduced by this Committee provides greater detail in a number of areas that VA request lacks and The American Legion would only caution the Committee to remember the number of times that VA, VSOs and the Committee were called to introduce and support legislation needed to fix unintended consequences of the original Choice legislation.

The American Legion is particularly grateful for the Committee's diligent and well-articulated procedures, as detailed in primary and specialty care in Section 101 of the Committee's draft. The American Legion appreciates this Committee's dedication and hard work while producing this comprehensive draft, and in our written report, I have highlighted some areas we believe need further discussion. And for sake of time, I will only discuss two.

Included in the VA request is a provision that seek to increase capacity while saving on emergency room visits by creating or contracting with a network of walk-in clinics. The American Legion believes Section 202, improving veterans access to walk-in care, will be a benefit for VA patients and will decrease the prevalence of illnesses that if left untreated because patients are deterred from going to the emergency room until their illness or injury becomes so severe that more costly and time-consuming measures are needed to stabilize and cure the patient.

The American Legion is concerned about the introduction of copay features that would be assessed for care directly related to illness or injuries caused or aggravated by a veteran's honorable service.

The American Legion looks forward to working with the VA and this Committee to come up with a plan to mitigate these charges.

Thank you, again, Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee on Veterans Affairs. I appreciate the opportunity to present The American Legion's views and look forward to any questions that you may have.

[THE PREPARED STATEMENT OF MR. BUTLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Butler.

Ms. Keleher, you are recognized for 5 minutes.

STATEMENT OF KAYDA KELEHER

Ms. KELEHER. Chairman Roe, Ranking Member Walz, and Members of the Committee, it is my honor to represent the women and men of the VFW and our auxiliary.

Over the last three years, the VFW has surveyed thousands of members asking them about their VA care. Their answers are clear; the majority of VFW members like and prefer using their VA health care. They want to fix, not dismantle, their health care system.

This is why the VFW is grateful for the hard work this Committee and its staff has put into moving forward, not just with consolidating community care, but overall improvements for a better and stronger VA.

While VFW members may prefer using VA, the VFW understands that sometimes care in the community is necessary. Whether that decision is based on a provider shortage for one veteran or travel barriers for another, the VFW thanks this Committee and VA for their efforts to ensure if a patient should use VA or community care as a clinical decision made between a patient and their provider. This is also why the VFW believes it is imperative for VA primary care providers to remain the coordinators of care.

The VFW is also pleased to see in the Committee's draft legislation that this program would finally be made discretionary. This transition from mandatory has been a long time coming and will ensure that the program not only becomes permanent, but also assists in avoiding a gradual erosion of the VA health care system. Though, we must add that the VFW would oppose using COLA round downs to offset funds for the Choice Program.

In VA's Care Act, there are multiple improvements made to personal practices in collaborations with Federal partners, which is something the VFW is eager to see passing into law. Some of these include telemedicine authorities, medical residency programs, partnering with other Federal agencies, and a pilot program between VA and DoD health care facilities.

Moving forward with this legislation, this Committee must make sure that all unintended consequences are avoided to the fullest extent possible. This includes making sure no veterans are forgotten, such as those in need of a live-organ transplant or IVF.

The VFW opposes H.R. 3642. All veterans deserve access to mental health care, whether that access is needed due to chronic mental health disorders, current life events, or previous sexual trauma. And aside from data showing that VA has the best mental health care for veterans, VA must also have an active role in coordinating all community care.

The VFW has opposed handing out universal Choice cards like candy in the past, and we still do. Not only is it opening the floodgates to allow veterans to receive lesser quality care, but it fragments VA's current continuum of care, and this legislation would do so for one of the most vulnerable populations within the veteran community.

If all VA survivors of sexual trauma are given a full access card to private providers, they will be faced with most of those providers probably not understanding their veteran-specific needs. VA would have no guarantee of receiving their health records or knowing whom to offer the assistance of VA sexual assault coordinators. If a veteran who has been sexually traumatized needs care which the VA is unable to provide, then they should absolutely be able to get that care. But, if the needs of the veteran can be met by VA, then they should be met by VA.

Survivors of sexual trauma are among the highest for increased risk of suicide and we all know that 14 of the 20 veterans who die by suicide each day are not currently using VA health care. The VFW believes Congress and VA must do all they can to assist sexual trauma survivors and that means increasing their ability to access VA.

The VFW understands the intent of Representative Banks' draft legislation, but must oppose it as written. Though this legislation

does not explicitly state VA must begin gathering data not currently collected by VCL, the VFW is concerned that passing legislation requiring VA to report data not currently collected will result in VA having to collect that data and then gamble with the possible unforeseen consequences.

Without asking for personally identifiable information, VA would not be able to report some of the information required in this legislation such as the number of veterans who contact VCL who have every received VA hospital care or medical services. By forcing VCL to ask for this information to obtain data, the VFW is concerned veterans would be frightened to use the crisis line, and I am confident, and we are all aware, how fast veterans like to spread information that they are dissatisfied with VA. And, unfortunately, we believe that would only further defer veterans from using the VCL.

The VFW is supportive of using data already collected by VA and VCL, such as the data referred to those who use the suicide prevention coordinators or those whom VCL must send emergency dispatch to assist. This is why we believe removing reporting requirements for information not gathered by VA must be done before legislation is passed.

The VFW would be happy to support this legislation once it removes those reporting requirements and looks forward to working with the Committee to make sure that happens.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes my testimony. Thank you, again, for the opportunity to represent the Nation's largest combat-veterans organization, and I look forward to your questions.

[THE PREPARED STATEMENT OF MS. KELEHER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, all and I thank the panel. And I am going to go rather quickly because I just got a note that we have votes at 12:50 to 1:05, so I will move on.

A couple of things, first of all, thank you for working with us. And do any of you all just briefly see any deal breakers? We have really worked hard on this legislation with you all and other stakeholders, including the secretary. Is there anything in there that is really a deal-breaker in the legislation that we have—that you would say, this absolutely—we wouldn't support it because of this provision?

Mr. ATIZADO. So, Mr. Chairman, based on a revised draft that we received, not in particular.

The CHAIRMAN. Okay. We still want to continue to work with you, absolutely, to iron out these problems that you all clearly brought up and we want to see if we can work our way—but I mean, is there anything in there that really just—because we have tried to avoid that and if there is, we need to know about it so we can work it out.

Mr. ATIZADO. Yes, sir. So, as I mentioned, some of the pay-fors for the bill is of a concern for our organization. We understand that is part of a much larger package and we take that with the consideration of this bill. By all means, we will continue opposing that, of course, but the overall approach, I think is appropriate.

I think a couple of things that require continued clarification and that really deals with the execution of this bill from VA's standpoint. A lot of issues with regards to coordination of care—VA is required to coordinate care, although, some of its tools to do that seem to be a little bit hampered. So, we have some concerns, but overall, sir, nothing that would come to the deal-breaker, I think.

The CHAIRMAN. And Mr. Butler?

Mr. BUTLER. Mr. Chairman, thank you. We really appreciate the bill. We think that the House Bill and the VA draft has come a long way and working together, you guys will be able to deliver, the Committee will be able to deliver a very comprehensive bill. So, we don't see any deal breakers.

There are things in our written testimony, which we stated we oppose to—

The CHAIRMAN. Okay.

Mr. BUTLER [continued].—but otherwise, we think that the bill and VA's draft is a great start.

The CHAIRMAN. Thank you.

Ms. KELEHER. Good afternoon. I would agree with my colleagues here that I don't believe that there is anything that is necessarily a deal-breaker for the VFW. We mirror concerns with the proposals for different pay-fors and offsets, but generally speaking, we are very grateful for the Committee and staff and how much they have been working with us to iron out those technical differences that we have had and seeing those changes made in the most recent draft legislation.

The CHAIRMAN. Well, that goes both ways.

Ms. KELEHER. Yes, thank you. There are, as we put in our testimony, different provisions we would like to see added into your Committee's legislation; Urgent Care, the different personnel provisions that are in Title III and Title IV of the Care Act and we are happy to continue working with you to see if we can get those in there, but nothing that is going to make the VFW oppose.

The CHAIRMAN. Well, your point on Urgent Care, I read a statistic the other day that as late as 2010, half the care in this country is provided, half the visits were in emergency rooms. And I think you make a great point; you are seeing these walk-in clinics all over the country.

And the VA is doing a pilot project, I think in California and Arizona, and I think those are going to be very helpful to us. It may not be ready for prime time yet, but I think it is coming, where you have access to walk-in. I mean, maybe, it may be the next thing we do, but I think you are spot-on right about that, easy, convenient care. Maybe keeping the CBOC open until 9:00 or 10 o'clock at night, maybe one provider there.

I know our practice has an Urgent Care center with it, now. We have about 120 providers in our practice that we open early in the morning before people go to work. We are open until 10:00 or eleven o'clock at night. You have x-ray, you have all these things that you are able to do. And maybe it won't be that comprehensive at every one, but I think if you kept it open at the CBOC, I think that is absolutely right. The problem is finding providers.

One of the things before my time is expired that I want to get to is when we were in Canandaigua about, what, 3 weeks ago?

Yeah, 3 weeks or so I visited Canandaigua, and I told the folks there and they agreed with me and I said, Look, we are doing all this work and you are answering all these calls, but are we actually reducing suicide by doing it. And we need to evaluate whether we are or whether we are not. That is one thing.

And two, on Andy Barr—Congressman Barr's—my concern—I am an OB/GYN doctor and VA's many times, are not set up to take care of women. And we have a program in Tennessee called Guard Your Buddy. And the guard commander told me when he first took over, I think it was in 2011, he had four—in the first six or eight weeks he was a commander, he had like four suicides. They had immediate access to people. You pick up the phone, you call, you are talking to a master's level person literally in a minute or two. They dropped that number by 70 percent. So, we know that immediate access to care reduces that.

And Dr. Wenstrup mentioned some other things. My time is expired. I am preaching now, so I am going to yield to Mr. Walz.

Mr. WALZ. Well, I would say preach on, brother. We need the choir to sing loudly. We know that is who is here.

But to each of you, thank you all. And full disclosure, to the millions of veterans that you represent, those—Dr. Roe and I included in that up here—we are grateful. We are grateful for that and I think about those folks who are out there in Koochiching County, Minnesota sitting there watching if they are still awake are watching this thing, but they are engaged and that he want to know. And they are sharing their impact—their experiences and they just want to get care. They just want it to be as efficient as it possibly can and they understand that that is going to mean maybe some changes and some sacrifices.

But I think Dr. Roe's question is one I would ask you. Keep us apprised of redlines. I know they talk about the sausage-making or whatever. At least the sausage-making here is done in the open and it is done forward, and I don't necessarily see sausage-making as a pejorative. I represent the Hormel Corporation and every can of SPAM is made in my district, so sausage-making is good. But you need to let us know on the redlines.

And something Dr. Roe has done that I very much appreciate, when I have brought up issues and we have talked about pay-fors, I think a fair challenge was, well, then help me find one that is satisfactory. I would ask all of us and your Members, if we can't live with the round down, what would you suggest? How do we go about this? And there is a broad array of things that we can do to make that happen. So, I am grateful. So, just let us know on that.

I just have one question on another bill, a specific one. One of the draft bills on today's agenda seeks to improve veterans' access to same-day mental health care, which is a goal all of us share. It was part of the emphasis on us working together on the Clay Hunt Act and making sure those things happen. So, there is great agreement on that.

But on this one, it removes VA from the process of allowing Community Care and nonprofit providers for say who is eligible for accessing that care. That idea of the guarantor and the coordinator was always—and I bring this up because this is nothing new—many of you in this room remember in 2013 in Atlanta when we

couldn't get in, we gave vouchers to enter the private sector, which basically we lost track of those folks.

Well, it turns out a year later, there were 372 people on the waiting list, the back waiting list in the private sector. VA's showed zero and it looked like we had great efficiency. The problem was we lost total track of them. We lost total track of how they were getting their care and many were not getting their care. So, I ask you in this, and I know this came late to the review on this piece of legislation, have you got a chance to review this and what concerns do you have when, again, the goal is noble, the goal is shared, but I am very hesitant because of our experiences on the guarantor and the coordinator, if anyone wants to tackle that if you are ready.

Mr. ATIZADO. Mr. Walz, thank you for asking that question. And I appreciate you recognizing that we got that bill late. We did do a preliminary read on that and based on that preliminary read, we are unable to support the SAV Act. I think that is what you were referring to, is the SAV Act.

Mr. WALZ. That is correct.

Mr. ATIZADO. Simply because, you know, military sexual trauma or post-traumatic stress disorder, and the depressed disorder that comes from that event requires not just access—yes, access is important—but the kind of care they get, the follow-up care that they need, the full range of services beyond just clinical care that VA provides as a provider of military sexual trauma care is what appears to be lacking in this bill. And so, that is where our concern really stems.

Yes, it does provide access, but what kind of care is being provided? How does it link up with VA? Like you said, a coordination of care? Many folks that work in a veterans health policy space know that mental health patients in the VA health care system require a lot more care and services and benefits than just health care and so that is where the weaknesses are that I think we see.

Mr. BUTLER. For The American Legion, we have not had an opportunity to review it, but we will get back to you with our comment.

But for your explanation of what happened in Atlanta, that is concerning, and so the coordination of care and all the things that have to come together in such a bill like this would—we would have to have the assurance that everything that needs to occur is articulated in that particular bill so that there isn't any unintended consequences. But we will review it and get back to you with our official comment.

Mr. WALZ. Thank you.

Mr. BUTLER. We will take it for the record.

Ms. KELEHER. Thank you for that question, Ranking Member. The VFW mirrors your same concerns with making sure that where these five pilot sites would be, making sure VA would have access to the health care records, making sure there is the continuum of care, making sure that the veterans who may possibly use that pilot program still have the ability to get into VA for say, sexual dysfunction or whatever other physical health—I hate using that term because mental health and physical health are all health—whatever physical ailments they have.

And to mirror with your concerns regarding Atlanta in seeing if that might be something that would tie into this, at the VFW we had psychologists from the Atlanta VA, which we worked with the Committee to bid on, after their crisis, they had thousands of veterans seeking care in the community that they weren't keeping track of those contracts which actually ended in, I believe, September and their estimate was they were about to have a thousand veterans without access to VA mental health care services because they still had the provider shortage.

So, how would that play out in a pilot such as this if we were allowing everybody to seek private practice in five different location sites?

Mr. WALZ. I appreciate that input. We will follow up on this. It is new to it and we have work to do.

The CHAIRMAN. Thank you. Mr. Poliquin, you are recognized.

Mr. POLIQUIN. Thank you, Mr. Chairman. I appreciate it. Thank you all very much for being here and being a service to our country. We very much appreciate it.

Mr. Dunn has submitted a draft form of a bill, the VICTOR Act, H.R. 2601. Are you folks familiar with that? I want to make sure we submit a copy of this report. For the record, it was in March of 2014 and it was conducted by the Journal of American Medical Association and it is entitled, "The Association of Distance From a Transplant Center With Access to Wait List Placement, Receipt of a Liver Transplantation and Survival Among Our Veterans."

And the study effectively concludes that if veterans live beyond 100 miles, that they are less likely to be put on a wait list or on a list for transplants or a transplant. And they have a lower likelihood of actually getting the transplant and, therefore, an increased risk of death or severe injury.

So, my question to you, folks—and Ms. Keleher, if you don't mind, I will direct this question to you—the study concludes that this 100 mile from a transplant center is not arbitrary; it is based on science. And I know that the sponsors of this bill wants to make sure that science backs up this study and that this is recognized.

Have you studied this and how can you comment on that?

Ms. KELEHER. Thank you for the question. I will say, I haven't seen that study specifically, but the VFW does believe that the decision should be based on patient and provider decision. We clearly want everybody in need of an organ transplant to, aside from actually being able to receive the organ, get that transplant done in the quickest and most efficient manner for the most likely outcome of survival and lack of infection, so on and so forth, later on down the road.

Mr. POLIQUIN. Any of the other gentlemen, either of the other gentlemen like to comment?

Mr. ATIZADO. So, thank you for raising that study. That is actually in our testimony with regards to the bill. And our organization's position on the bill is such that because we don't have a specific resolution that would allow us to support the bill, we are unable to take that position. That is to say, we wouldn't oppose its favorable consideration.

You know, clearly, going through a transplant is the kind of procedure that could end somebody's life, not just having it done, but

leading up to it. And I think these bills that look at allowing these veterans to be involved in a veteran-centric procedure, process and policy, I think is a good way forward and hope that this bill does get favorable consideration by this Committee.

Mr. POLIQUIN. Thank you. Mr. Butler?

Mr. BUTLER. The American Legion supported the bill. We understand and when we did our analysis of everything, we saw an either IG or GAO Report that we included in our written testimony that talked about VA experiencing difficulties in providing timely access to transplant patients. And we believe that that is a critical health care need. Veterans can't survive—and the donor—without the transplant and the ancillary services immediately following the transplant. That is a lifelong event. So, we believe that that is a needed service, which we support.

Mr. POLIQUIN. Thank you. Mr. Chairman, before I yield back, I just want to, for the record, make sure we submit this for the record, this study that, in fact, concludes that there is worse care for veterans that live beyond 100 miles of a transplant center. I know Mr. Dunn from Florida has done a heck of a job on H.R. 2601 and I yield back, sir.

The CHAIRMAN. Thank you. And so, without objection, so ordered.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

First of all, I would like to say I want to associate myself with Ranking Member Walz's comments earlier about the VA's role as a coordinator of care. I think that is an essential function of the VA.

And one of the other bills on the agenda that was added late—and I was disappointed it was added late last week and didn't provide you all with enough time to review the text and prepare testimony—is Representative Gallagher's bill and it had to do with the veteran suicide. Have you had a chance to review that bill and ascertain whether or not your organization's support can support this bill, and starting with Mr. Atirazo—Atizado, I'm sorry, Atizado.

Mr. ATIZADO. Is this the military SAV Act; is that what we are talking about?

Mr. TAKANO. No, no. This is the—

Mr. ATIZADO. I couldn't.

Mr. TAKANO. It is the Same Day Access to Mental Health Care.

Mr. ATIZADO. Yeah, I think we share the same concerns with regards to the comprehensiveness of that and I think that the approach of the bill was, if I understand it correctly, was concerning about the comparing these services, but I hesitate to answer this question in full. If I could answer that for the record, Mr. Takano, I would appreciate it.

Mr. TAKANO. Please. I would be interested in your response.

The American Legion?

Mr. BUTLER. We did not have an opportunity to review any of the bills that came in late, so we are going to have to go back and take a look at those and submit our comments for the record.

Mr. TAKANO. Great.

Ms. KELEHER. The VFW will have to submit for the record as well; we don't have an official stance right now.

Mr. TAKANO. Already thank you very much.

Mr. Atizado—I will look forward to those responses—Mr. Atizado, in your testimony regarding the minority's draft language, you indicated DAV generally supported the intent of the section that would provide VA with new authorities to incentivize medical students to fill the 1500 slots created under the VA CAA; however, you indicated alternative incentives should be considered as well.

Would you care to elaborate on what those alternatives are, in your opinion?

Mr. ATIZADO. Sure. I would—first of all, I would like to take that for the record, Mr. Takano.

Mr. TAKANO. Okay.

Mr. ATIZADO. Only because I know there are specific—there are very specific recommendations that we have and I don't want to misspeak. This is a very important issue, Mr. Takano.

Mr. TAKANO. I appreciated the secretary's response, I mean, he believes that the sheer numbers of medical students competing for these slots is going to be enough of an incentive for students to compete for slots that will require them to serve in the VA; however, my concern is that certain market realities may actually put that belief in doubt. And why? Because I have no doubt that many medical students will take the opportunity to serve at the VA; those slots can be filled.

My question is: Will they be filled with our best student? I think we need to incentivize our best students to serve at the VA and I think maybe we—I would love to hear what the American—what the DAV has to say about that.

Anybody else happy to answer that question? If not, we will just take it for the record.

Ms. Keleher, in your written testimony, you mentioned VFW's concern on how VA's Care Act continues to treat care in the community as a mandatory program. Can you explain why that is so concerning to VFW and what it could mean for VA.

Ms. KELEHER. Thank you for the question, Mr. Takano. VFW, as well as, I believe, all the VSOs here in front of you, support seeing the Choice Program being made into discretionary and we are thankful for the legislation containing that. There are concerns in the community that if the program were to stay mandatory, first of all, we don't want to continuously have the crisis that we keep having with having to find money to fund them again; it is rather exhausting.

And also, we were concerned that over time, there would be a gradual erosion of VA health care systems. If we are continuously having to find money to put into mandatory spending for VA and Community Care providers and then we are having to put up a fight to make sure VA is receiving matching, or at least somewhat close to the similar amount of money so that they can continue building VA, whether that be infrastructure, IT, hiring more providers, there are various things that VA needs to continuously do. So, by making it discretionary, that makes sure that we are not continuously handing money over that we have to keep finding while allowing money that VA already has to—

Mr. TAKANO. We would have to continue to ask the question about the proper balance instead of it being on auto-pilot mandatory spending, we would have to continually ask that question and

take a look at making sure that our core VA programs are being funded properly.

Ms. KELEHER. Yes.

Mr. TAKANO. Thank you very much.

The CHAIRMAN. Thank you. I thank the gentleman for yielding.

I now ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material.

Mr. Walz, do you have any closing thoughts?

Mr. WALZ. Just final thoughts. Thank you, all.

And, again, I think it is important, sometimes people don't process—process does matter. There—out—one of those veterans, I saw Joe Bousea [ph] and his service dog were sitting next to me and he leaned over to me in confidence and said, I don't trust politicians very much, but I am hopeful. I am hopeful that you guys can get this together.

They are watching. They are watching how we act. They are watching you, as organizations on what we are doing. And once again, I think that word that Joe said, I am hopeful that we are in a good spot here, I am hopeful for as your feedback. I always remain committed that we can find these answers. And, again, if we never lose sight, providing quality access to care for our veterans in a timely manner. That is what we are looking for.

So, thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

And I totally agree with that. That is the whole purpose of all of these hearings this morning. And one of the challenges Dr. Shulkin mentioned was he is going to hire a thousand new mental health providers and he lose—and he hires 900 and he loses 945, that is going backwards.

And I think you see that—and as I travel around the country to go to VAs and I will do some more traveling in a couple of weeks to the West Coast and into the middle part of the country, you hear that a lot: We don't have enough primary care people. But you also hear that in the private sector. It is not just a VA problem; it is a problem of our health care system in this country.

So, what Mr. Takano has done in trying to add new primary care slots at VA, and others are going to come up with ideas to add more slots, I think those are all good ideas.

I can't thank you all enough for the work that your teams have put in, with putting this Choice Program pilot program—not pilot, but program together. Without your help, we couldn't have gotten to where we are. We have got a few little things we have got to change and we will start working on those this afternoon. We have got our marching orders.

And hopefully we can get this marked up. And the reason that we need to do that as soon as we can is because the Secretary just pointed out how much money we have left in the program and I agree with you on the discretionary versus mandatory; we need to get it in one pot. We can then find out what the needs are and appropriate the money for it. So, I agree with that, it makes it simpler to certainly administer. As he pointed out, a 13 percent administrative fee is incredibly high. That money could be going for health care for veterans or a new clinic somewhere.

So, I want to thank you all very much and without any further comments, this meeting is adjourned.

[Whereupon, at 1:07 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of The Honorable Jim Banks

Chairman Roe, Ranking Member Walz, thank you for holding this hearing today and for including my bill on the agenda. I am proud to be a member of the Veterans Affairs Committee in which the focus of our work is to ensure the brave men and women of our armed services are never forgotten. Our gratitude for our servicemen and women leads us to address the personal impact of their service. We are responsible for their care and healing.

Veteran Suicide

Suicide is our nation's 10th leading cause of death, claiming over 40,000 lives a year, almost five times as many people as make up my entire hometown of Columbia City, Indiana. This rate has increased by over 32% since 2001. Veterans account for 18% of those deaths, even though they only constitute 8.5% of the nation's population. Every day, 20 veterans die from suicide. Veterans are 22% more likely to commit suicide. Our female veterans are two and a half times more likely to commit suicide than their female civilian counterparts. Post-Traumatic Stress Disorder (PTSD) affects 7–8% of the regular population, but for those who have served in warzones, it affects between 11–20% of our veterans. The invisible wounds of PTSD are a large contributing factor to many of the suicides that take place among veterans. As research on PTSD continues and treatments are refined, we must remain vigilant in addressing the needs of our veterans.

The Department of Veterans Affairs' Efforts

In recognizing the increase in veteran suicides from 2001 to 2014, the Department of Veterans Affairs (VA) has refocused their services for veterans. Part of those efforts is the creation of the 24/7 Veterans Crisis Line (the VCL) in 2007. The hotline serves as a space for those in crisis to discuss their feelings privately. As of May 2016, the hotline answered over 2.3 million calls and 55,000 text messages. Emergency services were dispatched 61,000 times and 376,000 referrals to VA's Suicide Prevention Coordinators were made to help make sure veterans reach further care options. The VCL is a critical component to providing direct, immediate care to those in crisis and aid in the prevention of suicide.

Draft Bill Background

My draft bill seeks to enable the VCL to be an even more effective component in the VA's overall approach to veteran mental health. In our information age, the power of data analytics is useful tool to help the Veterans Crisis Line continue the mission of decreasing the number of veteran suicides. As the current crisis continues, analyzing the data collected by the hotline can help determine the efficacy of VA mental health services.

An Inspector General report from March 2017 indicated room for improvement regarding data analysis and performance measures. Currently, there is no overarching approach to ensure the VA knows the efficacy of the VCL in preventing future suicide attempts.

My bill seeks to ensure the VA has the proper research tools and data necessary to continue comprehensively integrating the VCL in the VA's mental health services program.

Draft Bill Summary

The draft bill would require the VA to conduct research and prepare a report that would provide the following answers:

- The efficacy of the VCL as a conduit for veterans to be connected to opportunities for sustained mental health treatment through the VA.
- The visibility of the VCL to veterans.
- The efficacy of VA health care in ensuring that those receiving physical care find help for any additional mental needs.
- The efficacy of VA mental health care in decreasing the chance of a veteran needing to contact the VCL again.
- The efficacy of the VCL as a conduit for non-veterans to be connected to opportunities for their veteran friends to receive sustained mental health treatment through the VA.
- If the amount of times a veteran contacts the VCL changes outcomes.
- The efficacy of mental health care decreasing the risk of suicide.

With these answers, the VA can be further empowered and enabled to fight suicide. These answers will allow the VA to determine the impact of mental health services to veterans in need and the impact of the VCL. We must ensure our veterans know they are not alone after the phone call. Suicide attempts usually result from mental health concerns that require further care to find complete resolution. This bill would help ensure that suicide is not simply delayed but that the mental health concerns leading to it are being addressed and treated.

Addressing Veteran Service Organizations' Concerns

Through talks with the Veteran Service Organizations, I have learned of their concerns for veterans' information privacy. I firmly believe in that privacy and seek to maintain it. That is why this bill will not change the manner of the phone conversations that veterans have with the VCL. This bill does not require any change in the practices and procedures already implemented by the VCL.

With the call method remaining the same, veterans are still able to maintain anonymity. The VA will simply be required to analyze the data that is collected, and provide a report detailing the findings to the Committee on Veterans Affairs in the House and the Senate.

Another concern raised is in regards to the privacy of the information that would be analyzed. This bill does not intend to jeopardize the privacy and therefore, I intend to work with the committee to clarify stringent privacy protection during data analysis. With these concerns addressed, the VA can receive quantitative insight into the efficacy of its life-saving programs.

Conclusion

To stem the tide of veteran suicide, I urge my colleagues to support this bill. With 20 veterans taking their lives every day, we must do everything we can to better understand and improve the effectiveness of the currently available assistance programs.

Prepared Statement of Honorable Mike Gallager

Chairman Roe, Ranking Member Walz, and distinguished Members of the Committee: Thank you for inviting me to join you today.

My draft legislation before you seeks to address the unmet suicide prevention needs of America's military veterans. Every day, 20 veterans take their own lives, and on average, 14 of the 20 veterans who commit suicide each day did not receive care within the VA.

In May 2017, the Secretary of Veterans Affairs, Dr. David Shulkin, stated the following: "[N]othing is more important to me than making sure that we don't lose any veterans to suicide. As you know, 20 veterans a day are dying by suicide. That should be unacceptable to all of us. This is a national public health crisis, and it requires solutions that not only VA will work on, but all of government and other partnerships in the private sector, nonprofit organizations."

As a veteran myself, I could not agree more with Dr. Shulkin. That is why my colleague Seth Moulton-a fellow veteran-and I have been working on legislation to address this crisis.

Simply stated, our bipartisan legislation would improve veterans' access to evidence-based mental health care services at community or non-profit mental health providers participating in the Veterans Choice Program.

Our bill would allow eligible veterans in need of mental health services to access the care they need on a same-day basis in the community, without a referral. This

narrow provision would apply only to mental health services, in order to address the suicide crisis affecting the men and women who have served our nation.

We believe this legislation is sorely needed. In 2016, the VA Center for Innovation published a report titled "Veteran Access to Mental Health Services." The report-which is a compilation of interviews with veterans from across the country-is remarkable. I believe the candor of these findings is truly a testament to the VA's commitment to transparency and I commend the Department for recognizing that some veterans need mental health care choices outside of the VA.

For example, the report states: "For many Veterans, private providers and non-profits that offer confidential, bureaucracy-free access to timely care feel like a positive and desirable alternative to VA processes."

The report also states: "Many Veterans are dismayed (and left feeling like the VA wants to fob them with drugs) when they are offered psychotropic medication before exploring non-medicated treatments options."

Further, in discussing proposed solutions, the report finds: "Many Veterans don't want to use VA services for mental health care even if the red tape is cleared so how can we enable other avenues for care that benefit both Veterans and non-VA providers?"

These findings exemplify why Congressman Moulton and I are teaming up to find a bipartisan, commonsense solution to this crisis.

By allowing eligible veterans to access same-day, evidence-based mental health care services at community and non-profit providers that are credentialed under the Choice program's care delivery network, veterans in crisis will be able to get the help they need, when and where they need it.

The United States has now lost more veterans to suicide than the nation has lost in Iraq or Afghanistan, and we believe our nation has a continuing obligation to the men and women who have served it to help address their mental health needs.

Community-based and non-profit mental health care providers stand ready to help fill the gap in addressing the unmet need in veterans' mental health care. This legislation gives Dr. Shulkin the ability to allow such providers to meet these urgent needs, in order to continue to address what the Secretary has described as his number one clinical priority.

I hope every Member of the Committee will support this effort, and I look forward to working with you all moving forward. Thank you again.

Prepared Statement of Honorable John R. Carter

Chairman Roe, Ranking Member Walz, and other Members of the Committee, it is an honor to speak before you this morning. Chairman, I thank you for including my bill, H.R. 1133 Veterans Transplant Coverage Act of 2017, in today's hearing.

I am here this morning on behalf of the thousands of American veterans who find themselves in need of transplant care. Under current law, a veteran in critical need of a live donor transplant can't, with their VA coverage, receive a donation from a non-veteran. This excludes children, siblings, and other non-veteran family members the people a veteran would most likely find a willing and successful organ match with.

This is unacceptable. My legislation, the Veterans Transplant Coverage Act of 2017, removes unnecessary barriers that prevent veterans from receiving the care they deserve. H.R. 1133 will allow veterans to receive donations from a live donor regardless if the donor is a veteran or non-veteran, and allow them to have the procedure done at a non-VA facility if that makes more sense for the patient. This is common-sense, life-saving policy, and I'm proud that it has received robust and bipartisan support as a standalone bill.

This legislation is a good fit for the Veteran Coordinated Access & Rewarding Experiences (CARE) Act because it seeks to give Veterans more options when it comes to their health care, both in donors and providers. This is especially beneficial for veterans who live in rural areas, far from the closest VA Medical Center, to say nothing of the closest VA transplant facility.

Chairman, I want to take this time to pause and recognize my constituents, the inspiration for this bill, Mr. and Mrs. Charles Nelson and their son Austin, in from Leander, TX. Mr. Nelson, a 100% disabled service-connected veteran, served his country and did everything this grateful nation asked of him. Unfortunately, while serving in Korea, he developed kidney disease which further led to the need of a kidney transplant. His then 28-year old son Austin was a willing donor, and a match. Initially, Mr. Nelson was told the surgery would be covered under the VA Choice Program of 2014 and able to be performed at the University Hospital in San

Antonio. However, because his son is not a veteran, the VA Central office denied coverage of the costs. The Nelsons were forced to use Medicare and private donations, and their own savings to cover the surgery's costs.

Mr. Charles Nelson deserved better..Our veterans deserve better. VA Health should be there to address the health care needs of those who have served this country in uniform. For Mr. Nelson, who served our nation bravely, to be forced to solicit donations to cover life-saving medical treatment was a failure of the VA system and an insult to his service.

I am proud to represent Mr. Nelson and the more than 84,000 veterans in my congressional district. Each one of them, along with the 22 million nationwide, deserves access to life-saving transplant procedures regardless of donor, and in a facility which makes sense for them and their family. I hope that, with the passage of H.R.1133 Veterans Transplant Coverage Act of 2017, and of the entire Veteran Coordinated Access & Rewarding Experiences (CARE) Act our veterans can access the care they need in the best facility though their VA coverage. Our veterans deserve nothing less than the best we can offer them for their service.

Chairman Roe and Ranking Member Walz, I want to thank you again for the opportunity to speak here today, and I want to thank all the Members of the Committee for their service to our country and our veterans.

I yield back.

Prepared Statement of Honorable Glenn 'GT' Thompson

Chairman Roe and Ranking Member Walz, thank you for inviting me to testify before the House Veterans Affairs Committee with regard to H.R. 2123, the Veterans E–Health and Telemedicine Support Act, also known as The VETS Act.

The issues before this committee are critically important to ensure that those who selflessly served our nation receive the care and support they rightfully deserve.

With this in mind, a constituent approached me a few years ago to discuss the barriers to care that his fellow Veterans were experiencing through the VA system.

As an active-duty soldier, he told me stories of his friends coming home from deployments and falling through the cracks in our system. Some were suffering from PTSD, TBI and depression, and required the care of specialists. Others had difficulty traveling from their rural communities to VA Medical Centers because of injuries sustained during combat.

It broke my heart to hear the stories of this soldier's friends not receiving the care they deserve.

What made it more difficult was the fact that this soldier is my son.

After numerous conversations about how we can help our service members when they return home, we determined that expanding access to telehealth would be a great start.

Many of our Veterans live in rural areas or are unable to travel far distances. Allowing them to see their health care provider in the comfort of their home would increase their access to care.

As a result, I introduced the Service members Telemedicine and E–Health Portability Act of 2011, or The STEP Act. This bill allowed Department of Defense healthcare professionals and contractors to provide telehealth care to members of our Armed Forces anywhere in the country, even across state lines. This bill was included in the Fiscal Year 2012 NDAA, which was subsequently signed into law.

The STEP Act has allowed more than 32,000 servicemen and women to gain access to telehealth and has been the basis for a number of telehealth expansions throughout the years. The DoD recently decided to expand telehealth care for recipients of TRICARE based on the successes of the bill.

The STEP Act has proven that telemedicine can be expanded safely and responsibly across state lines. While DoD patients can receive telehealth care no matter where they are located, those who receive care through the VA are not afforded the same liberties.

This is why Rep. Julia Brownley and I introduced H.R. 2123, The Veterans E–Health and Telemedicine Support Act.

The VETS Act will similarly allow VA-employed health care providers to practice telehealth across state lines, no matter where the doctor or patient is located.

It also commissions a study of the effectiveness of telemedicine programs utilized by the Department of Veterans Affairs.

While the VA has made major strides in advancing telehealth access, outdated barriers limit its growth. My bill will eliminate these barriers by giving VA-employed providers an exemption to practice telehealth across state lines.

Currently, each state has its own licensing requirements for health care providers to practice medicine within its borders. For example, if a doctor has offices in Pennsylvania and Ohio, they must hold a license from each state.

VA-provider licensing requirements are different. As long as a doctor is licensed and in good standing in a single state, they can practice in-person care within the VA system in any state.

This reciprocity, however, is not afforded to their practice of telehealth. VA providers seeking to provide telehealth care to patients must also be licensed in the state where the patient is located.

While this licensing requirement can be waived if both the doctor and patient are located in a federal facility, such as a VA Medical Center, this still forces a Veteran to travel to a VA facility and applies a separate, unnecessary level of regulation to VA telehealth providers.

These outdated regulations are hurting our nation's Veterans.

The Department of Veterans Affairs has successfully been using telemedicine for quite some time. Since 2002, more than two million Veterans have received telehealth care through the VA. In 2016 alone, more than 12 percent of Veterans receiving VA care utilized telehealth in some capacity. 45 percent of these Veterans live in rural areas.

Veterans who have accessed telehealth are overwhelmingly pleased with the quality of care and access they have received. Those receiving at-home care, for example, cite an 88 percent satisfaction rate.

The VETS Act continues to expand telehealth access for Veterans in a responsible manner. It allows states to hold providers accountable while increasing access to quality care for Veterans who need it. The VETS Act is the result of legislators, practitioners and advocates coming together to negotiate workable language in good faith, and these efforts will result in Veterans across the country gaining access to quality care in the comfort of their homes.

Our Veterans should receive the best care available to them, and this starts with the passage of The VETS Act.

Thank you, again, Chairman Roe and Ranking Member Walz for inviting me to testify before the Committee. I look forward to working with you to expand access to quality care for our Veterans.

I yield back the balance of my time.

Prepared Statement of Honorable Neal P. Dunn, M.D.

Thank you, Chairman Roe and Ranking Member Walz for including my bill, H.R. 2601, the Veterans Increased Choice for Transplanted Organs and Recovery, or VICTOR, in today's legislative hearing agenda. I'd also like to thank all the witnesses for their testimony.

It goes without saying that timely organ transplants can make the difference between life and death. It's always a race to bring the patient, organ and transplant team together in time. Patients must be ready at a moment's notice, and the stakes and risks are always high.

Now, the Department of Veterans Affairs has participated in transplant medicine since 1962, but is a relatively small program which is limited by scope and location. As a result, veterans in need of organ transplants suffer unique challenges in trying to receive transplant care.

Currently, when a veteran receives care through the VA for a transplant, they are subject to traveling to one of only fourteen Veterans Affairs Transplant Centers (VATCs) throughout the United States.

This means that a veteran may be required to travel hundreds, even thousands of miles across several states for a transplant, despite potentially passing many other transplant centers on the way.

To illustrate this point, in the United States, there are currently 147 liver transplant centers. 141 of those transplant centers are civilian transplant centers, 6 are VA transplant centers. A veteran in Florida has 7 liver transplant centers in the state and cannot go to any of them if relying on the VA for care. Similarly, a veteran in California has 13 liver transplant centers in the state but again cannot go to any of them.

The difficulties associated with transplant care are particularly apparent with liver transplants. Given the incidence of end-stage liver disease in the Veteran population, liver transplants are an especially important, life-saving healthcare concern within VA transplant care.

Out of the fourteen VATCs, just six of these transplant centers are designated liver transplant centers. For those veterans who are waiting for a liver transplant at a VATC, they face a 32 percent longer wait time on average than those at non-VA facilities.

The VICTOR Act addresses these challenges by simply reducing the existing barriers to care. If a veteran in need of a transplant lives more than 100 miles from a VATC, the bill allows them to seek care at any federally approved transplant center closer to them that also treats Medicare patients.

Speaking as both a surgeon and a veteran, this is the right course of action.

And this policy change in transplant medicine builds on our larger strategy to improve quality health care access for those, as Lincoln said, "who shall have borne the battle."

Thank you, Mr. Chairman for allowing me to testify on behalf of H.R. 2601 before the Committee today. I yield back the remainder of my time.

Prepared Statement of Honorable Andy Barr

Congressman Andy Barr's Testimony Before the House Committee on Veterans Affairs Legislative Hearing On

Community Care

Tuesday, October 24, 2017

Good morning. I would first like to thank Chairman Roe and Ranking Member Walz for allowing me the opportunity to speak before the House Veterans' Affairs Committee this morning about providing access to community care for survivors of military sexual assault (MST), which my legislation, H.R. 3642, the Military Sexual Assault Victims Empowerment Act also known as the Military SAVE Act helps to improve.

According to the findings of the Department of Veterans Affairs' National Screening Program, 1 in 4 women and 1 in 100 men reveled that they have been victims of military sexual assault during their time serving in the military. This problem was first brought to my attention by a group of women in the Sixth Congressional District of Kentucky, led by MST survivor Karen Tufts. Sadly, due in-part to this emotional stress, two of these women have since committed suicide.

In fact, according to independent nation-wide studies conducted by the National Victims Center, the Medical University of South Carolina, and Florida State University, research has found that female victims of MST are 14 times more likely to commit suicide than women who have never been assaulted.

In addition, according to RAINN (Rape, Abuse & Incest National Network), the nation's largest anti-sexual violence organization, sexual assault is also commonly associated with adverse mental health outcomes such as depression, anxiety, substance abuse, and non-suicidal self-injury, which are also commonly associated with suicidal ideation, attempts, and death by suicide.

While Congress has taken several actions recently to better protect survivors of MST within the military justice system, many survivors have expressed concern that services available within the Department of Veterans Affairs (VA) healthcare system may still not match their specific post-MST needs.

That is why I have been working closely with this committee, veteran service organizations, and my VA Pilot Program Development Task Force to improve medical care for survivors of MST, in order to help get those survivors the care that best fits their unique physical and psychological needs.

This legislation would allow survivors of MST the ability to seek treatment specifically related to their MST injuries by a private healthcare provider of their choice during a 3 year pilot program. MST survivors would be given a choice to participate in this pilot program or remain in the VA healthcare system for treatment options. Participants in both this pilot program and those being treated within the VA healthcare system for MST related injuries would participate in a pre-treatment and post treatment survey as well as a development survey conducted every six months to study individual progress. This pilot program would study the results of the effects that direct access care provides that the VA does not.

A certified VA researcher will be assigned as a member of the VA Community Care Office, which will ensure the quality and integrity of collecting and analyzing data for the study, which would be submitted to Congress for review.

As I mentioned before, I did not create this legislation alone. It has been through the dedicated support and trusted advice of MST survivors and subject matter experts who are members of my VA Pilot Program Development Task Force. I created this task force by carefully selecting each of these outstanding individuals who

helped to develop and determine what the best possible pilot program for MST survivors should look like. Each of these members brought a unique experience and different skillsets to the table, which was ideal for this task force, and I thank them for their contributions.

In conclusion, I ask that my legislation be included in the "Veteran Coordinated Access & Rewarding Experiences (CARE) Act," in order to help provide survivors, both male and female, the proper medical care that best fits unique medical needs.

Again, thank you for allowing me to testify before this committee today, and I am happy to answer any questions that you may have about my legislation.

Prepared Statement of Honorable David Shulkin, M.D.

Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. Thank you for inviting us here today to present our views on bills on the agenda today, including very critical legislation to improve-in a comprehensive way-the delivery of health care to Veterans. Joining me today are Carolyn Clancy, Executive in Charge, Veterans Health Administration, and Dr. Laurie Zephyrin, Acting Deputy Under Secretary for Health for Community Care.

We greatly appreciate the Committee including the Administration's proposal for comprehensive improvements to the Department of Veterans Affairs' (VA) Community Care program, the Veteran Coordinated Access & Rewarding Experiences (CARE) Act. We look forward to working with the Committee in the days ahead to continue our dialogue on how we move forward together on the critical and complex issue of how we provide the best possible health care for Veterans, using the best that VA and other health care providers can deliver in a complementary way.

We received a discussion draft from the Committee describing the future of VA Community Care, dated September 19, 2017, and it is this draft we will discuss in this statement. We understand this discussion draft continues to evolve, and we are happy to assist the Committee in this effort.

We are unable at this time to provide views on the following bills: H.R. 2601, the VICTOR Act, H.R. 3642, the Military SAVE Act, a draft bill to furnish mental health care to veterans at community or non-profit mental health providers that participate in the Choice program, and a draft bill to conduct a study of the Veterans Crisis Line. We will be glad to follow up with the Committee on these bills after the hearing.

H.R. 1133 Veterans Transplant Coverage Act of 2017

H.R. 1133 would add section 1788 to Title 38, authorizing the Secretary of Veterans Affairs to provide for an operation on a live donor to carry out a transplant procedure for an eligible Veteran, notwithstanding that the live donor may not be eligible for VA health care. VA would be required to provide to a live donor any care or services before and after conducting the transplant procedure that may be required in connection with the transplant. The bill would specifically authorize the Secretary to furnish this care at a VA facility or through an agreement or contract with a non-Department entity or provider

VA supports H.R. 1133, contingent on the provision of additional resources to support implementation, although we recommend some clarifications in the bill language. We believe it would be appropriate to limit the duty and responsibility to furnish follow-on care and treatment of a living donor to 2 years after the procedure is furnished by VA. This would be consistent with the recommendations of the United Network for Organ Sharing and the Organ Procurement and Transplant Network. We further recommend that the duty to provide follow-on care and treatment should be limited to that which is "directly related to" the living donor procedure (rather than what "may be required in connection with such procedure," as the bill would provide).

There are other potential issues related to organ transplantation that the bill does not address that we would be pleased to discuss with the Committee in its contemplation of this proposal.

We estimate the bill as written would cost $1.8 million in fiscal year 2018, $9.7 million over 5 years, and $21.5 million over 10 years.

H.R. 2123 Veterans E–Health and Telemedicine Support Act of 2017

Section 2(a) of H.R. 2123, the "Veterans E–Health and Telemedicine Support Act of 2017," would amend title 38, United States Code (U.S.C.), to add a new section 1730B, which would permit a covered health care professional to practice their health care profession at any location in any state, regardless of where such health

care professional or the patient is located, if the health care professional is using telemedicine to provide treatment under chapter 17 of title 38. New section 1730B would specify that this authority would apply regardless of whether the covered health care professional is located in a facility owned by the Federal Government. In addition, new section 1730B would state that nothing in that section would be construed to alter any obligation of the covered health care professional under the Controlled Substances Act (21 U.S.C. 801 et seq.). New section 1730B would define "covered health care professional" to mean an individual who: (a) is employed by VA and appointed under the authority of sections 7306, 7401, 7405, 7406, or 7408 of title 38, or title 5; (b) is authorized by the Secretary to provide health care under chapter 17 of title 38; (c) is required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable VA policies; and (d) has an active, current, full, and unrestricted license, registration, or certification in a state to practice the health care profession of the health care professional.

Section 2(b) would provide a clerical amendment to the table of sections at the beginning of chapter 17 of title 38.

Section 2(c) would require the Secretary, not later than 1 year after the date of enactment of the Act, to submit to Congress a report on VA's effective use of telemedicine. The report would require specific elements such as the assessment of the satisfaction of Veterans and health care providers with VA telemedicine; the effect of VA-funded telemedicine on the ability of Veterans to access health care; the frequency of use by Veterans of telemedicine; the productivity of health care providers; wait times for appointments; any reduction in the use of in-person services by Veterans; the types of appointments for telemedicine that were provided; the number of requested appointments for telemedicine disaggregated by Veterans Integrated Service Networks (VISN); and any VA savings, including travel costs.

VA supports this bill, which is similar to section 301 of the Administration's Veteran CARE Act and section 4 of one of the draft bills; however, VA prefers the language in section 301 of the Administration's Veteran CARE Act and section 4 of the draft bill to the language in H.R. 2123 for the reasons expressed in our views on those bills.

VA does not have a cost estimate for section 2(a) of the bill at this time. VA estimates that implementation of the one-time reporting requirement in section 2(c) of the bill would cost $17,000.

H.R. XXXX Draft Veteran Coordinated Access & Rewarding Experiences (CARE) Act

VA presented the House and Senate Veterans' Affairs Committees on October 6, 2017, with its draft Administration legislative proposal, the Veteran CARE Act, designed to improve Veterans' experiences with and access to healthcare, building on the best features of VA's existing Community Care programs and strengthening VA's ability to furnish care in its facilities. The bill also would provide new workforce tools to assist in maintaining and strengthening VA's world-class medical staff, enhance business processes to improve financial management of the Community Care program, and strengthen VA's ability to partner with other Federal agencies and streamline VA's real property management authorities.

The bill's provisions would clarify and simplify eligibility requirements, set the framework for VA to continue to build a high-performing network, streamline clinical and administrative processes, implement new care coordination support for Veterans, and merge and modernize community care programs.

The bill would replace the current wait-time and distance eligibility criteria under the Choice Program (30 days/40 miles) with criteria based on clinical need in light of access, quality of care, and convenience.

A description of each provision of the CARE Act follows.

Section 101 of the bill would improve VA's flexibility to meet Veterans' demands for hospital care, medical services, and extended care services by authorizing VA to enter into agreements (Veterans Care Agreements, or VCA) that, in general, would not be subject to the competition or other requirements associated with Federal contracts, while still subjecting eligible entities and providers to all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.

Section 102 would allow similar flexibility for State Veterans Homes.

Section 111 would create a new section 1730B to allow VA to record an obligation for community care when the amount is certain (i.e., when VA approves the payment of the claim for the incident of care). This provision would reduce the potential for large de-obligation amounts after the funds have expired.

Section 112 would reform VA's payment process to provide prompt payment of all community care.

Section 113 would clarify the payment rates for VA-provided community care..

Section 114 would allow the Secretary to pay a provider for services rendered even if the Secretary has not entered into a contract, agreement, or other arrangement for the furnishing of care and services with that specific provider. This would provide a legal authority for the Department to pay for care or services furnished in good faith by a provider.

Section 121 would amend the existing provision in section 7332(b)(2)(H) that permits VA to disclose protected information to community providers and create a new exception in subparagraph (I) that would allow VA to share records with third parties to recover or collect reasonable charges for care provided. The amendment to existing law would revise subparagraph (H) to clarify that VA could share records with non-Department providers for the purpose of furnishing hospital care, medical services, or extended care services to an individual and for performing other health care-related activities or functions. This authority would also allow VA to disclose medical records for purposes of billing, thereby increasing VA's ability to recover funds from Veterans' other health plan contracts or other responsible third parties for care furnished by VA.

Sections 131 and 132 would strengthen VA's ability to collect reimbursements due for non-service-connected care from health plan contracts and third parties responsible for the payment of such care.

Section 201 would amend section 1703 to establish the eligibility criteria for the consolidated VA Community Care program to improve Veterans' access to community care. The bill would provide for a clinically-driven referral process that would enable a Veteran to access community care if the service they need is not available at a VA facility, if the Department could not schedule an appointment for the Veteran within a clinically acceptable period of time, or if the Veteran and the Veteran's primary care provider agree that it would be in the best medical interest of the Veteran to receive care in the community. In making the determination regarding the best medical interest, the Secretary would consider, for example, the distance the Veteran would travel for such care, the nature of the care or services required, and the frequency that such care or services need to be furnished.

In addition, Veterans would be authorized to opt to receive community care if the Secretary determines that a certain type of care furnished by a VA facility does not meet the quality and access standards of the Department. The Secretary would make regular determinations once each year and would have the authority to limit access to community care by the type of care or service required, the length of time such services would be available, and where such services would be available.

Decisions under either of these scenarios would be considered clinical determinations and outside the jurisdiction of the Board of Veterans' Appeals.

Section 202 would create a new section 1725A to provide Veterans access to walk-in care from community providers that are part of VA's community care network to ensure their access to care when minor injury or illness arises.

VA would be required to develop procedures to ensure that enrolled Veterans who have received care from VA within the prior 24 months are able to access walk-in care from qualifying non-Department entities or providers.

Section 211 would amend section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) to authorize VA to use the existing Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-VA facilities or through non-Department providers furnishing care in VA facilities.

Section 221 would repeal and amend current authorities to account for the changes to section 1703 made by section 201 of the bill.

Section 301 would create a new section 1730C to authorize VA health care professionals to practice in any state, including by telemedicine, notwithstanding the location of the health care provider or the patient.

Section 302 would rescind section 7409, which is VA's authority to contract for scarce medical resources. This authority has not been used by VA recently as other authorities are sufficient to fulfill the purpose of section 7409.

Section 303 would authorize VA to increase the number of graduate medical education residency positions at covered facilities by up to 1,500 positions in the 10-year period following enactment of this Act. The Secretary would be authorized to provide a stipend and other benefits for residents appointed under this section, whether they are assigned in a Department facility or not. Individuals would be required to apply to participate and agree to serve a period of obligated service in return for payment of educational assistance. These benefits and requirements would apply solely to the new positions and will assist the Department in determining whether such a program is attractive to graduate medical education residents.

Section 304 would repeal section 705 of VACAA (Public Law (P.L.) 113–146; 38 U.S.C. 703 note), which currently prescribes limits on awards and bonuses that can be paid to VA employees through fiscal year 2024.

Section 305 would amend 38 U.S.C. § 7411 to include authority to reimburse continuing professional education for full-time board certified Advanced Practice Registered Nurses.

Section 306 would modify 38 U.S.C. § 7309 to remove the requirements for the Chief Officer of the Readjustment Counseling Service (RCS) to have at least 3 years of experience in providing and administrating direct counseling services or outreach service that is specifically within RCS. This would expand the pool of applicants for the RCS Chief Officer position.

Section 307 would enact a technical correction to ensure that individuals appointed under 38 U.S.C. § 7401(4) can be compensated within the full-range for Senior Executive Service pay, $124,406 to $187,000. Section 207 of the VA Accountability and Whistleblower Protection Act of 2017 (P.L. 115–41) allows for an individual to have their pay set up to $187,000, but because the Act failed to amend 38 U.S.C. § 7404(d), it prevents such an individual from being paid more than $151,700.

Section 308 would expand the definition of compensation to include pay earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave, or other paid absences for which pay is not already regulated.

Section 309 would amend 38 U.S.C. §§ 7455 and 7401 to include Certified Clinical Perfusionists in the list of excepted positions and convert such positions to full Title 38 status to assist in the recruitment and retention of highly skilled Perfusionists.

Section 321 would amend section 8104(a)(3)(B) to redefine the term "major medical facility lease," providing a cost increase to a dollar threshold that was last changed in October 2008.

Section 322 would amend sections 8101 and 8104 to expand VA's capacity to do more detailed planning and design, leasing, and construction of joint facilities in an integrated manner.

Section 323 would amend section 8104(a)(3)(A) to exclude the Department's nonrecurring maintenance projects from the definition of a "major medical facility project."

Section 324 would amend section 8162 to improve VA's Enhanced-Use Lease (EUL) authority. Specifically, it would modify section 8162(a)(2) to allow the Secretary to enter into new EULs if the lease will not be inconsistent with or adversely affect the Department's mission and will either enhance the use of the property or be for the provision of "supportive housing" as defined in section 8161(3).

Section 401 would allow VA and DoD to collaborate to carry out a joint pilot program to determine the feasibility and advisability of sharing health care resources without entering into reimbursement agreements for such services.

Section 501 would amend section 101(p) of VACAA to modify the termination date for the Veterans Choice Program. VA would have authority to authorize care and services under the Veterans Choice Program through September 30, 2018, and would be able to complete all episodes of care authorized on or before that date.

Section 502 would authorize to be appropriated to the Veterans Choice Fund established by section 802 of VACAA, as amended, $4,000,000,000 in mandatory funds.

Section 503 would extend until 2027 the requirement that, in computing cost-of-living adjustments for disability compensation and dependency and indemnity compensation, increased monthly rates and limitations must be rounded down to the nearest whole dollar amount.

Section 504 would amend section 3313 to impose tuition and fee payment caps at Institutions of Higher Learning with flight training programs and establish that only flight courses determined necessary for completion of a degree program may be approved for payment.

Section 505 would amend section 5503(d)(7) to extend by 1 year until September 30, 2028, VA's authority to reduce the amount of pension furnished by VA for certain Veterans covered by Medicaid plans for services furnished by nursing facilities.

Section 506 would amend section 3729 to extend by 1 year until September 30, 2028, VA's authority to continue collecting home loan fees at their current rates.

VA strongly supports enactment of all of these provisions. We will continue to work closely with the Committee as we create additional legislative proposals to strengthen our ability to modernize the VA healthcare system and to develop innovative ways of delivering high-quality, timely healthcare to our Nation's Veterans.

H.R. XXXX Draft Bill to Establish a Permanent Veterans Choice Program

Description of Discussion Draft

The draft bill contains a number of provisions amending different authorities related to VA's Community Care program. Section 101(a) would create a new section 1703A in title 38, U.S.C., titled "Veterans Choice Program." Proposed section 1703A(a) would broadly require the Secretary, subject to the availability of appropriations, to furnish hospital care and medical services to eligible Veterans, at the election of the Veteran, through contracts or agreements with network providers. The Secretary would be required to establish regional networks of providers and would be required to determine the regions based on annual capacity and market assessments of the VISN; such assessments would be required by a later provision of this bill.

Proposed § 1703A(b) would require the Secretary to assign each Veteran upon enrollment into the VA health care system to a VA patient-aligned care team (PACT) or otherwise to a dedicated primary care provider of the Department. If the Secretary were unable to assign a Veteran to a VA PACT or primary care provider, the Veteran would select a community primary care provider from a list of such providers among network providers in the Veteran's community. Each year, the Secretary would determine if the Veteran could be assigned to a VA PACT or primary care provider and make such an assignment if able. VA could only furnish specialty care or services to eligible Veterans upon the referral from the Veteran's primary care provider. The Secretary would determine whether or not to furnish such specialty care in a VA facility, through a network provider, or pursuant to another agreement where a non-Department provider furnishes care in a VA facility or a VA provider furnishes care in a non-Department facility. In determining where to furnish the care, the Secretary would give priority to VA medical facilities and providers, but would take into account several factors, including whether the Veteran faces an unusual or excessive burden in accessing such specialty care based on several criteria and whether the Veteran's primary care provider recommends the care be furnished by a network provider.

Proposed § 1703A(c) would require the Secretary ensure that, at the election of an eligible Veteran receiving care and services under this section, the Veteran receives care through the completion of the episode of care, including all specialty and ancillary services determined necessary by the provider. If the provider were a network provider, the provider would consult with the Secretary to determine which specialty and ancillary services are necessary.

Proposed § 1703A(d) would require the Secretary to enter into contracts or agreements with network providers to furnish care and services to eligible Veterans under this section. The Secretary would be required to negotiate rates for the furnishing of care and services under this section. In general, reimbursement rates could not exceed the Medicare rate, although the bill includes six exceptions to or conditions on this requirement. Under proposed § 1703A(d)(5), the Secretary could compensate a provider for furnishing care and services if any part of care or services were furnished by a medical provider who was not a network provider, but the Secretary would be required to take reasonable efforts to enter into a contract or agreement with that provider.

Proposed § 1703A(e) would require the Secretary to ensure that claims for payments for care and services furnished under this section are processed in accordance with the prompt payment standards articulated in this subsection. This requirement would apply regardless of whether the claim was made by a network provider to the Secretary, by a network provider to a regional network, or by a regional network to the Secretary. This subsection would define deadlines for submission and payment of claims for covered claimants and covered payers.

Proposed § 1703A(f) would require an eligible Veteran to pay a copayment for the receipt of care or services under this section only if the Veteran would have owed a copayment for the receipt of such care or services at a VA medical facility and such copayments could not exceed what the Veteran would have owed if the care or services were furnished at a VA medical facility. VA would be authorized to recover or collect reasonable charges from a health care plan for care or services for a non-service-connected disability in accordance with section 1729 of title 38, U.S.C.

Proposed § 1703A(h) would require the Secretary to ensure that the Veterans Health Identification Card, or its successor, includes sufficient information to act as an identification card for an eligible entity or non-Department facility. The Secretary would not be authorized to use any available funds to issue separate identification cards with respect to care or services furnished under this section.

Proposed § 1703A(k) would require the Secretary, on an annual basis, to assess the capacity of each VISN and VA medical facility to furnish care and services under chapter 17 of title 38, U.S.C., including how network providers can fill gaps

in care or services. In forecasting shortand long-term demand, the Secretary would have to forecast based on future projections, rather than historical trends.

Proposed § 1703A(l) would require the Secretary to develop a plan to allocate funds from the Medical Community Care account and such plan would have to be modeled on the Veterans Equitable Resource Allocation system or any successor system.

Section 101(b) would make various conforming amendments to reflect this new authority.

Section 101(c) would amend section 1701 of title 38, U.S.C., to include definitions of the terms "network provider" and "Veterans Choice Program."

Section 101(d) would prohibit this Act, and the amendments made by this Act, from being construed as affecting the Secretary's obligations under contracts or agreements for the furnishing of care or services under contracts or agreements entered into before this Act's enactment.

Section 102 would require, by the implementation date of the new Veterans Choice Program created by section 101, VA's Chief Information Officer to ensure the information technology system used by VA to receive, process, and pay claims under the Veterans Choice Program includes a number of specific elements.

Section 103 would provide that funding to carry out the Veterans Choice Program would be derived from the Medical Community Care account. It would further provide that any amounts in the Veterans Choice Fund would be transferred to the Medical Community Care account on the date that is 1 year from the date of the enactment of this Act. Section 802 of VACAA (P.L. 113–146, 38 U.S.C. 1701 note), which established the Veterans Choice Fund, would be repealed, and section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114–41) would be amended to allow for the use of the Medical Community Care account for the Veterans Choice Program.

Section 104 would terminate VA's authority in section 1703 effective on the date the Secretary certifies to the Committees on Veterans' Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A, as established by section 101 of this bill. It would further make conforming repeals to a number of authorities in title 38 and title 42 to reflect the new program's authority and to repeal other authorities.

Section 105 would require the Secretary to commence operation of the new Veterans Choice Program established by section 101 of this bill by not later than 1 year from the date of the enactment of this Act. Before commencing the new Veterans Choice Program, the Secretary would be required to certify to the Committees on Veterans' Affairs of the House of Representatives and the Senate that each network provider and non-Department health care provider that furnishes care or services under the new section 1703A has been trained to furnish such care and services under this program, and that each VA employee that refers, authorizes, or coordinates such care or services is trained to carry out this program. It would also require the Secretary to establish standard, written guidance for network providers, non-Department health care providers, and any non-Department administrative entities acting on behalf of such providers with respect to the policies and procedures for furnishing care or services under such section.

Section 106 would establish a new section 1703B in title 38, U.S.C., authorizing the Secretary to enter into Veterans Care Agreements (VCAs) with certain providers. Under proposed § 1703B(a)(2), these VCAs could be entered into to furnish hospital care, medical services, and extended care services when the Secretary determines that it would be impracticable or inadvisable to furnish care to a Veteran at a VA facility or through contracts or sharing agreements otherwise established by the Secretary.

Proposed § 1703B(c) would define eligibility criteria for providers. First, the gross annual revenue of the provider under contracts or agreements entered into with the Secretary in the preceding year could not exceed $2 million, as adjusted in a manner similar to the amounts adjusted pursuant to section 5312 of this title. Second, the provider could not otherwise provide care or services to patients pursuant to a contract entered into with a Federal department or agency. Third, the provider would have to be a Medicare or Medicaid provider or supplier; an Aging and Disability Resource Center, an area agency on aging, or a state agency; or a center for independent living. The provider would also have to meet any further criteria determined appropriate by the Secretary.

Proposed § 1703B(d) would require the Secretary to establish a process for the certification of eligible providers to enter into VCAs under this section.

Proposed § 1703B(e) would stipulate a number of terms in these agreements. In general, payment under VCAs would be limited to the Medicare rate, but VA could pay higher amounts in six different situations or areas.

Proposed § 1703B(f) would provide that the Secretary could enter into a VCA using procedures other than competitive procedures. In general, eligible providers that enter into a VCA would not be subject to any provision of law that providers of services and suppliers under the original Medicare fee-for-service program or the Medicaid program are not subject to. Providers entering into a VCA would be subject to any applicable law regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties. Providers would also be subject to certain identified provisions of law, including Title VII of the Civil Rights Act of 1964, to the same extent as such title applies with respect to the eligible provider in providing care or services through an agreement or arrangement other than under a VCA.

Proposed § 1703B(g) would allow an eligible provider and VA to terminate a VCA at such time and upon such notice as the Secretary may specify.

Proposed § 1703B(h) would require the Secretary to establish administrative procedures for eligible providers to present any dispute arising under or related to a VCA.

Proposed § 1703B(i) would authorize the Secretary to compensate a provider who is not an eligible provider, but who furnished hospital care, medical services, or extended care to an eligible Veteran pursuant to a VCA. The Secretary would be required to make reasonable efforts to enter into a VCA with any provider who is compensated under this subsection.

Proposed § 1703B(j) would require the Secretary to report by October 1 of each year after VA has first begun using VCAs a list of all VCAs entered into as of the date of the report.

Proposed § 1703B(k) would require the Secretary, in carrying out this section, to use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services.

Proposed § 1703B(l) would allow the Secretary to delegate the authority to enter into or terminate a VCA, or to make a determination under the dispute resolution procedures referenced in subsection (h)(2), at a level not below the Assistant Deputy Under Secretary for Health for Community Care.

Section 201 would amend section 1725(c) of title 38, U.S.C., to require the Secretary to treat such services as emergency services for which reimbursement may be made under this section if the Secretary determined that the request for ambulance services was made as a result of the sudden onset of a medical emergency and that the individual was transported to the closest and most appropriate medical facility capable of treating the emergency medical condition. These amendments would apply with respect to ambulance services provided on or after January 1, 2018.

Section 202 would amend section 7332(b) of title 38, U.S.C., to authorize the disclosure of certain medical records of Veterans to a public or private health care provider to provide treatment or health care to a shared patient, and to third parties in order to recover or collect reasonable charges for care furnished to a Veteran for a non-service connected disability under section 1729 of title 38, U.S.C.

Section 203 would establish that copayments required by chapter 17 of title 38, U.S.C., would apply notwithstanding any other provision of law that would allow the Secretary to offset a Veteran's copayment obligation with amounts recovered from a third party under section 1729.

Commentary on Discussion Draft

First, we would like to thank the Committee for their hard work in preparing this discussion draft and for your willingness to share prior drafts with the Department for discussion and consideration, including the Committee's October 3 Roundtable. We look forward to continuing to collaborate closely on the future of VA Community Care.

We recognize that both the Committee and the Department are committed to developing legislation on the future of VA Community Care, and we believe there is a fair amount of alignment between the Department's proposed Veteran CARE Act and the discussion draft.

There are a number of provisions in this bill that are consistent with the Department's proposals. For example, the discussion draft provides broad flexibility in payment rates, which we have found to be important in ensuring we are able to bring the most talented providers into our network to furnish care to Veterans. We appreciate the legislation's recognition of the role of contractors in establishing the provider network and in the importance of conducting market assessments to determine what services are available in VA and the community. The discussion draft also clarifies prompt payment standards in ways that generally match the Department's proposal. We appreciate the discussion draft's efforts at providing clear funding for this program and in consolidating existing authorities to streamline commu-

nity care. The discussion draft would further authorize VA to enter into VCAs, which is a critical authority for furnishing Veterans with timely and appropriate care when other options (such as care within the Department or obtained through other contracts or agreements) are not available. The discussion draft would give VA more authority to share records for shared patients and would also eliminate the current process whereby VA offsets a Veteran's first party copayment liability through use of funds received from their other health insurance or third-party payer.

There are some important differences in our approaches, however, that we wish to highlight in our statement.

Initially, the discussion draft defines eligibility for a Veteran to make a choice to receive community care in a manner that is considerably different from the Department's proposal. The Committee's discussion draft, for example, defines Veteran eligibility to choose to receive community care based on whether or not VA is able to assign the Veteran to a primary care provider of the Department. We are concerned that this approach is narrow and relies upon administrative, rather than clinical, criteria. We further believe that in operation, this could produce confusion among Veterans, as well as among VA and community providers. The discussion draft would allow any Veteran to receive community care, but the decision where to furnish such care would largely be in VA's control, except for those who are unable to be assigned a VA primary care provider and thus are able to select a primary care provider from a list of primary care providers. The Department's proposed CARE Act would base eligibility for all community care on clinical factors and the Veteran-provider relationship. We believe this is a more appropriate approach to determining whether or not a Veteran should receive community care, as it empowers Veterans and their providers to work together to make these decisions.

Furthermore, the scope of the Veteran's choice is noticeably different between the two proposals. Under the discussion draft, Veterans would only be able to choose a community primary care provider if VA were unable to assign the Veteran to a Department primary care provider. If VA had enough primary care providers, Veterans would have no choice in terms of where they receive care. Under the Department's CARE Act, Veterans and their VA providers would collaborate to determine the most appropriate place to receive subsequent care.

A third concern is the discussion draft's reliance on a clear distinction between primary and specialty care. We understand the Committee's intent with this approach, but we have found in practice that the distinction between primary and specialty care is not all that clear. Certain services that would generally be considered specialty care, such as audiology and optometry, are now available at VA facilities without a referral from a primary care provider. Additionally, through the current Veterans Choice Program, VA authorizes the full episode of care, including necessary specialty and ancillary services, to be furnished by community providers when needed. The discussion draft's approach would interrupt these referral patterns and create confusion among Veterans and community providers alike. It would also increase VA's workload without an appreciable improvement in patient care or care coordination.

Finally, while we appreciate the Committee's inclusion of provider agreement authority, we are concerned that, as drafted, this provision would only address some of the problems that require the use of such agreements in the first place. Provider agreements are intended as a backup only in cases where our contracted network cannot provide the care a Veteran requires. The discussion draft would impose a cap of $2 million on how much VA could spend in a year through a provider agreement. In our experience, providers of certain services or in certain areas have exceeded this threshold, and such providers would generally be unable to comply with the requirements of a Federal contract. For example, the top nine highest value provider agreements currently in effect (all of which are in excess of $2 million) are with providers of homemaker/home health aide services, but these organizations could not operate and furnish these services if they were subject to Federal contracting requirements. We also note that the requirement that each provider agreement be signed by someone at or above the level of the Assistant Deputy Under Secretary for Health for Community Care would be administratively burdensome and create a bottleneck that could impede Veterans' access to care. We understand the intent behind these and similar limitations, but we caution against constraining our authority in this area. We would be pleased to discuss this further with the Committee.

We look forward to working closely with the Committee on its draft bill as well as concepts and provisions in the draft Veterans CARE Act. Together I know VA and Congress can provide the comprehensive improvements Veterans deserve.

H.R. XXXX Draft Bill on Agreements with State Homes, Graduate Medical Education Expansion, and Other Matters

Section 1 of the draft bill would amend section 1745 to authorize the Secretary to enter into agreements with State Veterans Homes that would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. State Homes entering into these agreements would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to State homes entering into these agreements. These changes would become effective upon the Secretary's publishing regulations to implement these new authorities.

We generally support section 1, although we have some concerns with respect to the applicability of certain laws. Section 102 of the Administration's CARE Act, we believe, includes language that addresses these concerns, and we support enactment of our proposed language.

Section 2 of the draft bill would create a new section 1730B in title 38 authorizing the Secretary to record as an obligation of the United States Government amounts owed for hospital care or medical services furnished at non-Department facilities on the date on which a claim is approved, rather than the date on which the services are authorized.

Section 2 of the draft bill is similar to section 111 of the Administration's Veteran CARE Act, but we prefer the language in the Veteran CARE Act for several reasons. First, the Veteran CARE Act's language is not discretionary. Second, the Veteran CARE Act's language includes additional services by using the term "health care" instead of the more limited "hospital care or medical services" in section 2 of the draft bill. Third, the Administration's Veteran CARE Act delays the effective date of these changes until the beginning of the next fiscal year after enactment. This would allow VA to begin a fiscal year using a common approach, rather than attempting to change how obligations are recorded during the middle of a year, which could create administrative confusion and budgeting issues.

Section 3 of the draft bill would require the Secretary to carry out a program of educational assistance (which would be determined by the Secretary) to encourage individuals to fill currently unfilled graduate medical education residency positions established pursuant to section 7302 of title 38 and section 301(b)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113–146, as amended). This section further provides terms and conditions relating to administration of this benefit,

This section is similar to section 303 of the Administration's Veteran CARE Act, and we prefer the language in the Veteran CARE Act, as it is discretionary and would provide greater flexibility to the Secretary in terms of recruiting residents and offering them benefits (in particular when they are not at a VA facility).

Section 4 of the draft bill would create a new section 1730B that would authorize VA health care providers to practice, regardless of their location within a State, their health care profession, including through the practice of telemedicine. Such authority would extend to situations where the provider is not located on Federal property. It would specifically invoke Federal Supremacy to protect VA health care providers operating within the scope of their employment from any adverse action by a state or local government based upon their Federal employment. It would also require a report on how this authority has affected the use of and satisfaction with telemedicine by VA providers and patients.

VA strongly supports section 4 of the draft bill, which matches section 301 of the Administration's draft Veteran CARE Act. We have one minor technical edit to offer, amending the proposed section 1730B(a) to refer to "the direction of the Secretary," rather than "the discretion of the Secretary." While VA has published a proposed rule to assert Federal Supremacy for telemedicine providers, this legislation would go further by providing statutory protection and by codifying VA's longstanding practice of allowing VA providers to practice in any state as long as they are licensed in a state. We greatly appreciate Congress' attention to this issue and inclusion of this proposal in the draft bill.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to answer any questions you may have.

Prepared Statement of Honorable Adrian M. Atizado

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration by the Committee.

H.R. 1133, Veterans Transplant Coverage Act of 2017

This legislation, if enacted, would require the Secretary to extend health care eligibility through the Department of Veterans Affairs (VA) to a live organ donor before and after conducting a transplant procedure for a qualifying veteran, even if the donor is not eligible for VA health care. The bill also authorizes transplant surgery to be performed at non-VA facilities and be paid for through the Veterans Choice Program, at the discretion of the Secretary.

Currently, enrolled veterans have limited options through the VA health care system when requiring transplantation surgery. Since there are only 13 VA medical centers that offer transplantation procedures, many seriously ill veterans are forced to travel great distances, or even move near a VA facility that provides this service in order to receive necessary preand post-operative care, and to await a donor match. Some veterans are forced to relocate their families for months at a time with no guarantee that a donor will even be found.

Unfortunately, due to the overall lack of organ donors nationally, and the current statutory constraints in the VA system, many veterans pass away while awaiting donors. Furthermore, due to the expenses involved in traveling while pursuing organ donation through the VA health care system, veterans as well as surviving family members are often left in difficult financial situations.

Extending limited eligibility and care to live organ donors who are not otherwise eligible for VA care could open up additional possibilities for some seriously and terminally ill veterans. Allowing VA to cover the cost of transplantation procedures in non-VA facilities through the Choice program could also alleviate some of the burden and cost that veterans and family members incur when traveling to distant VA medical centers that perform these life-saving procedures.

DAV does not have a resolution from our membership on this specific proposal; however, we are not opposed to passage of this legislation.

H.R. 2123, the Veterans E–Health and Telemedicine Support or VETS Act of 2017

This bill would enable a VA health care professional licensed, registered, or certified in a state to practice his or her profession at any location in any state, regardless of where the professional or veteran is located, to treat a veteran through telemedicine. If enacted, the bill would permit telemedicine treatment regardless of whether the professional or the patient were physically located in a federally owned facility.

The bill would require VA to report to Congress one year following its implementation on a variety of aspects of the Department's telemedicine program, including patient and provider satisfaction, access, productivity, waiting times and other information related to appointments made and completed through telemedicine.

Because health professional licensure is a state-regulated function, as a national system, VA has experienced barriers in its efforts to broaden the use of telemedicine across state lines. A number of VA telemedicine initiatives have been frustrated because of the interstate restriction. Enactment of this bill would eliminate that barrier, and would promote much greater use of telemedicine, especially in facilities whose treatment populations come from multiple states (Martinsburg, West Virginia-patients from Virginia; Washington, DC-patients from Virginia and Maryland; Pittsburgh, Pennsylvania-patients from Ohio; New York City, New York-patients from New Jersey; Boston, Massachusetts-patients from New Hampshire, Vermont and Maine; Fayetteville, Arkansas-patients from Missouri, Oklahoma, and Kansas, etc.). Enactment of this bill would open the door to VA specialists treating veterans through telemedicine irrespective of state jurisdiction, physical location, or the distance that separates patient from provider (for example, VA specialists in Seattle would use technology in real time to treat VA patients at the VA Outpatient Clinic in Anchorage, Alaska), and should also be highly cost-effective and more convenient for veterans who live at a distance from their VA medical centers, or who must travel long distances for access to basic VA care.

Delegates to our most recent DAV National Convention approved Resolution No. 128. Among other priorities, this resolution calls on VA and Congress to establish and sustain effective telemedicine programs as an aid to veterans' access to VA

health care, particularly in the case of rural and remote populations. Our delegates also approved Resolution No. 230, fully supporting the right of rural veterans to be served by VA. This bill is consistent with these resolutions and DAV policy; therefore, DAV strongly supports its enactment and appreciates the sponsors' intention to promote the use of telemedicine in the care and treatment of veterans.

H.R. 2601, Veterans Choice for Transplanted Organs and Recovery Act of 2017

This legislation, if enacted, would allow a veteran in need of organ transplantation who lives more than 100 miles from a VA transplant center to receive hospital care and services related to the required organ transplant at an outside facility that meets the requirements under the Veterans Choice Program.

Under current policy, veterans needing organ transplantation surgery must travel to travel to one of the VA's 13 transplant centers, which requires seriously ill veterans to travel hundreds of miles not only for the surgery, but also for preand postoperative care. A 2014 study published in the Journal of American Medicine found that longer travel distances between a patient's home and transplant center correlated to higher mortality rates.

DAV does not have a specific resolution in regards to this legislation; however, we are not opposed to its passage. Veterans who require organ transplantation but have serious access challenges to receiving that care because they reside far from a VA transplant center should have additional options for necessary life-saving surgery.

H.R. 3642, the Military Sexual Assault Victims Empowerment Act or the Military SAVE Act

This bill would require the VA Secretary to establish a three-year pilot program in five locations to provide non-VA medical care to veterans with conditions related to military sexual trauma (MST). For eligibility, veterans must, in the judgment of a Department mental health professional, have experienced an incident of sexual trauma while the veteran was serving in the military during active duty, active duty for training or inactive duty training, and reside in an area offering the pilot. Pilot participants would be able to select a non-VA care provider of their choice as long as they accept VA's pay rate for services rendered through Vas Choice Program or an existing contract.

VA would be required to notify all eligible veterans about their opportunity to participate in the pilot and provide "educational referral materials" regarding non-Department providers in the area. Additionally, on a case-by-case basis, VA would be authorized to provide veterans who elect to participate in the community care pilot continued access to that provider until the completion of the episode of care.

The measure would also require VA to survey, at six-month intervals, all eligible veterans at the pilot site who are receiving care for a MST-related condition to determine the quality and effectiveness of VA versus non-VA care. The survey must include information about the differences in wait times, distance to a treatment facility, frequency of appointments, duration of treatment, medication use, access to emergent mental health care services and clinical outcomes. Survey findings must be collected and analyzed by a qualified VA researcher and a final report provided to Congress not later than 60 days before completion of the pilot program.

While this bill's stated goal is to "improve the access to private health care" for MST survivors its more apparent intent appears to be to evaluate quality of care and access to services for a MST-related condition in VA compared to a non-VA care setting. DAV has no resolution calling for a comparative survey for MST-related care, but we would like to take this opportunity to express our concerns with this bill.

Currently, VA has the authority to send veterans to the private sector for care in cases where VA cannot provide the care needed, or cannot provide care in a timely manner, at the recommendation of a VA physician, when there is geographical hardship in commuting to a VA facility, and in cases where the veteran may have a special circumstance or need to be seen outside of the VA. DAV supports veterans access to care in the community in these noted circumstances; however, we want to ensure the care is high quality and that the non-VA provider has the cultural competency and expertise in treating patients who have experienced sexual trauma during their military service.

VA is well known for its targeted MST-related research, clinical training and specialized treatment for veterans. All enrolled veterans using VA care are screened for MST, and survivors who are in need of mental health care receive tailored treat-

ment plans. In fiscal year 2016, VA provided nearly 1.5 million MST-related outpatient visits to veterans (male and female) who screened positive for MST.

All VA mental health and primary care providers are required to complete MST training to ensure they are sensitive to the unique factors surrounding sexual trauma and can provide effective treatment to veterans who have experienced MST. According to VA more than 6,300 mental health providers have received extensive training and supervision in the most effective evidence-based psychotherapies (EBP) for PTSD to include Prolonged Exposure and/or Cognitive Processing Therapy. More than 1,800 VA providers have received extensive training and supervision in one of three EBPs for depression. VA reports that veterans who received this specialized treatment have experienced clinically meaningful and significant improvement in their PTSD and depressive symptoms.

By contrast, RAND's Ready to Serve national study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or the Department of Defense, "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high quality mental health care to service members or veterans with these conditions." According to the study only 18 percent of Tricare and six percent of non-Tricare community therapists were trained in and used an EBP.

Additionally, VA reports there is a national initiative within the Department to disseminate evidenced-based therapies for mental health conditions related to MST as well as web-based resources, monthly calls with mental health providers and an annual conference for clinicians to ensure they receive up-to-date information about delivery of care options to this population. VA also has a designated coordinator in every VA medical center who serves as the contact person for veterans for MST-related issues and services.

VA's ability to provide high quality care to MST survivors is more than providing specialty treatment; it is also understanding military culture and that this population often has other mental health and physical comorbidities, in addition to an increased likelihood of experiencing homelessness, substance use disorder and an elevated risk for suicide. VA's comprehensive care model allows providers to address the whole veteran by having an array of health care treatment options, benefits and wraparound services to support them. VA's mental health programs, VA's Vet Center, the Veterans Crisis Line and other complementary and alternative care options along with specialized care programs for PTSD, homelessness and substance-use disorders, are just a few ways in which VA coordinates its resources, benefits, and medical services to not only meet the health needs of veterans, but also simultaneously address their psychosocial and economic well-being.

There is no comparable program in the private sector and providers are less likely to have the necessary skills and experience to provide the most effective care and health outcomes for MST survivors. When it comes to caring for these veterans, it is essential that they receive the right care, at the right time, by a qualified health care provider that is able to deliver effective care and supportive services. Given VA's comprehensive and integrated health care response to military sexual trauma and proven expertise in effectively treating veterans with PTSD or other mental health conditions resulting from MST, we believe these veterans are best served in VA. For these reasons DAV is unable to support this measure.

Draft Bill, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs

Section 1 of the draft legislation would amend Section 1745(a) of title 38 to modify VA's authority to enter into provider agreements with State Veterans Homes for the purpose of providing skilled nursing care to certain service-connected veterans. Public Law 109–461 as amended by Public Law 112–154 authorizes VA to pay the "full cost of care" for veterans who require skilled nursing care due to a service-connected disability, or who have a disability rating of 70 percent or greater and are in need of skilled nursing care. Since enactment of these laws, VA has entered into provider agreements with each State Home for the provision of such care to eligible disabled veterans.

However, a few years ago, the Administration made a determination that the use of provider agreements by VA for this program and others in lieu of more burdensome federal contracting requirements was in conflict with federal labor laws. Since that ruling, VA has been prevented from entering into new provider agreements.

This section would provide VA with specific statutory authority to enter into provider agreements with State Homes to continue providing care to seriously disabled veterans under Section 1745(a), while ensuring that State Homes fully adhere to federal laws concerning integrity, ethics, fraud, as well as Title VII of the Civil Rights Act of 1964 prohibiting discrimination in hiring. State Homes would also remain subject to all applicable State labor laws concerning employment discrimination.

DAV supports Section I of the draft legislation in accordance with DAV Resolution No. 062, supporting the State Veterans Homes program, which calls for providing, ".states greater flexibility in providing long-term supports and services to veterans in State Veterans Homes," and specifically addresses VA's ability to ".enter into provider agreements with State Veterans Homes to pay the full cost of care provided to veterans with 70 percent or higher service-connected disabilities or who require nursing home care for service-connected disabilities."

Section 3 of the draft legislation would provide VA with new authorities to incentivize medical students to fill the 1,500 graduate medical education residency positions created by Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014.

Under this section, the Secretary would create a program to provide additional educational assistance to individuals in return for a period of "obligated service" working for the VA health care system. The legislation contains specific penalties for failure to complete the residency program or to fulfill the service obligation to VA.

While DAV supports creating additional financial incentives to help VA recruit, hire and retain high-quality medical professionals, concerns have been raised about whether the requirement for "obligated service" is the most effective manner in which to achieve that goal. The underlying graduate medical education residency program currently does not have such a requirement. Further, this provision lacks specificity regarding the level and type of financial assistance to be provided, as well as the length of the required "obligated service."

While we support the intent of creating new incentives to bring clinicians into the VA health care system, we believe that further discussion and consideration of alternate incentives should occur before moving forward with this provision.

Draft Bill, to establish a permanent Veterans Choice Program

VA Legislative Proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act

DAV deeply appreciates the commitment and work of the members and staff of this Committee and the VA for the two draft bills being considered in today's hearing. Both bills seek to improve veterans' access to community care by, among other things, consolidating some of VA's purchased care authorities, ensuring coordination of care and health information sharing. DAV is pleased both bills contain some of our recommendations to reform the VA health care system while preserving and strengthening it so that DAV members and all eligible veterans may continue to enjoy the unique benefits and vital services VA provides well into the future.

Over the past year, DAV and our Independent Budget (IB) partners developed 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 these draft bills that 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 Veteran-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.

Veteran-Centered Integrated Health Care Networks

Veteran-Centered Integrated Health Care Networks were proposed in response to fragmented care delivery by providing a coordinated continuum of services-from wellness and preventive services to urgent care, inpatient care, outpatient care, extended care and hospice-to a defined veteran patient population. The goal of improv-

ing veterans health outcomes at lower cost by operating effectively and efficiently greatly depends on the performance level and degree of integration.

Degrees of such integrations can be measured by the use of evidence-based disease management, formularies, continuum of care and mix of available services, and the use of technology such as information systems and integration level as well as real time central medical records.

CARE Act: To this end, the CARE Act provides little concrete description as to how Veteran-Centered Integrated Health Care Networks will be created, implemented, administered, overseen and how to determine if they are successful.

Veterans Choice Program (VCP) draft bill: The VCP draft bill would establish the Veterans Choice Program under which VA would, subject to appropriations and the election of veterans, provide hospital care and medical services to eligible veterans through contracts and agreements with non-VA providers. The Secretary would be required to establish regional networks of providers and may enter into one or more contracts to manage the operations of these networks.

To assure quality throughout the network of providers contemplated under the VCP draft bill, DAV recommends that any contracts made by the VA health care system with non-Department providers contain standards and requirements that allow VA to ensure these providers are able to uphold at least the same quality of care available at medical facilities within the Department, allowing the Secretary to measure, monitor and thereby be accountable for, care delivered through non-VA providers. VA, and not the network provider, should be held accountable for coordinating the veteran's care (1703A(a)(3), (b), (c), (d)(5)(A),(g)) and the ability to generate efficiencies (1703A(k)) that reduce costs (1703A(d-f), Sec. 102(a)(1)) while meeting certain quality, or care metrics (1703A(i)).

Such standards would include all matters related to scheduling and timely access to care standards, quality of care standards, and health information sharing capability. This proposed change directs the Secretary to use the Veterans Choice Program as it uses Department facilities and employees to furnish care to ill and injured veterans (see 38 USC 1710).

From a veteran patient's perspective, a Veteran-Centered Integrated Health Care Network should provide veterans information they would need to make an informed decision. 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 their 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.

The Veteran-Centered Integrated Health Care 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.

To ensure formation of the local Veteran-Centered Integrated Health Care Networks requires the function of a high performing network. Our framework places VA as the coordinator and principal provider of care, which we discuss immediately below. VA's primary care (medical home) model with integrated mental health care, is more likely to prevent and treat conditions unique to or more prevalent among veterans, particularly those with disabilities or chronic conditions, but is not a requirement of non-VA primary care providers, which is a concern for DAV.

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

DAV 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 case managers and coordinators of care and work with the veteran's health care team to provide for the veteran patient's medical, nursing, emotional, social and rehabilitative needs as close as possible to 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.

CARE Act: We strongly recommend the language be added to the CARE Act to ensure VA remains the coordinator of veterans' care, especially if that care is provided in the community and paid for by the Department.

VCP draft bill: While DAV applauds the VCP draft bill for its appreciation of the medical home model featuring assignment to a primary care team or provider, we strongly recommend the Committee ensure VA remains the coordinator of veterans' care, especially if that care is provided in the community and paid for by the Department.

We further recommend the required assignment of a veteran to a dedicated VA primary care provider or VA Patient-Aligned Care Team (PACT) be made at the time the veteran seeks care, not at enrollment, and not necessarily for all veterans. We believe the current proposal will lead to gross misalignment of resources because not all veterans who enroll in VA access the system and other veterans just use VA for certain types of care such as prosthetics, sensory aids, or spinal cord injury care. In addition, highly disabled service-connected veterans have never been required to enroll for health care.

Many veterans have several types of health insurance and have defined utilization patterns inside of VA and with other providers. If all are assigned to VA primary or Choice providers, would veterans be required to use them as gatekeepers when they already have a primary care provider elsewhere and really just need a new prosthetic limb or wheelchair? To relieve waiting times, one medical center looked at the effect of allowing veterans to self-refer to audiology for services related to hearing loss, rather than requiring a primary care provider's referral. During the previous Administration, this change was identified as a "best practice" for relieving waiting times and increasing access. DAV hopes that VA will use its utilization data to identify those veterans who are most reliant upon it for care and make these assignments to PCPs and PACTs, and case management as appropriate. Less reliant veteran patients are accounted for in VA's resource allocation methodologies, but may not require assignment to a regular primary care provider. In addition, VA should give veterans an opportunity to elect a new provider if there are extenuating circumstances such as a new VA resource (such as a community-based outpatient clinic) becomes available, their medical condition changes or their transportation provider is no longer available. Veterans should also be able to leave an assigned network provider if that provider can no longer provide timely access to care.

The proposed section 1703A(b)(1)(B)(iii) in the VCP draft bill requires VA to ensure an "eligible veteran is not simultaneously assigned to more than one patient-aligned care team or dedicated primary care provider." We remind Congress and VA in executing this provision of the Department's current policy regarding traveling veterans who are assigned to a PACT at the veteran's preferred facility as well as assignment to a PACT at an alternate facility for their annual extended travel. We urge the Committee to ensure this patient-provider relationship is not adversely affected.

Telemedicine:

CARE Draft Bill: We support the intent of section 301 of this draft measure. DAV has previously testified that, as a national health care provider making extensive use of telemedicine, VA must ensure that its providers' state licensure is legally protected if they offer medical services across state lines. We note H.R. 2123, the Veterans E–Health and Telemedicine Support or VETS Act of 2017, is on today's agenda and based on previous testimony from VA on a similar bill, section 2(a) would remove the barriers that might be imposed by local licensure laws of the places where the patient or the covered health care professional are located, or the state of licensure of the health care professional. Further, section 2(a) would make clear that any telemedicine services that involve prescribing controlled substances would have to be provided in accordance with the Controlled Substances Act. We refer the Committee to our discussion on this authority under H.R. 2123 and urge swift and favorable action.

Use of Veterans Health Information:

VCP Draft Bill: The disclosing of medical information under section 202 was discussed before the Subcommittee at the June 23, 2016 legislative hearing on H.R. 5162, the Vet Connect Act of 2017.

We testified that "DAV understands and supports increased use and appropriate sharing of health data; however, veteran patients also want to be assured of the privacy and security provided for protected information. We urge the committee and the sponsor of this legislation strike a more balanced policy between the competing aims of sharing data and protecting privacy. We recommend such broad language be amended to affect only shared patients and only for the purpose of completing

a treatment plan to which the veteran patient has agreed." Accordingly we recommend language be inserted after line 16:

"(II) An entity to which a record is disclosed under this subparagraph may not redisclose or use such record for a purpose other than that for which the disclosure was made."

Consolidation of Existing Authorities

VA has a number of statutory authorities, programs, and other methods for purchasing community care. The various methods for receiving community care have conflicting structures, responsibilities, ownership, and management, with different application at the local and national levels and has led to inefficient implementation and significant confusion among veterans, community providers, VA providers, and staff.

These authorities, programs and methods have differing requirements and processes for key components, including, but not limited to, eligibility criteria and eligibility determinations; referrals and authorizations; provider credentialing and network development; health care and health information coordination; reimbursement/payment rates, and; claims management.

The CARE Act proposes to consolidate existing community care authorities under section 221 of the Act but is limited to Section 1703, dental care under Section 1712, counseling and related mental health services under Section 1712A, burial under Section 2303, and care for ill Persian Gulf War veterans under Section 1117 (note). This consolidation is a far cry from the planned consolidation of Section 7409 (Scarce Medical Resources), Project ARCH, Section 403 of Public Law 110–387 (as amended), the Pilot Program of Assisted Living for Veterans with TBI, Section 1705 of Public Law 110–181(as amended), and emergency care under Sections 1725 and 1728 and the proposal to authorize VA to pay the reasonable costs of urgent care.

Moreover, it appears section 201 of the CARE Act would impose another eligibility criteria on those purchased care authorities under section 211.

Veterans Care Agreements [1]

We support the establishment of provider agreements to meet the need for this authority to be enacted into law without delay. VA purchases a broad spectrum of medical and extended services from private sector providers for veterans, their families and survivors under specific but fragmented authorities. These authorities have in some cases created confusion and uncertainty among ill and injured veterans and private providers in their community.

CARE Act: Section 101 the CARE Act would allow VA to use provider agreements to purchase medical care and services in certain circumstances. The bill appears to preserve key protections found in the contracts based on the Federal and VA Acquisition Regulations including protections against waste, fraud and abuse. It intends to streamline and speed the business process for purchasing care for an individual veteran that is not easily accomplished through a more complex contract with a community provider, and thus be more appealing to some providers.

We understand this proposal is not intended to supplant long-standing regional and national contractual and sharing agreements, which is helping to build VA's Extended Network of community providers. Rather, this authority is intended to play a supporting role in specific situations when, for a variety of legitimate reasons, needed care cannot be purchased through existing contracts or sharing agreements.

Since VA's current authority to enter into provider agreements is in section 101(d) of Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), is proposed to be terminated after September 30, 2018, under section 501 of the CARE Act, we believe section 101 and 501 must be favorably considered simultaneously.

Furthermore, we believe under Veteran Care Agreements, extended homeand community-based care and services will be provided to severely ill and injured veterans and aging veterans with chronic conditions. For this patient population, it is essential that the care and services they receive be carefully coordinated. We therefore recommend language be included requiring care coordination to realize the best health outcomes and achieve veterans' health goals.

We appreciate language in the CARE Act intended to improve VA's administrative functions, business practices and employment of data analytics to ensure the purchases are cost effective, preserve agency interests, and enhances the level of service VA directly provides veterans.

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[1] https://www.dav.org/wp-content/uploads/Atizado20150603.pdf

VCP Draft Bill: While VA would remain the primary source of care for veterans with network providers serving in a back-up role, there will be some instances, likely in highly rural or medically underserved areas where sole practitioners who cannot meet the same standards as network providers are the only available health care resource. We support the establishment of Veterans Care Agreements as a necessary source of care within the new model this draft develops.

Because this draft bill would not bar an eligible provider from participating as a network provider under 1703A as well as Veteran Care Agreements, we recommend language be included to address the potential for these "dual-participating" community providers to not confuse the authority for receiving referrals which may result in their sending claims to the wrong payer (VA vs. Network Manager).

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. However, 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.

CARE Act: DAV supports the approach under Section 201 of the CARE Act to determine a veteran's eligibility to elect to receive care in the community. However, there is no remediation plan included in this draft bill that would reinforce the need for community care to supplement rather than supplant the VA health care system. We discuss this aspect in greater detail under "Reform VA's culture."

VCP Draft Bill: DAV supports this draft bill's elimination of some of the arbitrary restrictions such as distance and waiting times that currently limit eligibility for community care. Instead, VA, to the extent that resources allow, would be required to make such a determination upon enrolling a veteran for care. We have already noted our concerns about that approach above. Enrollment would continue within VA facilities until such time that the Secretary determines VA can no longer assign veterans to primary care providers due to a shortage of health care professionals. At that time, VA would provide veterans with a list of private providers from which to choose. VA would reassess its internal capacity to enroll veterans with a primary care provider on an annual basis.

We are, however, concerned that this system of enrollment may be used to lock veterans out of the system should resources for community care be exhausted. It is also unclear if VA would use priority groups established in 38 USC 1705 for enrollment to primary care providers to ensure that service-connected veterans are never denied care. We also again note that service-connected veterans with conditions rated at 50 percent or more are not required to enroll for care, but should never be locked out of the system because they are not assigned to a primary care provider.

State Veterans Homes

DAV has previously raised concern when Congress considered legislation restructuring VA's relationship with non-VA community providers as it affects provider agreements with community providers and State Veterans Homes specifically.

As you know, it took several years, two public laws (Public Law 109–461 and Public Law 112–154) and an Interim Final Rule (RIN 2900–AO57) to achieve Congress' original intent of offering the most severely disabled veterans the option to receive extended care at State Veterans Homes. As the Committee moves forward, it is important to ensure that any legislation that addresses VA's provider agreement authority with community providers does not modify, diminish, endanger or eliminate State Veterans Homes existing provider agreements authorizing them to provide these critical long-term care services to thousands of severely injured and ill veterans.

We direct the Committee to our discussion of the other draft bill being considered by the Committee to modify VA's authority to enter into agreements with State homes to provide nursing home care to veterans.

Emergency and Urgent Care

DAV continues to recommend making 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 not complete without effective provisions for both urgent and emergency care.

We have raised the need to address the eligibility and payment issues that veterans and community providers face regarding emergency care, and this Committee

is aware of our organization's long-standing position opposing any and all copayments imposed on veterans and supporting legislation reducing the copay amount.

CARE Act: We therefore oppose the imposition of care copayments had veterans sought this type of care at VA medical facilities.

DAV also opposes the provision that would force veterans to pay copayments while their health insurance reimburses VA for emergency or urgent care. VA should be applauded and allowed to continue its current practice of offsetting a veteran's copayment debt with monies VA receives from billing the veteran's health insurance plan.

VCP Draft Bill: DAV supports the draft bill's emergency transportation benefit, but regrets that its authors did not address the ongoing problems that occur with emergency care or establish a benefit for urgent care. An urgent care benefit could limit the number of veterans using emergency care for lack of a better option. About half of all emergency care users claim that they sought care in that setting because their regular source of care was not available. We urge the bill authors to address these issues.

Emergency Care Eligibility

Carrying out the multiple and complex authorities[2] 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."

To address the inconsistent application of the prudent layperson standard, DAV recommended the "emergency condition" under title 38 be defined as follows:

"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."

We also recommend a change to the current requirement for veterans to have received VA care within the last 24-months prior to receiving emergency care in the community to be eligible for VA's emergency care benefit. This requirement unduly discriminates against otherwise healthy veterans who need not seek care at least once every 24 months, yet is required to make an otherwise unnecessary medical appointment in order to be eligible for payment or reimbursement for non-VA emergency treatment. We urge the Committee provide greater flexibility by including an exemption authority to the 24-month requirement for this and other unforeseen circumstances.

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.

Revenue Enhancing Provisions

CARE Act: DAV adamantly opposes any and all provisions in this measure that would effectively offset appropriated funds for VA medical care. These proposals can be found in sections 121, 131, 132 and 503, whereby this government is proposing to take an estimated $2.7 billion over 10 years from service-connected disabled veterans and their survivors based on the 10-year round down of cost-of-living adjustments for veterans benefits.

DAV is opposed to this rounding down provision. Veterans and their survivors rely on their compensation for essential purchases such as food, shelter, utilities and transportation. It also enables them to maintain a marginally higher quality of life.

The co-authors of the IB, DAV along with Paralyzed Veterans of America and Veterans of Foreign Wars, sent a letter to this Committee on May 24, 2017, stating "rounding down veterans' COLAs unfairly targets disabled veterans, their dependents and survivors to save the government money or offset the cost of other federal

[2] 38 U.S.C. §§ 1703, 1725 and 1728

programs. The cumulative effect of this provision of law would, in essence, levy a 10-year tax on disabled veterans and their survivors, reducing their income each year. When multiplied by the number of disabled veterans and recipients of Dependency and Indemnity Compensation or DIC, hundreds of millions of dollars would be siphoned from these deserving individuals annually. All totaled, VA estimates, this proposed COLA round down would cost beneficiaries close to $2.7 billion over 10 years."

Equally objectionable is the proposed requirement to charge veterans for the care they receive from VA. This provision seeks to improve VA's ability to receive information the agency requires to identify and receive reimbursements from a veteran's health plan. Such a heavy handed approach appears prejudicial considering insurance identification is only one of multiple elements across VA's revenue cycle to include accurate insurance verification, authorization, utilization management, claims processing, accounts receivable, and payor relations. We note there are no other provisions in the CARE Act requiring specific actions be taken to improve VA's responsibility in this area of its revenue cycle.

VCP Draft Bill: Service-connected disabled veterans must not be compelled to pay for their own care. According to DAV Resolution No. 115, which calls for the reduction or elimination of veterans' copayments, we oppose subsection (f) of Section 1703A, and Section 203. We recommend both provisions be stricken.

Section 1703A, subsection (f) would require certain service-connected disabled veterans to pay VA copayments for care received under the proposed Veterans Choice Program.

Section 203 proposes to eliminate VA's current practice of extinguishing veterans copayment debt from any third-party reimbursements received from that veteran's health plan. We urge the Committee strike this provision from the bill.

Veterans, especially those who incur disabilities during or as a result of military service, have already made their payments for health care through their service and sacrifice. Citizens of a grateful nation want our government to fully honor our moral obligation to care for veterans and generously provide them benefits and health care entirely without charge.

Funding Flexibility

Viewed together, sections 211, 501 and 502 of the CARE Act would eliminate the current authority to furnish veterans medical care in the community through the Veterans Choice Program, add $4 billion of what appears to be no-year mandatory funds into the account designated by Section 802 of Public Law 113–146, the VACAA to be used solely for care in the community.

We are concerned this proposal does not provide the funding flexibility contemplated under VA's own CARE Plan Consolidation that state, "in future budget requests, [VA] will request that Congress appropriate budget authority to this account in the annual appropriations act. The account, which will be known as the 'Community Care' account, will be the sole source of funding for care that VA provides to Veterans through community providers. Separating the funding of Veteran community care from the current VA hospital care and medical service funding will require local leaders to set a clear funding level and actively manage community care." (Emphasis added.)

Recording Obligations at Payment

VHA must adhere to certain business standards and practices when obligating funds for a variety of goods and services, including purchased outpatient, inpatient and extended care, and other health care related goods and services. To ensure it does not overspend, funds must be available to cover obligations and expenditures prior to entering into an agreement to purchase care and services.

To accomplish this, VHA estimates the amount of funds required for such purchase or obligation and payment, verifies that funds are available prior to recording the obligation in the financial system, monitor all transactions, certify goods and services were received prior to approving payments, and close any remaining balances within 30 days following the end of the month or fiscal year, in which all expected activity has been completed.

In this process it has been found VHA's process has led to overestimation of funds needed to pay for approved purchases of non-VA care. VA's Office of Inspector General found (VAOIG) in 2016 that VHA did not have a performance improvement plan for obligation management, did not have adequate tools to accurately estimate costs of goods and services, and did not routinely adjust cost-estimates of obligations to reflect better estimates of potential costs.

However, VAOIG also found that the VACAA (Public Law 113–146) effectively prohibited VHA from using no-year funds for non-VA care and services, which put all over-obligated funds at risk of not being available for any purpose.

We understand the desire to avoid over obligating no-year funds, which delays the availability to use these funds and puts single-year funds at risk of not being used due to expiration of the appropriation. However, the proposed solution to record obligations at payment may put VHA at greater risk of underestimating obligations and thus overspending, the implication of which is seriously concerning to DAV.

Unless appropriate monitoring and controls are in place to protect against the risk of overspending, community care may begin to supplant rather than supplement the VA health care system.

The other option is to improve VA's current processes, systems, and data. It should be noted that VAOIG found certain VHA medical facilities that thoroughly analyzed the historical costs of previous non-VA care authorizations, while time-consuming due to lack of standard data systems and average cost calculation procedures, produced reasonably accurate cost tables. Automating manual reconciliation is also necessary to timely release unobligated funds for use.

We believe the proposed sections 112–114 in the CARE Act to reform its provider payment rates, claims and payment processing would serve to help VHA's ability to more accurately estimate cost of care over time. The general lack of automation and refinement of estimations will persist longer if not address legislatively.

Claims Processing and Payment

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. We have also 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. We believe the responsibility of the government as first-payer and prompt payer for care and services should be reaffirmed.

CARE Act: DAV supports provisions that would improve VA's timely processing of claims and payment to community providers, including applying the prompt payment act, govern claims management and payments to community providers, and would set a firm date after which VA would not accept claims in other than electronic form. Sections 112–114 would mandate the establishment of an electronic interface to enable private providers to submit electronic claims as required by the section. To further strengthen this proposal, we recommend adding certain provisions requiring VA be primarily responsible for payment of all goods and services, and that equivalent protections for veterans proposed in Section 101(h) be provided under Subtitle B.

VCP Draft Bill: DAV is pleased that the draft bill takes steps to address claims processing and urges the Committee to take immediate action to protect veterans from suffering the consequences of VA's late payments for their care.

IV. Reform VA's culture to ensure that there is sufficient transparency and accountability to the veterans this system is intended to serve.

Beginning on October 1, 2014, the VACAA transferred Non-VA Medical Care (NVMC) Program payment responsibilities from local medical facilities to the Veterans Health Administration's (VHA) Chief Business Office and separated NVMC funding from other VHA Medical Services appropriation funds. We believe it is beneficial to require, rather than make discretionary, the transfer of funds and payment of services to VHA's Office of Community Care. This would help ensure transparency and accountability to a single entity when conducting oversight.

We also strongly urge the Committee to preserve the organizational model required in Section 106 of VACAA 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.

VCP Draft Bill: DAV supports efforts within the draft bill that would better assure that VA networks within the Veterans Choice Program are held accountable for outcomes including quality of care, care coordination, access, and costs, but recommend that the bill address adding standards to allow VA to measure and monitor to their contracts with network providers.

Moreover, in managing resources, capabilities and capacities of the VA health care system, DAV believes the development of integrated community networks must be based on dynamic demand and capacity analysis, which would include modeling of the need to expand, contract, or relocate VA facilities. Local stakeholder input would be essential to ensure that local health care coverage would not be negatively affected by any facility realignment.

Clinical Appeals

VA's Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care clearly indicates, "a clinical appeals process will be available to Veterans who do not agree with the clinical referral decision of their providers. This clinical appeals process will focus on reaching agreement at the care team level, but if disagreements cannot be resolved at that level, an additional level of appeal will be available. Veterans will have a single point of contact for appeals and an opportunity to be heard at each step. Appeals will be timely based on clinical need." No such provision exists.

CARE Act and VCP Draft Bill: It is unconscionable that it is more important to propose statutory language requiring a procedure in both draft bills for community providers to be able to appeal a decision by VA, but did not propose similar language for veterans to appeal clinical decisions by VA.

We believe statutory language should be included in any legislation proposing to reform the VA health care system requiring the Department to establish by regulation a process for veterans to appeal a VA clinical decision.

DAV agrees with the Commission on Care that VA must ensure that veterans have access to a fair and effective appeals process, just like other federal health beneficiaries. At a minimum, VA must assure veterans access to a uniform process with decisions made within clearly defined timelines at different points of the process. Most federal health beneficiaries have a right to an external review at their discretion and veterans should also be allowed this review at the veteran's discretion rather than that of the hospital or VISN director. We understand that VA has convened an interdisciplinary group to review this process, but these are minimal standards that ensure a veteran of due process.

Supplementing the VA Health Care System:

CARE Act: To ensure community care serves to supplement and not supplant the VA health care system, we are disappointed this draft bill does not propose any sort of demand and capacity analysis.

VCP Draft Bill: We support the VCP draft bill's efforts to assess capacity in VA and the private sector. To strengthen the proposed section 1703(A)(k), we recommend you more fully consider VA's internal capacity such as including discrete language in the identification of existing gaps under (A) including:

- Considerations of capital and human capital needs and planning. Capital planning should include meeting new, renovated or replacement space needs, and the orderly disposal of unused, unneeded property.
- A plan to remedy such gaps should also be required in the assessment-including identifying necessary resources to timely close such gaps.

In forecasting for capacity and commercial market assessment, the proposed section 1703(A)(k)(1)(c) calls for the annual capacity and commercial market assessments to have "(C) forecast, based on future projections rather than historical trends, both the shortand long-term demand in furnishing care or services at such Veterans Integrated Service Network and medical facility and assess how such demand affects the needs to use such network providers."

Demand forecasting can help predict trends for at least three years, but not much longer than five years out. For staffing demand one generally looks at the primary service area population, its market share and out-of-area draw to determine its potential patient volume, as well as considering assumptions such as a population

growth and technology development to help calculate how many physicians would be needed to treat that population to estimate potential physician demand.

We also recommend language indicating such forecasts include valid and reliable historical data.

DAV is concerned that this system of enrollment may be used to lock veterans out of the system should resources for community care be expended. Also DAV is unclear if VA would use priority groups established in 38 USC 1705 for enrollment to primary care providers to ensure that service-connected veterans are never denied care. We also again note that service-connected veterans with conditions rated at 50 percent or more are not required to enroll for care, but should never be locked out of the system because they are not assigned to a primary care provider.

Ensure entitlement for compensation for negligent care:

VCP Draft Bill: The proposed section 1703A(b)(2)(C) would allow a network provider to practice specialty care in a Department facility or Department provider to practice specialty care in a network provider facility.

DAV recommends language extending entitlement, in these instances, to compensation under 38 USC, section 1151, which in general terms provides that veterans' disability or death as a result of negligent treatment furnished by VA, and not the result of such veteran's own willful misconduct, shall be compensated as if their disability or death are service-connected.

Discussion Draft on title 38, United States Code, appointment, compensation, performance management, and accountability system for senior executive leaders in the Department of Veterans Affairs.

Delegates to our most recent national convention passed two resolutions that may be relevant to this informal "discussion" proposal. DAV Resolution No. 126 calls for modernization of the VA human resources management system to enable VA to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans. DAV Resolution No. 214 calls for meaningful accountability measures, but with due process, for employees of the VA-by requiring that any legislation changing the existing employment protections in VA must strike a balance between holding civil servants accountable for their performance, while maintaining VA as an employer of choice for the best and brightest.

The discussion draft would apply personnel laws for Senior Executive Service (SES) members now working under title 5, United States Code, which covers most civil servants, to title 38, which allows greater pay flexibility to provide more competitive wages. Hiring under title 38 would also give the Secretary more authority to expedite hiring. These are key issues when competing against other federal agencies and the private sector for top talent. DAV supports the intent of these provisions.

However, there may be some issues when hiring individuals under title 38, which is generally reserved for personnel in health-related fields, and applying those standards to those who would lead the Veterans Benefits Administration, National Cemetery Administration, and VA staff offices. In addition, while the proposed reform would allow expedited SES hiring, DAV asks the Committee to carefully consider whether the proposed executive compensation, which would still lag far behind that of chief executives in private sector health care, is nearly sufficient to offset the new risks being created by other parts of this proposal.

In the final analysis, these individuals would serve at the pleasure of the VA Secretary, with little protection that is now available under current law to guarantee their status under title 5 to appropriately protect their due process rights and provide them retreat rights to lower-level assignments and to insulate them from politically motivated decisions-all hallmarks of the origins of the SES as envisioned in the Civil Service Reform Act of 1978. That act established the SES, the Merit Systems Protection Board, and created an array of procedures and requirements that govern the entirety of the SES program and many other aspects of federal personnel law.

Mr. Chairman, DAV and our members urge serious reform of the VA health care system to address access problems while preserving the strengths of the system and its unique model of care. We appreciate this Committee's hard work and are pleased that many of our recommendations have been incorporated into the measures under consideration today so that veterans will have more options to receive timely, high-quality care closer to home.

Draft Bill Study on the Veterans Crisis Line

This bill seeks to authorize a five-year study on the efficacy of the Veterans Crisis Line (VCL) beginning January 1, 2014. The additional information that is to be col-

lected from the VCL includes the number of VCL users who, after contacting the VCL and speaking to a suicide prevention specialist, begin and continue to receive health care furnished by the Secretary and those that do not; the number of veterans that begin care, but do not continue; the number of veterans who call the VCL, but have not previously received care from the Secretary; and those that have previously received such services in addition to a number of other data points regarding VCL use and suicide.

DAV Resolution No. 245, adopted by our members during our most recent National Convention, supports improvements in data collection and reporting relative to suicide prevention; therefore, DAV supports the intent of this bill. However, we do have some concerns and want to ensure the data collection effort does not impinge upon the mission of the VCL-to help veterans in crisis and prevention of suicide.

The VCL is a vital tool that provides veterans several ways of interacting with a qualified suicide prevention specialist. Veterans are able to call the VCL 24 hours a day, 7 days a week to receive high-quality prevention and crisis intervention services. The VCL has helped many vulnerable veterans in crisis averaging more than 500,000 calls per year. Since its inception, it has answered over 2.3 million calls, made over 289,000 chat connections, and completed over 55,000 texts resulting in over 61,000 dispatches of emergency service to callers in imminent suicidal crisis.

While we appreciate the desire to evaluate the effectiveness of the VCL, we also understand that many veterans utilize the VCL with the expectation that their call will be confidential. According to VA, only the responder is able to see his or her information, and the information will not be shared unless permission is obtained from the veteran indicating they would like contact after the call, chat or text message; or if the veteran provides their consent to release for other purposes. Only in cases of imminent danger will a veteran's location and other relative information be shared to facilitate rescue efforts that are coordinated with local officials. Veterans experiencing crisis are already in distress and at their most vulnerable. The stigma associated with mental health, and needing help is sometimes enough to keep veterans from reaching out to receive help. DAV understands the intent of this draft bill is to gather helpful information to improve or enhance VCL services for veterans; however, we urge the Committee to work with VA to determine if and what information is already being collected and analyzed to monitor the effectiveness of the program as it relates to the provisions in the draft measure. Additionally, it is not clear if all the information to be collected will be available based on the notes from the crisis intervention call and a subsequent record review or if the VCL employee taking the call will need to ask the caller if they can contact them at a later date to ask additional questions.

Data collection for the purpose of improving the effectiveness of the program may not qualify as being in the best interest of the patient. The need to collect information cannot outweigh the mission of crisis intervention and saving lives. In any case, we recommend a mental health provider be consulted about these sensitive issues prior to moving forward with the bill.

Thank you for inviting DAV to submit this testimony. We would be pleased to further discuss any of the issues raised by this statement, to provide the Committee additional views, or to respond to specific questions from you or other Members.

Prepared Statement of Honorable Roscoe G. Butler

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee on Veterans' Affairs; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprised of more than 2 million members, and serving every man and woman who has worn the uniform for this country, we thank you for inviting The American Legion to testify today and share our position regarding The American Legion's positions on pending legislation before this committee. Established in 1919, and being the largest veteran service organization in the United States with a myriad of programs supporting veterans, we appreciate the committee focusing on these critical issues that will affect veterans and their families.

Draft Committee Bill to Establish the Veterans Choice Program Permanent

Draft legislation to amend title 38, United States Code, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a pro-

gram to increase the number of graduate medical education residency positions of the Department of Veterans Affairs, and for other purposes.

The Department of Veterans Affairs (VA's) legislative proposal, The Veteran Coordinated Access and Rewarding Experiences (CARE) Act

Healthcare is evolving. Advances in medicine have allowed surgeons to become less invasive, diagnostic tests to become more precise, and we now routinely rely on scientific discoveries inconceivable just ten years ago. Yet our Department of Veterans Affairs (VA) Veterans Health Administration (VHA) is still operating in hospitals more than 50 years old and originated under a statutory framework that was established during the Civil War.

The 2014 wait time scandal helped to expose what veteran service organizations had been warning lawmakers about for years, that the VA has been systemically underfunded and was being forced to manage to budget, and not budgeted to need.

Despite these challenges, as an institution VA has emerged as a world-class leader in a number of veteran-centric medical disciplines, as well as conducting groundbreaking research, lifesaving emergency disaster preparedness, and leading the nation in medical education and residency programs and partnerships.

The draft legislation introduced by this committee combined with the legislative requests from VA begin to address the evolution of 21st century medicine at VA in a way that will allow the department to provide greater access and develop stronger relationships with non-VA providers, moving toward a more integrated system. This is just the first step in a long overdue transformation and The American Legion expects greater emphasis on VA's modernization in successive legislation that is able to capitalize on VA's strengths and core competencies while ensuring that veterans continue to have access to the best care anywhere.

The American Legion is aware of criticisms that suggests this transformation moves perilously close to increased privatization of VA services, and does not dismiss these criticisms as without merit. Nefarious intentions can indeed serve to undermine modernization efforts and The American Legion will continue to be a watchdog and ensure future political interests do not diminish the capacity or value VA represents in the medical or veteran community. It is with this in mind that The American Legion asks this Committee to include a requirement in the final legislation that requires VA to issue an annual report indicating:

1. How many patients VA intends to provide healthcare to through Veteran Care Agreements (VCAs)?

2. How many patients received healthcare through VCAs over the preceding year?

3. What is VA's plan to reduce dependency on VCAs for VA's primary and core services?

4. What are the projected costs associated with providing patient care through VCAs?

5. What was the cost for providing patient care through VCAs over the preceding year?

6. An analysis of healthcare services VA believes is more cost effective to provide through VCAs.

This effort to refine and make permanent a consolidated community care program begins a redesign of VA's infrastructure and capabilities that will next cause a review of what services VA hospitals and community-based outreach centers (CBOCs) perform, and how.

As internal medicine continues to shorten hospital stays and telemedicine expands medical access, the VA will need to have the statutory flexibility to adjust as patient needs fluctuate, while remaining nimble enough to adapt to advancements in technology. The legislative language introduced by this Committee provides greater detail in a number of areas that VA's request lacks, and The American Legion would only caution the Committee to remember the number of times VA, VSOs and the Committee were called upon to introduce and support legislation needed to fix unintended consequences of the original Choice legislation. Well-crafted legislative language that provided direction while giving VA sufficient flexibility to promulgate regulatory guidance served well during the Appeals Modernization project and should be used as an example of how successful legislative initiatives can work to serve veterans while providing sufficient oversight and stakeholder engagement. With that in mind, The American Legion is particularly grateful for the Committee's diligent and well-articulated procedures as detailed in "Primary and Specialty Care" in Section 101 of the Committee draft.

The American Legion appreciates this Committee's dedication and hard work while producing this comprehensive draft and we would like to take this opportunity to highlight some areas we believe need further discussion.

Under Title I, Section 101 subsection 1703A (a) Program (1) [p.2, line13] "at the election of such veteran" needs to include "through agreement and consultation of their primary care provider" or add "pursuant to (b)(2)(A)." Failure to adjust this provision accordingly insinuates the veteran maintains unfettered unilateral discretion as to whether they are seen by a VA physician, or one contracted by VA.

Under Title I, Section 101 subsection 1703A (d) [p8, line 20] The American Legion believes that the rebates or discounts often negotiated by third party administrators, and overpayment recoupment procedures should be addressed such as outlined in the September 12, 2017 Inspector General Memorandum on Accuracy and Timeliness of Payments Made Under the Choice Program should be addressed. [1]

Under Title I, Section 106 subsection 1703B(b) [p.38 line 16] The American Legion recommends adding sufficient protections for veterans receiving care not provided by a VA healthcare provider by including language that entitles veterans protections under Title 38 U.S.C. 1151, which allows veterans who have suffered an added disability while getting VA medical care or taking part in a VA program designed to help you find, get, or keep a job, to be able to get compensation. [2] This lack of 1151 protection suffered by veterans has always been troublesome, and this legislative effort provides the Committee with a chance to cure his deficiency in the program. This also highlights the dangerous lack of oversight this program would enjoy as there are no provisions or discussions that seek to monitor standards or quality of care being performed through community agreements, and this Committee's oversight jurisdiction ends at VA facilities. Should a contracted physician fail to provide the minimum standards of quality care to a VA patient, Congress has no ability to hold them accountable. Choice has been a functioning program now for three year and it is difficult to believe there have no issues or complaints with the quality or timeliness of care provided by private providers.

Included in the VA request is a provision that seeks to increase capacity while saving on emergency room visits by creating or contracting with a network of walk-in clinics. The American Legion believes Section 202 "Improving Veterans' Access to Walk-in Care" will be a benefit for VA patients and will decrease the prevalence of illnesses that are left untreated because patients are deterred from going to the emergency room until their illness or injury becomes so severe that more costly and time consuming measures are needed to stabilize and cure the patient. The American Legion is concerned about the introduction of a copay feature that would be assessed for care directly related to illness or injuries caused or aggravated by a veterans honorable service. The American Legion looks forward to working with VA and this Committee to come up with a plan to mitigate these charges.

In Section 201 of the VA's proposal [p.14], the Department addresses VA medical facilities the "Secretary has determined is not providing care that meets such quality and access standards as the Secretary shall develop". The American Legion is very concerned about this provision and looks forward to reviewing the criteria the Secretary will establish to evaluate such facilities. Further, The American Legion insists that the Department provide an action plan to properly lead and rehabilitate such facilities so as not to drain a VA medical center of resources and thereby reduce options for veterans in what may already be a community struggling to provide healthcare options. Finally, we adamantly oppose and fear it financially unsustainable line (4) of that section which states, "When the Secretary exercises the authority under this subsection, the decision to receive care or services from a non-Department entity or provider under this subsection shall be at the election of the veteran."

In both legislative proposals there are provisions for patients to appeal the Department's decisions. As it stands now, the VHA is America's largest integrated health care system, providing care at 1,243 health care facilities, including 170 medical centers and 1,063 outpatient sites. Appeals of this nature are overseen and determined by the medical center director, which creates 170 standards for review. The American Legion calls on the Department to come up with a minimum standard for review that is consistent across the Department and referenced in VA's handbook, making appeals equitable for all veterans. [3]

As highlighted in "VA Healthcare A System Worth Saving," a report written by Phil Longman, author of "Best Care Anywhere", and health-care journalist Suzanne

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[1] https://www.va.gov/oig/pubs/admin-reports/VAOIG–17–00000–379.pdf
[2] https://www.benefits.va.gov/COMPENSATION/claims-special-1151.asp
[3] VHA DIRECTIVE 1041: APPEAL OF VHA CLINICAL DECISIONS (October 24, 2016)

Gordon, it makes sense for VA to partner with community physicians because it serves to enhance VA's ability to serve veterans:

A related challenge is the acute shortage of doctors, nurses, and other health-care professionals across the U.S. system generally. The problem is particularly acute in rural areas and low-income inner-city neighborhoods. Though VA tends to attract health-care professionals who have an idealistic commitment to veterans issues and to public service, its recruitment efforts are challenged by its inability to offer employees the same income they could earn in the private sector.

For these reasons and many more, in some communities it makes sense for VA to partner with other providers rather than offer all medical services itself. Instead of operating its own dialysis centers in every community, for example, in some medical markets it may be more efficient and convenient to patients for VA to contract with an existing local facility. Similarly, in smaller communities there may not be enough heart patients to keep more than one catheterization laboratory working at a safe and efficient volume, and there is no point in VA building a cath lab of its own. Where VA lacks the infrastructure or personnel to offer patients timely and convenient access to a particular kind of care, it may make sense for VA to partner with outside providers in order to shorten wait times or give veterans a greater choice.

In doing so, VA must, however, preserve the high levels of evidence-based, coordinated care that has made it a model of best practices in health care and avoid the dangerous fragmentation and overtreatment that is a hallmark of so much of the U.S. health-care system. Outsourcing care simply to maximize choice of doctors does not make sense when it conflicts with other critically important values that VA supplies to its patients, including its excellence in providing care that is safe and effective precisely because it is coordinated. Practically speaking, outsourcing can reduce the choices available to veterans if it causes VA hospitals and clinics to be starved of resources and then forced to close. [4]

Overall, The American Legion is extremely pleased with these proposals and with some minor adjustments, we believe this will begin the type of transformation VA has needed for a very long time.

In closing, with regard to how Congress will pay for the future healthcare for American veterans, The American Legion is appalled that either Congress or the Administration would recommend that veterans disability checks be debited, even one dime, to cover the costs of other veterans benefits. The COLA round down provision as proposed many times over the past several years would tax service disabled veterans to pay for service disabled veteran benefits. Regardless of what the annual amount of money debited from a veterans check would be each month, the very thought that this is okay is insulting and offensive. Veterans' healthcare should not be subjected to offsets or pay-fors, and the full burden of providing care for service disabled veterans needs to be borne by the federal government through a debt to the U.S. Treasury.

H.R. 1133: Veterans Transplant Coverage Act

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide for an operation on a live donor for purposes of conducting a transplant procedure for a veteran, and for other purposes.

This bill would authorize the Department of Veterans Affairs (VA) to provide organ transplants to veterans from a live donor regardless of whether that donor is a veteran or whether medical services required are done in a VA facility or non-VA facility.

Current VA policy excludes non-veteran live donations from coverage under the VA Choice Program and requires veterans to travel to specific VA treatment facilities. These eligibility constraints mean that veterans are required to travel hundreds, even thousands of miles when non-VA hospitals closer to home can do the same transplants. Overcoming travel distances and other barriers to care is one of the main objectives of the Choice Program and its intent should apply when a veterans needs a necessary organ transplant too.

The American Legion can support this bill through Resolutions No. 25, The American Legion Support of the VA Organ Transplant Program which supports a system of organ distribution that will ensure that veteran patients receive equitable consideration when in need of transplants; and No. 46, Department of Veterans Affairs (VA) Non-VA Care Programs, which calls on VA to develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a pa-

[4] VA Healthcare A System Worth Saving (August 2017)

tient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into [5]account[6].

The American Legion supports H.R. 1133.

H.R. 2123: "Veterans E–Health and Telemedicine Support Act" or the "VETS Act of 2017"

To amend title 38, United States Code, to improve the ability of health care professionals to treat veterans through the use of telemedicine, and for other purposes.

This bipartisan legislation would allow U.S. Department of Veterans Affairs (VA) health professionals to practice telemedicine across state borders if they are qualified and practice within the scope of their authorized federal duties. Currently, cumbersome location requirements can make it difficult for veterans especially those struggling with mental health and/or mobility issues to get the help they need and deserve.

Telehealth is one of VA's major transformational initiatives, one aimed at making care more convenient, accessible and patient-centered. VA Telehealth services have increased in recent years, creating more access to health care for veterans, especially those residing in rural areas throughout the country. However, current legal barriers limit the level of services and number of veterans VA can serve. American Legion Resolution 44, Department of Veterans Affairs Rural Healthcare Program, passed at The American Legion's 2016 National Convention urges Congress and VA to look for opportunities to expand telehealth services for veterans residing in rural communities.[7] By clearing away certain legal barriers, the VETS Act would ease access to the care veterans need and deserve.

The American Legion was pleased by the VA's newly proposed rule effectuating the goals of the VETS Act of 2017 and allowing VA telehealth providers to more easily administer care across state lines.[8] We look forward to timely implementation of a final rule and continue to urge Congress to build on this administrative action with permanent legislation in the form of the bipartisan, bicameral VETS Act.

The American Legion supports H.R. 2123.

H.R. 2601: "Veterans Increased Choice for Transplanted Organs and Recovery Act of 2017" or the "VICTOR Act of 2017"

To amend the Veterans Access, Choice, and Accountability Act of 2014 to improve the access of veterans to organ transplants, and for other purposes.

This bill would allow veterans who live more than 100 miles from one of the nation's 14 Department of Veterans Affairs' Transplant Centers (VATCs) to seek care at a federally certified, non-VA facility that covers Medicare patients.

The VA's organ transplant system has a well-known problem: To focus specialized expertise and manage costs, the VA only does organ transplants at 14 locations nationwide, and each location only does certain types of transplants. The result is that veterans are required to travel hundreds, even thousands of miles when non-VA hospitals closer to home can do the same transplants.

Currently, these 14 VATCs are located at VA healthcare facilities across the country that specialize in solid organ and' bone marrow/stem cell transplantation to eligible veterans. They are located in Palo Alto, CA (Heart), Portland, OR (Kidney, Liver, Liver-Kidney), Seattle, WA (Bone Marrow, Lung), Houston, TX (Kidney, Liver, Liver-Kidney), San Antonio, TX (Bone Marrow), Salt Lake City, UT (Heart), Iowa City, IA (Kidney-Pancreas, Pancreas), Madison, WI (Heart, Heart-Lung, Liver, Lung), Birmingham, AL (Kidney), Nashville, TN (Bone Marrow, Heart, HeartKidney, Heart-Liver, Kidney, Liver, Liver-Kidney), West Roxbury, MA (Heart), Bronx, NY (Kidney), Pittsburgh, PA (Kidney, Liver, Liver-Kidney, LiverSmall-Bowel, Small Bowel), and Richmond, VA (Heart, Liver).

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[5] The American Legion Resolution No. 25 (May 2004): The American Legion Support of the VA Organ Transplant Program

[6] The American Legion Resolution No. 46 (Oct. 2012): Department of Veterans Affairs (VA) Non-VA Care Programs

[7] The American Legion Resolution No. 44 (2016): Department of Veterans Affairs Rural Healthcare Program

[8] VA proposed rule: Authority of Health Care Providers to Practice Telehealth (10.2.17)

A recent study suggests that travel can have a negative impact on medical outcomes. [9] The study looked into the association between distance from a VATC and veterans actually receiving liver transplantation. The research found the greater the distance from a VATC a veteran lived, the lower their likelihood of being placed on the waitlist, receiving a transplant, and therefore the greater their likelihood of death.

How far a veteran resides from one of the VATCs can, therefore, reduce the veteran's chances of getting evaluated and eventually proceeding with the needed transplant. Some veterans even have to consider the possibility of relocating near one of the VATCs in order to go through the recovery process. VAOIG's October 2015 March 2016 Semiannual Report to Congress substantiated that some patients referred for liver transplant evaluations at all VATCs experienced delays. [10] Timely organ transplants can be the difference between life and death.

The American Legion can support this bill through Resolutions No. 25, The American Legion Support of the VA Organ Transplant Program which supports a system of organ distribution that will ensure that veteran patients receive equitable consideration when in need of transplants; and No. 46, Department of Veterans Affairs (VA) Non-VA Care Programs, which calls on VA to develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into [11]account [12].

The American Legion supports H.R. 2601.

H.R. 3642: "Military Sexual Assault Victims Empowerment Act" or "Military SAVE Act"

To direct the Secretary of Veterans Affairs to carry out a pilot program to improve the access to private health care for veterans who are survivors of military sexual trauma.

This bill would establish a pilot program that would allow survivors of military sexual trauma (MST) to seek specialized care outside the Veterans Health Administration through the Choice program. H.R. 3642 would make a victim of a military sexual trauma potentially eligible for non-VA care under the Veterans Choice Program.

Ultimately, this is about trying to find the right treatment for every patient, and in the case of MST, unique challenges can shape treatment needs, so VA should be flexible to ensure these veterans receive the care they need. The American Legion is deeply concerned with the plight of survivors of MST and has urged Congress to ensure the VA properly resources all VA medical centers, vet centers, and community-based outpatient clinics so that they employ a MST counselor to oversee the screening and treatment referral process, and continue universal screening of all veterans for a history of MST. [13]

A January 2011 landmark women veterans survey conducted by The American Legion found that respondents reported serious challenges receiving gender-specific care sensitive to their needs, particularly with regard to MST. The American Legion has since fought for better awareness training in VA for MST sensitivity, significant increases in outreach, and more comprehensive care options for MST survivors, including better availability of female therapists, female group therapy and other options to make MST care more accessible. [14]

VA is working to improve in these areas, as is evidenced by VA publications that note:

- VA knows that MST survivors may have special treatment needs and concerns. For example, a Veteran can ask to meet with a clinician of a particular gender if it would make him or her feel more comfortable. Similarly, to accommodate Veterans who do not feel comfortable in mixed-gender treatment settings, many facilities throughout VA have separate programs for men and women. All residential and inpatient programs have separate sleeping areas for men and women.
- VA has specialized treatment programming available for MST survivors. VA facilities have providers knowledgeable about evidence-based mental health care

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4586113/
[10] https://www.va.gov/oig/pubs/sars/VAOIG–SAR–2016–1.pdf
[11] Resolution No. 25 (May 2004): The American Legion Support of the VA Organ Transplant Program
[12] Resolution No. 46 (Oct. 2012): Department of Veterans Affairs (VA) Non-VA Care Programs
[13] Resolution No. 67: (Aug. 2014) Military Sexual Trauma
[14] Resolution No. 18: (Oct. 2015) Women Veterans

for the aftereffects of MST. Many have specialized outpatient mental health services focusing on sexual trauma. Vet Centers also have specially trained sexual trauma counselors. For Veterans who need more intensive treatment and support, there are programs nationwide that offer specialized sexual trauma treatment in residential and inpatient settings.

- In VA, treatment for all mental and physical health conditions related to MST is free and unlimited in duration. Veterans do not need to have a disability rating (that is, be "service-connected"), to have reported the incident(s) at the time, or to have other documentation that MST occurred in order to receive free MST-related care. There are no time limits on eligibility for this care, meaning that Veterans can seek out treatment even many years after discharge.
- Veterans may be eligible for free MST-related care even if they are not eligible for other VA services. There are special eligibility rules associated with MST-related care and many of the standard requirements related to length of service or financial means do not apply. [15]

However, implementation of change within VA can take time, and even the best of programs can have irregular results from facility to facility. Veterans should not have to suffer because the care they need is not well implemented at their local VA facility.

The American Legion recognized that the Choice program was an emergency measure to get care to veterans where VA was struggling to deliver care. In recognition of the needs of an integrated system to deliver non-VA care when needed, The American Legion believes VA needs to "develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses [emphasis added] as well as their travel and distance into account." [16]

One of the unique problems that survivors of MST face is that the treatment environment at VA is not always conducive to their comfort level, and comfort is critical in particular when dealing with issues such as psychiatric care for Posttraumatic Stress Disorder (PTSD) which is frequently a major side effect of MST. In the case of these survivors, getting them to a treatment program within their comfort level can mean the difference between a survivor continuing treatment or abandoning treatment. The latter could result in them feeling further isolation and possibly cause an escalation of their symptoms.

For veterans who are suffering right now, they need to get the treatment they need, but we should also be mindful that this is not a panacea for the problems faced by MST survivors. Ensuring integration with the VA system is also beneficial to their overall health picture. As with any care outside VA, The American Legion stresses the importance of ensuring non-VA care has quality of care standards equal to or better than they receive within VA, that the care is coordinated effectively to ensure veterans are not stuck with billing problems with outside providers that can adversely affect their credit, and perhaps most importantly, that the providers have access to VA healthcare records for the patient and vice versa. [17] One of the best assets of VA healthcare for veterans is the ability for providers within the system to have a total picture of the veteran's health.

By seeing all interconnected conditions, and being aware of the unique health challenges of veterans, providers can spot patterns leading to early screening for conditions such as PTSD, health conditions related to environmental exposures like Gulf War Illness and Agent Orange, and other things an average civilian provider would miss. While sometimes it's necessary for veterans to get the care they need outside the system, it's important to make sure when that's done, they do not lose out on the real and tangible benefits to care they get as part of the integrated care network that is VA.

But first, for veteran survivors of Military Sexual Trauma, we have to make sure they get the care they need in the environment that's going to maximize the effects of treatment.

Through Resolution No. 67: Military Sexual Trauma, The American Legion, recognizing the unique and sensitive nature of MST, supports a pilot program relying on VA's over 20 years of experience in treating veterans with MST to determine if this

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[15] Top Ten Things All Healthcare & Service Professionals Should Know About VA Services for Survivors of Military Sexual Trauma

[16] Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs OCT 2014

[17] Resolution No. 46: Department of Veterans Affairs (VA) Non-VA Care Programs OCT 2014

type of care is most beneficial to the veteran and will assess the merits of this program on the findings. [18]

The American Legion supports H.R. 3642.

Draft legislation

To direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line.

The Veterans Crisis Line (VCL) connects veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs (VA) responders through a confidential toll-free hotline, online chat, or text. The responders at the VCL are specially trained and experienced in helping veterans of all ages and circumstances.

Since its launch in 2007, the VCL has answered nearly 2.8 million calls and initiated the dispatch of emergency services to callers in crisis nearly 74,000 times. The VCL anonymous online chat service, added in 2009, has engaged in more than 332,000 chats. In November 2011, the VCL introduced a text-messaging service to provide another way for veterans to connect with confidential, round-the-clock support, and since then has responded to more than 67,000 texts. The VCL plays a critical role in VA's initiative of suicide prevention, and ongoing efforts to decrease the estimated 20 veterans who die by suicide each day.

This legislation would direct VA to conduct a study on the VCL, which would require VA to gather data which it does not currently collect nor should it. Focus rather should be on better understanding the circumstances of the 14 veterans who die by suicide each day who are not actively enrolled in the VA.

The American Legion opposes this draft bill.

Conclusion

The American Legion looks forward to continuing to working closely with VA and this Committee on these important issues and we applaud the Committee for working with VSOs and VA as partners to ensure that The Detriment of Veterans Affairs is properly structured to meet the needs of the 21st century veteran.

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact the Legislative Division at The American Legion's Legislative Division at (202) 861–2700.

Prepared Statement of Honorable Kayda Keleher

WITH RESPECT TO

"H.R. 1133; H.R. 2123; H.R. 2601; H.R. 3642; Draft legislation to establish a permanent Veterans Choice Program; draft legislation to modify VA's authority to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions, and for other purposes; Draft legislation to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line; and the Department of Veterans Affairs' legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act"

Chairman Roe, Ranking Member Walz and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this committee.

H.R. 1133, Veterans Transplant Coverage Act of 2017

The VFW supports this legislation, which would authorize Department of Veterans Affairs (VA) to provide care and services to non-veterans for purposes of donating organs to VA-eligible veterans.

Currently, VA provides care to certain non-veterans, ranging from survivors and dependents, newborn children of women veterans, to humanitarian care for emergency room visitors. Under the current Choice Program veterans in need of using

[18] Resolution No. 67 (Aug. 2014): Military Sexual Trauma

the program to receive a live organ donation are denied access when the donor is not eligible to receive VA care. The VFW urges this committee to ensure any future community care program is able to be used by veterans who need an organ transplant from a live donor. But until then, veterans should not be forced to wait any longer to receive the organs they need. Individuals in need of an organ transplant are in life or death situations, and finding a matching organ donor is time consuming and often rare.

H.R. 2123, Veterans E–Health and Telemedicine Support Act of 2017

The VFW strongly supports this legislation, which would authorize qualified VA health care providers to practice telemedicine across state lines. This legislation would be especially helpful for veterans who do not live in the same state as the VA facility in which they are enrolled. With geographic distance remaining a significant barrier to care for many veterans, the use of telemedicine technology has emerged as a highly effective method of providing veterans with timely and convenient care.

A recently signed Executive Order authorizes doctors to perform many of the duties this legislation would authorize. The Executive Order was based on VA's belief that it has authority to conduct telehealth in such manner. However, some doctors have expressed an unwillingness to practice under the authority of an Executive Order. As such, legislation would provide VA doctors the assurance they need to practice telemedicine.

H.R. 2601, Veterans Increased Choice for Transplanted Organs and Recover Act of 2017

The VFW agrees with the intent of this legislation, which would ensure veterans in need of organ transplants do not have to travel long distances to receive care. Congress and VA have learned that placing arbitrary distance and timelines requirements to use VA community care programs leads to unintended consequences. For that reason, the VFW cannot support this legislation.

The legislation is an example of why VA has multiple community care programs with different eligibility criteria. The VFW supports consolidation of community care programs to ensure veterans can receive the care they need, where they need it, instead of creating exemption or rules for specific circumstances. Doing so would provide VA the flexibility it needs without forcing veteran to wait longer than needed for life saving care. It would also allow VA to make decisions in circumstances where the VA may be under 100 miles away, it is best for a veteran to receive an organ transplant in the community, closer to home.

H.R. 3642, Military Sexual Assault Victims Empowerment Act

The VFW opposes this legislation, though understands the intent of the bill. After conducting six health care surveys and hearing directly from more than 20,000 VFW members, the VFW understands that veterans often face barriers accessing needed care. However, we view this bill as an overcorrection which would diminish the care veterans receive from VA.

Ensuring sexual assault survivors receive the care they need is a top priority for the VFW. This became especially clear when VA released their veteran suicide data July 2016. This study showed women veterans who have survived sexual trauma from their time in the military are at an increased risk of death by suicide compared to those who did not experience sexual trauma. That is why the VFW believes we must continue providing VA with the resources and authorities it needs to hire mental health care providers who specialize in not just the traumas of war, but the traumas of sexual assault.

Health care for survivors of sexual trauma must also be more inclusive than strictly mental health care. Survivors may need to seek treatment for health issues such as sexual dysfunction or substance abuse treatment. These survivors are also at increased risk for needing assistance with housing and employment. All of these are specialties of VA's continuum of care and holistic medical scope for veteran patients. To make accessing these benefits easier VA also offers Military Sexual Trauma Coordinators at all VA medical centers yet another example of something VA does which is not available in the private sector.

The VFW strongly believes VA must be the coordinator of care for veterans and continue to guarantee the quality of care veterans receive regardless of where the care is provided. This legislation would limit VA's ability to coordinate care for a very vulnerable segment of the veteran population and would lead to such veterans receiving fragmented care, which health care experts believe endangers patient safety.

The VFW also believes there are unclear discrepancies between the survey and reporting requirements of this legislation. One example of this is the surveying of the private sector timeframe between when a veteran would be able to make an appointment and when they have their appointment. Currently VA is held accountable for not just the wait time between when a veteran makes an appointment and when they get in for their appointment, but also for the veteran's preferred date. When gathering data to compare VA to the private sector, it is imperative VA and the private sector be compared and judged on the same playing field. The VFW also believes surveying for all medications a veteran may have so VA can later report which ones are being taken for sexual assault related illnesses or injuries is overbearing.

Draft Legislation to Modify Authority of the Secretary of Veterans Affairs to Enter into Agreements with State Homes to Provide Nursing Home Care to Veterans

The VFW supports this legislation and has a recommendation to improve it. This legislation would improve VA's current authorities to enter into agreements with state veterans homes.

This legislation would also increase the number of graduate medical education (GME) residency positions within VA. While the VFW supports increasing GME opportunities within VA, we urge this committee to expand this legislation to include psychology residencies. A recent VA Office of Inspector General reported entitled "OIG Determination of VHA Occupational Staffing Shortages" listed psychologists as the third largest staffing shortage within VA. This committee must ensure VA is able to address all of its staffing shortages.

Draft Legislation to Direct the Secretary of Veterans Affairs to Conduct a Study on the Veterans Crisis Line

The VFW understands the intent of this legislation, but opposes it as written. This legislation would direct VA to conduct a study on the Veterans Crisis Line (VCL), which would require VA to gather data which is does not currently collect nor should it.

In 2007, the Veterans Health Administration (VHA) established a suicide hotline, which later became known as the VCL, to provide 24/7, suicide prevention and crisis intervention to veterans, service members and their families. This was necessary as a means of constant availability for individuals in need of crisis intervention. The VCL provides crisis intervention services to veterans in urgent need, and helps them begin a path toward improving their mental wellness. The VCL plays a critical role in VA's initiative of suicide prevention, and ongoing efforts to decrease the estimated 20 veterans who die by suicide each day. The VCL answers more than 2.5 million calls, responds to more than 62,000 text messages and initiates the dispatch of emergency services more than 66,000 times each year. Recently, the VCL has expanded to three call centers located in Canandaigua, N.Y., Atlanta, Ga. and Topeka, Ks.

When veterans contact the VCL they are answered by professional staff with extensive background and expertise in social work and crisis prevention/intervention. These unseen heroes answer thousands of calls by veterans in their most vulnerable moments. No veteran in need should contact the VCL only to be asked for their personally identifiable information. Just as Vet Centers, veterans must have the ability to seek care for the VCL anonymously.

The VFW understands that when VCL staff must dispatch emergency responders, or do a warm hand-off between the veteran and a VA suicide prevention specialist that personally identifiable information will be collected. At that point, the VFW believes identifying and tracking the veteran's progress should begin. The purpose of the VCL is to provide crisis intervention and prevent veterans from dying or attempting suicide. Prevention is key here. And Congress must not implement measures which would deter veterans from utilizing the VCL.

Tracking the successes and possible downfalls of VCL is important to the VFW. But we believe the data already available shows the crisis line is successful. One reason for its success is that callers are only asked whether they are veterans, therefore veterans who may not be eligible for VA services are able to use the line. It is currently well known that of the 20 veterans who die by suicide each day, 14 of those veterans were not actively enrolled in VA. If Congress and VA sincerely want to eradicate veteran suicide then we must dive deeper into data on the 14 veterans not using VA. What better outreach can be done? Are they eligible for VA and not using it? What can VA do to further assist in prevention and intervention for these veterans?

The VFW firmly believes the VCL has improved and will continue to improve. Such improvement will continue to be slow, frustrating and life-endangering if the VCL does not begin collaborating with others. Aside from working with patient advocacy offices to cut down on non-crisis calls and VHA Member Services to readjust the advisory board and increase clinicians, the VCL must also work more closely with the Office of Suicide Prevention (OSP).

Member Services has undoubtedly assisted the VCL in quantity control, but OSP can also assist the VCL in quality control. If the goal of the VCL is to intervene for veterans in need of immediate assistance while they are in the middle of a mental health crisis, the VCL should be working with the subject matter experts and leaders in suicide prevention and outreach for VA. If all three offices could collaborate together, with better guidelines, Member Services must be able to continue improving the VCL call center expertise and business, while OSP can make sure the VCL is up-to-date with the most current clinical expertise on suicide prevention and outreach.

Draft Legislation to Establish a Permanent Veterans Choice Program & Draft Legislation from Department of Veterans Affairs, Veteran Coordinated Access and Rewarding Experiences Act (CARE Act)

In the past three years the VFW has assisted hundreds of veterans who have faced delays receiving care through the Choice Program, and has surveyed more than 8,000 veterans specifically on their experiences using VA community care. Through this work, the VFW has identified a number of issues and has proposed more than 15 common sense recommendations on how to improve this important program. The VFW would like to thank the committee for its leadership in addressing many of the issues the VFW has identified, such as making VA the primary payer for Choice Program care, removing restrictions on when VA is able to share medical records with Choice providers and making clinical necessity the trigger for community care.

The VFW must also commend VA and the third party administers for their willingness to work with us to address issues veterans encounter when obtaining care through the Choice Program. VA has made more than 70 modifications to the Choice Program's contract to address many of the pitfalls that have plagued the program, such as allowing the contractors to conduct outbound calls when they have the proper authorization to begin the scheduling process. The VFW is also supportive and pleased to see VA's eagerness to establish a pilot program which would share health care resources with Department of Defense at up to five locations.

However, the Choice Program continues to face several challenges that must be addressed. That is why the VFW is very concerned that VA's CARE Act does not request to make the Choice Program a permanent discretionary program. The VFW believes this program must be improved and consolidated with other VA community care programs, but we oppose continuing it as mandatory program. VA's medical care accounts are under discretionary spending and subject to sequestration budget caps. Having the Choice Program as the only VA health care program not subject to spending caps could lead to a gradual erosion of the VA health care system. Also by consolidating VA's community care programs, the VFW believes all programs must be consolidatedto include dialysis.

The VFW and its Independent Budget partners (DAV and PVA) also oppose VA's and this committee's proposal to eliminate of copayment offset for veterans who health insurance. The VFW strongly believes implementing this change would limit VA medical collections. VA recently shared outreach material that urges veterans to share and update their health care insurance information with VA. The outreach material rightfully incentivizes veterans to share their information with VA because their VA copayments would be offset by money VA collects from their health insurance and such monies also covers their annual deductibles. Removing this offset would remove the incentive for veterans to share their health insurance information with VA and may even remove the need for veterans to keep their health insurance.

The VFW also opposes section 503 of VA's draft CARE legislation, which would round down cost of living disability pay increases, a proposal which the VFW has opposed in the past and continues to strongly oppose.

The Administration has also proposed a cap on the amount of tuition and fees that may be paid under the Post-9/11 GI Bill for programs of education in which a public institution of higher learning enters into an agreement with another entity to provide such education. Currently, third party training programs that contract with public schools are able to charge unlimited fees since public schools have no set dollar amount cap. A couple of years ago, it came to light that some contracted flight training programs were charging exorbitant fees, which far exceeded the cost

of an average in-state education. The VFW supports the Administration's proposal to place a reasonable cap on these sorts of training programs.

The biggest issue the VFW hears from veterans who use the program is the breakdown of communication between VA, the third party administrators, Choice providers and veterans. This breakdown has a significant impact on the care veterans receive. The VFW has heard from too many veterans that they were sent to the wrong doctor because VA and the contractor could not figure out how to make certain the veteran sees the specialist that can provide the care the veteran needs. For example, veterans who need to receive the recently developed cure for Hepatitis C have been sent to hepatologists who cannot provide them the lifesaving medications they need.

The VFW has also heard from veterans that the breakdown in communication between VA, contractors and Choice providers often delays their care because their Choice doctors do not receive authorization to provide needed treatments. What is concerning is that veterans are left to piece together the entire story or else they do not receive the care they need; or they are left to pay for the care out of pocket because their Choice doctors performed treatments beyond the scope of the Choice authorization. This is why the VFW is pleased to see the committee's draft legislation provide VA with consolidated networks and contracts while easing the payment process to the community care providers. Though the VFW would like to see the draft legislation amended to provide VA with authority to incorporate use of a value-based reimbursement model, instead of requiring VA to do so. This authority would be best utilized initially as a pilot program, similar to Centers for Medicare and Medicaid Services, to see if value-based payments lead to better outcomes or reduced costs.

The VFW strongly supports provisions in the committee's draft legislation which would ensure VA remains the coordinator and primary provider of care for veterans. This includes ensuring VA is maximizing its resources before turning the community care to fill demand and continually evaluating whether care VA is purchasing from community care providers should be delivered in house. However, the VFW urges that committee to amend the bill to ensure veterans who are assigned a community primary care provider receive assistance from VA in selecting the provider that best fits their needs instead of simply giving them a list of network providers and left on their own to find one willing to see them.

VA has taken a number of steps to address this breakdown in communication. It is in the process of implementing a new authorization management system to eliminate the confusion regarding which provider veterans need to see. It has also worked with TriWest Healthcare Alliance and Health Net, Inc. to have contractors co-located with VA community care staff at VA medical facilities to address and issues in approving secondary authorizations or ensuring veterans are sent to the right doctors. The VFW has received good feedback from VA employees and veterans at facilities with co-located VA and contract staff.

However, the underlying issue that causes this breakdown in communication is the fact that TriWest and Health Net are required to maintain their own systems to track Choice casework. VA transmits information to them instead of granting the contactors access to VA systems or using the same systems, which would eliminate the need to transmit data and documents between VA and the third party administrators. To avoid having to go through a third party when scheduling Choice Program appointments, VA has proposed to have its community care staff resume responsibilities for all the scheduling, which they have done in the past and continue to do under other community care programs.

The VFW supports utilizing VA community care staff to schedule Choice Program appointments when possible, but it is unreasonable to expect VA to be able to staff up enough to keep pace with the expanded use of the Choice Program. For that reason, the VFW recommends VA build on its co-located staff model and rely on contracted staff to support VA's community care staff when demand for Choice Program care spikes. To ensure veterans are not negatively impacted when they are rolled over to contract staff, VA must ensure the contracted staff has access to the same systems as VA community care staff.

As the VFW has highlighted in our two Choice Program reports, which can be found on our VA health care watch website, www.vfw.org/vawatch, the eligibility criteria for the Choice Program must also be reformed. The VFW firmly believes that VA must reevaluate how it measures wait times. In the VFW's most recent VA health care report only 67 percent of veterans indicated they had obtained a VA appointment within 30 days, which is significantly less than the 93 percent VA reported in its most recent access report. This is because the way VA measures wait times is not aligned with the realities of scheduling a health care appointment.

VA uses a metric called the preferred date to measure the difference between when a veteran would like to be seen and when they are given an appointment. However, this completely ignores and fails to account for the full length of time a veteran waits for care. For example, when veterans call to schedule an appointment they are asked when they prefer to be seen. The first question they logically ask is, "When is the next available appointment?" If VA's scheduling system does not preclude them from doing so, schedulers have the ability to input the medical facility's next available appointment as the veteran's preferred date—essentially zeroing out the wait time. VA must correct its wait time metric to more accurately reflect how long veterans wait for their care.

However, VA's wait time measurement must not be used as an eligibility criterion for the Choice Program. While the VFW agrees using a clinically indicated date to determine eligibility is the right approach, we do not believe Congress or VA should dictate how long veterans must wait before receiving care from community care providers. Arbitrary thresholds such as 30-days or 40-miles do not reflect the health care landscape of our country. Veterans may not need to be seen within 30 days for appointments such as routine checkups. Likewise, such arbitrary thresholds do not account for veterans with urgent medical needs for which they need to be seen before 30 days, or veterans who suffer from disabilities which prevent them from traveling 40 miles. That is why the VFW is happy to see both this Committee's and VA's draft legislation improve community care eligibility to be a clinically based decision between a patient and their provider.

Though, the VFW does suggest amending the draft legislations to ensue VA is able to provide care and services to non-veterans if needed when caring for a VA-eligible veteran. In particular this has greatly affected both live donor organ transplant patients as well as veterans seeking In Vitro Fertilization (IVF). If a veteran who uses VA and is in need of an organ transplant is matched with a non-VA eligible individual, that donor is not eligible to receive the operation or care under the current Choice Program eligibility requirements. Also if a veteran is approved for IVF services through VA and his or her spouse is a non-veteran, the veteran is not able to use the Choice Program to receive IVF.

When scheduling veterans for medical appointments, whether it is with VA or a community care provider, VA must take into account veterans' clinical needs and personal preferences. If a veteran has an urgent care need that must be met within 48 hours, that veteran must be seen within 48 hours. Additionally, VA must take measures to meet veterans' preferences when seeking care. For example, a male veteran who was sexually assaulted by a male may want to seek care from a female provider. VA should not have to interrogate veterans every time a veteran needs care, but it must give veterans the opportunity to discuss their preferences.

This would also require VA care coordinators to be able to view the availability and characteristics of VA and community care providers. VA must invest in information technology systems that would allow it to compile appointment availability for community care and VA. Doing so would enable veterans to truly work with their care teams to determine what options are best for them.

In its draft CARE legislation, VA has requested authority to reimburse veterans for walk-in care they receive from clinics around the country to fill the gap between emergency care and traditional appointment-based outpatient care. Doing so would ensure veterans with acute medical conditions that require urgent attention, such as the flu, infections, or non-life threatening injuries, do not wait days or weeks for a primary care appointment. Enabling veterans to be reimbursed for walk-in care would also curb the reliance on emergency rooms for non-emergent conditions, which is more expensive for veterans and VA. The VFW urges Congress to consider and swiftly pass legislation authorizing VA to reimburse veterans for using community walk-in and urgent care clinics. The VFW does, however, oppose any attempt to bill veterans for the cost of providing service connected care, regardless of when or where the care is delivered. Furthermore, the VFW believes that copayments for community care programs must be the same as if veterans received such care at a VA medical facility. Veterans must not be penalized because the care they need is not readily accessible at a VA medical facility.

The VA health care system delivers high quality care and has consistently outperformed private sector health care systems in independent assessments. The VFW's numerous health care surveys have also validated that veterans who use VA health care are satisfied with the care they receive. In fact, our latest survey found that 77 percent of veterans report being at least somewhat satisfied with their VA health care experience. When asked why they turn to VA for their health care needs, veterans report that VA delivers high quality care which is tailored to their unique needs and because VA health care is an earned benefit.

VA has made significant strides since the access crisis erupted in 2014 when whistleblowers across the county exposed how long veterans were waiting for the care they have earned and deserve. However, VA still has a lot of work to do to ensure all veterans have timely access to high quality and veteran-centric care. Veterans deserve reduced wait times and shorter commutes to their medical appointments. This means turning to community care when needed, but also means improving VA's ability to provide direct care. In this committee's draft legislation, the VFW believes the annual capacity and commercial market assessment must include a requirement to identifying how building internal capacity either through construction or hiring would improve access, as well as identify barriers preventing VA from doing so. This would ensure Congress and VA know what improvements are needed within VA.

The VFW thanks Congress for its commitment to improving VA's community care authorities and programs. VA also needs the resources and authorities to quickly recruit and properly compensate a high performing health care workforce, properly train its employees, hold wrongdoers accountable, and update its aging capital infrastructure. Community care must continue to supplement direct VA health care. This means VA and Congress must continue to invest in VA to ensure it remains a premier health care system. That is why the VFW supports sections 301, 303, 304, 305, 307, 308, 309, 321, 322, 323, 324 and 401 of VA's draft CARE legislation.

The VFW supports passage of provider agreement legislation. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not able to provide the care.

Provider agreements are particularly important for VA's ability to provide long term care through community nursing homes. The majority of the homes who partner with VA do not have the staff, resources or expertise to navigate and comply with FAR requirements and have indicated they would end their partnerships with VA if required to bid for FAR contracts. In fact, VA's community nursing home program has lost 400 homes in the past two years and will continue to lose 200 homes per year without provider agreement authority. This means thousands of veterans are forced to leave the place they have called home for years simply because VA is not able to renew agreements with community nursing homes. Congress must end this injustice by quickly passing provider agreement legislation.

STATEMENT FOR THE RECORD

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGIGSTS

Regarding

H.R. 3642, The Military SAVE Act

Chairman Roe, MD, Ranking Member Walz, and distinguished Members of the Committee on Veterans' Affairs, we are pleased to submit written testimony on behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners in women's health, in support of H.R. 3642, the Military SAVE Act.

ACOG Supports H.R. 3642, the Military SAVE Act

We would like to thank Representative Andy Barr (R–KY) for his leadership in introducing this legislation, and your leadership, Mr. Chairman, in holding this important hearing. ACOG enthusiastically endorses H.R. 3642 and we urge Committee to include this legislation in the broader VA health reform effort.

H.R. 3642 represents an innovative effort to ensure access to gender-sensitive, high quality care for Veterans who experienced military sexual trauma (MST) while serving the United States as active duty members of our Armed Forces.

Women play a vital role in the U.S. military, constituting 16 percent of all active duty and reserve members of the military, and nearly 10 percent of the total Veteran population in the United States. Women are at an increased risk for military sexual assault and the long-term health effects that can accompany this trauma. ACOG applauds the Veterans Health Administration (VHA) for requiring all women Veterans be screened for MST, and the significant progress made in reducing gender disparities in health care in recent years. Yet while there are many mechanisms in

place to support the health needs of women Veterans, there is more that can and must be done to ensure MST survivors get the care they need.

Military Sexual Trauma (MST)

Sexual assault is a crime of violence and aggression, and encompasses a continuum of sexual activity from sexual coercion to rape. Military sexual trauma (MST) is the experience of sexual harassment or attempted or completed sexual assault during military service. MST is a unique risk of military service, and perpetrators may include military personnel, civilians, commanding officers, subordinates, strangers, friends, or intimate partners. Although perpetrators and survivors can be of either sex, women are more likely than men to be victims of military sexual assault.

Military and Veteran women often have increased rates of lifetime exposure to interpersonal violence, including sexual assault or abuse, and intimate partner violence, when compared to civilian counterparts. , Twenty percent of women Veterans who use VHA facilities report a history of MST. This is a cause for concern because MST can have long-term health implications, including diminished levels of function, alterations in health perceptions, chronic pelvic pain, dysmenorrhea, sexual dysfunction, and post-traumatic stress disorder (PTSD). , , , ,

Military service can increase the risk of mental health problems for all Veterans, including depression, PTSD, and substance use disorder, when compared with civilian counterparts. However, the prevalence of PTSD is increased more than twofold in women Veterans, and is commonly attributed to women Veterans' greater exposure to MST. , , PTSD is linked to diminished physical health and decreased willingness to pursue preventive reproductive health care in women Veterans. ,

The increased likelihood of mental health disorders, including major depression and other mood disorders, has also been associated with increased risk for suicide. According to a recent VA report on Veteran Suicide, the rate of suicide among younger female Veterans (18–29) who used VHA services increased at a faster rate from 2001 to 2014 than that of the civilian population. Notably, the rate of suicide among women Veterans is 2.5 times higher than that of civilian women.

Access to Care

Women veterans have served our country and deserve the best health care available. The VA has taken many steps to increase access to needed care for survivors of MST. Currently, women can receive MST-related care at any VA health system. VA policy requires each Veteran Administration Medical Center (VAMC) to have an MST coordinator and to provide all MST-related care free of charge. VA policy also encourages facilities to give Veterans being treated for MST the option of a same-sex care provider, although this option is not mandatory or always available.

While VA policy requires all facilities to accommodate and support women with safety, privacy, dignity and respect, a 2016 Government Accountability Office (GAO) report found the VHA lacked complete and accurate data on VAMC compliance with sex-specific environment requirements. Among the six VAMCs included in the study, compliance with select VHA environment requirements, including physical and audible privacy, ranged from 65–81 percent. Additionally, the GAO report found that 18 percent of VA facilities providing primary care lacked a women's health primary care provider, and of those who did have a dedicated women's health provider, they were only available on average six hours per week.≥

Women Veterans have unique health care needs, but their minority status within the VHA has led to disparities in health care access when compared to men. While the VHA has made significant progress in reducing gender disparities for many measures, there is still a perception among women Veterans with a history of MST that they do not receive the same quality of care as male Veterans.

A Solution

Unfortunately, some studies suggest Veteran women who use the VHA for their care may experience instances of greater physical and psychiatric morbidity, and insufficient social support when compared with civilian women. , , At this time, Veterans can only seek treatment outside the VA if a VA facility is unable to treat the patient, the patient lives outside a reasonable travel distance, the VA cannot arrange an appointment in a 30-day time frame, or a VA employee issues an official authorization letter.

H.R. 3642, The Military SAVE Act, would establish a pilot program allowing survivors of MST to seek treatment at a provider of their choice, either in the VHA or through the private sector. The legislation would also establish a survey to assess MST treatment for Veterans both inside and outside the VHA. Such research designed to evaluate the association of military service and women's sexual and repro-

ductive health is critical to ensuring the development of best practices for women's care. This pilot program will:

- Ensure MST survivors have increased access to their preferred health care provider;
- Enable VHA to collect and analyze data to identify gaps in the services available between VAMC and private sector providers, and further develop best practices for the treatment of MST; and
- Allow the VA to better serve the unique needs of female Veteran survivors of military sexual trauma.

As the population of women Veterans continues to grow rapidly, it will be increasingly important to ensure high quality, gender sensitive care that meets the unique needs of women Veterans. ACOG supports H.R. 3642, the Military SAVE Act as a positive step to providing women increased access to their preferred care for treatment of the symptoms of MST, while implementing a robust research agenda regarding the health needs of women Veterans.

Thank you for the opportunity to provide written testimony in support of H.R. 3642.

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AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. Chairman and Members of the Subcommittee:

The American Federation of Government Employees (AFGE) appreciates the opportunity to submit a statement for the record on pending legislation under consideration today. AFGE represents nearly 700,000 federal employees across the nation, including 250,000 employees at the Department of Veterans Affairs on the front lines providing health care and other critical services for veterans.

Draft legislation to amend title 38, United States Code, to establish a permanent Veterans Choice Program, and for other purposes

AFGE strongly opposes this draft legislation. It would establish a permanent Choice program that would continue to divert funding away from VA's internal capacity to pay for a costlier non-VA care services even when private sector wait times are higher and quality is lower. The bill is also likely to result in unsustainable costs by elimination of all wait time and distance eligibility restrictions. Increased use of non-VA primary care providers will deprive veterans of critical screenings for wounds of war and essential integrated care.

This bill lacks provisions for strengthening the VA's own capacity or for sending veterans back to the VA even when private sector primary care or specialty care is no longer necessary or adequate. It imposes new case manager duties on VHA staff without additional resources; Choice has already diverted staff away from direct care of veterans to handle overwhelming numbers of consults for non-VA care and to "clean up" after Choice clinical and bureaucratic problems.

Proposed market assessments lack transparency and rely too heavily on a private sector health care model and do not require an adequate focus on staffing and infrastructure needs.

Choice providers would continue to receive less scrutiny than VA's own providers under this bill. It does not require the same transparency about wait times for non-VA care as is required for VA care. It also makes it too easy for non-VA providers to receive certifications that allow them to participate in networks regardless of whether their skills and training are equivalent to those of VA's own providers.

In short, this bill would serve the agenda of privatizers but ignore the needs and preferences of veterans to receive the vast majority of their care from a fully-funded, fully-staffed, world-class integrated VA health care system. Rather than continue to expand a broken non-VA care program, we urge the Committee to provide the mandate and funding needed to fill the nearly 50,000 vacancies reported by Secretary Shulkin and finally address the modernization and infrastructure needs of the VA that have been neglected for too long.

Draft legislation to modify the authority of the Secretary of Veterans Affairs to enter into agreements with state homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of VA graduate medical education residency positions, and other purposes

AFGE has no specific position on this legislation.

H.R. 1133

AFGE has no specific position on this legislation.

H.R. 2123

This bill would extend federal preemption of state licensing requirements to all licensed VHA personnel using telemedicine to provide treatment. Last year, the Department amended its provider regulations to apply federal preemption to certain advanced practice registered nurses (APRN), relying on the federal supremacy clause of the Constitution.

AFGE opposes H.R. 2123. This bill could have unintended consequences, including an adverse impact on recruitment and retention of licensed medical personnel who are already in critical shortage occupations. The licensed health care personnel we represent have expressed serious concerns about the risks to their state licenses (and therefore their entire livelihoods) if management is allowed to mandate the performance of duties outside their scope of practice. These clinicians have received no assurances that the Department will assist them when their licensing boards pursue disciplinary actions against them for violating state licensing requirements.

This proposed change is premature. The new APRN rule has only been in effect for less than a year.

Therefore, AFGE urges the Committee to delay possible changes to current law until completion of a study of the workforce implications of a broader application of federal preemption. Current bill provisions for a telemedicine study fail to address any workforce issues. We recommend a study that focuses on the impact of federal preemption on the state licenses of APRNs and other licensed personnel, and the Department's ability to remain competitive with other health care employers who do not operate under federal preemption.

H.R. 2601

AFGE has no specific position on this legislation.

H.R. 3642

This bill would establish a three-year private sector pilot program for the treatment of military sexual trauma (MST). At the completion of the three-year period, the Secretary would have permanent authority to approve non-VA treatment of MST on a case-by-case basis.

AFGE strongly opposes H.R. 3642. In fact, it is hard to contemplate a more inappropriate combat-related condition to outsource to the private sector than MST. This proposed pilot project is unnecessary and represents another back-door attempt to dismantle the VA's comprehensive, integrated health care system, like almost every other VHA private sector pilot project previously implemented.

VHA is a world leader in the screening and treatment of MST and provider training and research in this area. VHA requires that every veteran receive screening

for MST and screening also plays a critical role in data collection on the treatment of this widespread condition. All VA mental health and primary care providers are required to complete initial and continuing MST training. MST specialists are available at every medical center and many outpatient clinics. The VA's National Center for PTSD plays an integral role in the VA's treatment of MST.

Rather than proceed with another wasteful pilot project that sends MST sufferers out into a broken, fragmented private health care system that does not understand their unique needs, AFGE urges the Committee to review existing direct care resources and telemedicine capacity within the VA to identify ways to increase access for treatment in hard-to-serve areas.

VA Legislative Proposal Veteran Coordinated Access & Rewarding Experiences (CARE) Act

AFGE strongly opposes the non-VA care provisions in Titles I and II and has concerns about some of the personnel provisions in Title III.

Non-VA Care

The VA's proposal to replace the Choice program would greatly accelerate privatization of its health care system through virtually open-ended access to non-VA care and the absence of any mandates to address short staffing and deteriorating infrastructure. It is absurd that non-VA programs would continue to rely on mandatory funds while VA's own funding would remain discretionary and therefore continue to have to close funding gaps on the backs of veterans through such proposals as COLA round-downs.

The bill's non-VA provisions are as problematic for what they say as for what they don't say. The lack of specificity through the bill will allow the VA to continue to engage in stealth privatization as illustrated by recent agency initiatives to convert specific purpose allocations to general purpose allocations and creation of pilot projects that send veterans out to CVS Minute Clinics without Congressional authorization.

AFGE strongly opposes the proposed replacement of the 30-day/40-mile restrictions with a vague patient-provider veteran's "best interest" evaluation process and criteria such as "clinically acceptable" wait times (Section 201).

We also strongly object to the expanded use of non-VA urgent care facilities already undertaken through pilot projects in numerous locations. This seems totally unnecessary considering Secretary Shulkin's recent announcements that the VA is providing same-day service at every medical center and significant increases in access to urgent care provided directly by the VA.

Personnel Practices

Section 301:

AFGE objects to the proposed expansion of "federal supremacy" that would extend federal preemption of state licensing requirements to all licensed VHA personnel. (In contrast to Chairman Roe's proposal, the VA's draft does not limit federal preemption to telemedicine.)

As already noted with regard to Chairman Roe's draft bill, this provision could have unintended consequences, including an adverse impact on recruitment and retention of licensed medical personnel who are already in critical shortage occupations. AFGE believes that this proposed change is premature as the new APRN rule has only been in effect for less than a year.

Therefore, AFGE urges the Committee to delay possible changes to current law until completion of a study of the workforce implications of a broader application of federal preemption.

Section 302:

This section repeals VA's longstanding statutory authority to contract for "scarce medical specialist services".

AFGE opposes this proposed change because it appears to broaden VA's authority to contract out medical services even when VA's own health care system can provide the care (and there is no scarcity). This will further erode VA's critical capacity to provide comprehensive, integrated, specialized care to veterans that has already been weakened by the Choice program.

Section 304

This section repeals the annual caps on VA bonuses across the entire VA workforce that were imposed by the Choice Act in 2014 and later modified downward through subsequent legislation.

AFGE supports elimination of annual dollar caps. AFGE appreciated the Sense of Congress language in the Choice Act that required fair allocation of bonuses to lower wage employees under the caps. AFGE urges Congress to continue to address the issue of lower wage employees' bonuses through a study of how bonus dollars have been allocated over the last five years and whether bonuses are used properly to incentivize high-performing non-management employees.

Section 305:

This section extends the statutory reimbursement right for continuing education from doctors and dentists to Advanced Practice Registered Nurses.

While AFGE supports the expansion of this critical medical professional benefit to other professions, we object to this provision as currently drafted. Reimbursement for continuing medical education is a critical recruitment and retention tool but AFGE opposes setting this benefit (for any professional group) at $1000 per year. This amount has not been updated since the legislation was first enacted almost twenty years ago. With each new year, VA becomes less competitive with private sector employees who adjust their reimbursement rates to match actual costs of attending these courses.

AFGE also objects to limiting this benefit to APRNs. It should also be available to physician assistants as they too are independent providers in the VA. Finally, AFGE urges a study of the reimbursement needs of all other VHA licensed professionals.

Thank you.

AMERICAN HEALTH CARE ASSOCIATION (AHCA)

October 13, 2017

Chairman Phil Roe, M.D.
United States House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Ranking Member Tim Walz
United States House Committee on Veterans' Affairs
333 Cannon House Office Building
Washington, D.C. 20515

Chairman Roe and Ranking Member Walz:

I serve as the Senior Vice President of Government Relations at the American Health Care Association (AHCA), the nation's largest association of long term and post-acute care providers. The association advocates for quality care and services for the frail, elderly, and individuals with disabilities. Our members provide essential care to millions of individuals in more than 13,500 not for profit and for profit member facilities.

AHCA, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies which balance economic and regulatory principles to support quality of care and quality of life. Therefore, I appreciate the opportunity today to submit a statement on behalf of AHCA for the hearing record regarding establishing a permanent Veterans Choice Program.

As you know, skilled nursing care centers were not included in the Veterans Choice Program as one of the eligible health care providers. That being said, AHCA has been advocating for policies which would grant the U.S. Department of Veterans Affairs (VA) the legislative authority to enter into Provider Agreements for extended care services. VA Provider Agreements would ensure that our centers are able to care for veterans in their communities or in close proximity to their families and support system. Our centers already meet very strict compliance guidelines under the Medicare and Medicaid programs. Adding additional regulations on top of this is simply inefficient, redundant, add cost and takes staff time away from these veterans at the bedside.

As you are aware, the VA released a proposed rule, RIN 2900–A015, on Provider Agreements in February of 2013. This important rule, among other things, increases the opportunity for veterans to obtain non-VA extended care services from local pro-

viders that furnish vital and often life-sustaining medical services. This rule is an example of how government and the private sector can effectively work together for the benefit of veterans who depend on long term and post-acute care.

In 2014, close to half of the U.S. Senate chamber and 109 U.S. House members signed onto a letter to the VA encouraging the release of the final VA provider agreement rule. It was ultimately determined that the VA needs the legislative authority to enter into these agreements.

It is long-standing policy that Medicare (Parts A and B) or Medicaid providers are not considered to be federal contractors. However, if a provider currently has VA patients, they are considered to be a federal contractor and under the Service Contract Act. The Office of Federal Contracting Compliance Programs (OFCCP) has administered onerous reporting requirements and regulations even beyond those required by Medicare and Medicaid rules, which have dissuaded nursing care centers from admitting VA patients. This limits the care available to veterans needing long term care in their local communities. Our veterans should not have to choose between obtaining the long term care services they need and remaining near loved ones in their community. Conversely, the same centers contracting with the Centers for Medicare and Medicaid Services (CMS) are not subject to the OFCCP regulations.

AHCA has been advocating for legislation that would make the VA requirements for providers the same as they are for CMS and waives the OFCCP federal contracting requirements. Legislation has been introduced in both chambers in the past to address this issue, including in this Congress. Earlier this year, Senators John Hoeven and Mike Rounds introduced the Veterans Access to Long Term Care and Health Services Act (S. 1611) that would ensure that extended care providers, including nursing center care, could legally enter into VA Provider Agreements, and would be subject to the same rules and regulations as any other Medicare or Medicaid provider. Senator Hoeven secured a commitment from Department of VA Secretary Dr. David Shulkin to work together on this effort. The Senator also secured a provision in the Fiscal Year 2018 VA funding bill expressing congressional support for allowing non-VA long-term care facilities to enter into provider agreements with the VA. The VA is in support of provider agreements for extended care services. There are plans for a House companion bill to S. 1611 to be introduced in the near future by Representative Bruce Poliquin.

The use of Provider Agreements for extended care services would facilitate services from providers who are closer to veterans' homes and community support structures. Once providers can enter into Provider Agreements, the number of providers serving veterans will increase in most markets, expanding the options among veterans for nursing center care and home and community-based services.

AHCA appreciates the fact that your committee and the U.S. Senate Veterans' Affairs Committee has discussed and considered VA provider agreement related legislation. AHCA will continue to advocate for a VA provider agreement legislative proposal that will ensure that those veterans who have served our nation so bravely have appropriate access to quality health care. Thank you again for the opportunity to comment on this important matter. If you have any questions, please do not hesitate to contact me at cporter@ahca.org or AHCA's Senior Director of Not for Profit & Constituent Services, Dana Halvorson, at dhalvorson@ahca.org.

Sincerely,

Clifton J. Porter II
Senior Vice President of Government Relations

AMERICAN MEDICAL ASSOCIATION (AMA)

October 20, 2017

The Honorable Glenn Thompson
United States House of Representatives
124 Cannon House Office Building
Washington, DC 20515

Dear Representative Thompson:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our support for H.R. 2123, the "Veterans E–Health and Telemedicine Support (VETS) Act of 2017," as introduced. The AMA supports expanding veterans' access to clinically validated telehealth services within the VA.

This legislation would authorize physicians and other health care professionals who are employed directly by the Department of Veterans Affairs (VA) and have at least one valid state license to provide telehealth services to VA beneficiaries without regard to the location of the patient or the health professional. This bill would address the significant and unique need to expand access to health care services for Veterans being treated within the VA system while also ensuring that important patient protections remain in place, including the direct oversight, accountability, training, and quality control specific to VA-employed physicians and other health care professionals. Also, under such a system, VA-employed physicians and other VA-employed health care professionals are able to rely on the VA's telehealth infrastructure (including hardware and software) pioneered by the VA to ensure that access to telemedicine services meet and exceed the standard of care.

Importantly, the bill does not authorize a contracted physician or other health care professional who is not directly employed by the VA to provide health care services via telemedicine to a VA patient located in a state in which the contracted physician or other health care professional is not licensed. This is consistent with the VA's recently proposed rule expanding telehealth services within the VA which explicitly provides that multi-state licensure expansion for providing telehealth services applies only to VA employed providers and will not be expanded to contracted physicians or providers. A contracted physician providing health care services via telemedicine would still be required to be licensed in the state where the VA patient is being treated. This structure of accountability provides protections for VA patients receiving health care services outside a VA facility, whether in person or via telemedicine, by ensuring that the appropriate licensing boards have authority over the contracted physician or other health care professional in the state where the patient is located. Without such protections, should VA patients be subject to services that fall short of the standard of care, they would have limited recourse under their own state's medical practice and patient safety laws and regulations.

The AMA is committed to advancing patient access to care through new innovations, including telemedicine, and commends you for your leadership in expanding access to VA patients.

Sincerely,

James L. Madara, MD

AMVETS

on

"Pending Legislation"

H.R. 1133 Veteran Transplant Coverage Act of 2017
Support
H.R. 2123 Veterans E–Health & Telemedicine Support Act of 2017
Support
H.R. 2601 Veterans Increased Choice for Transplanted Organs & Recovery (VICTOR) Act of 2017
Support
H.R. 3642 Military Sexual Assault Victims Empowerment (SAVE) Act
Oppose
Draft to establish a permanent Veterans Choice Program
Support Discussion Draft
No Position on Amended Draft
Draft to direct the VA Secretary to conduct a study on the Veterans Crisis Line.Support
VA's legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act
No Position

Chairman Roe, Ranking Member Walz, and members of the committee; thank you for the opportunity to provide a statement for the record on behalf of AMVETS and our 250,000 members. We appreciate your efforts to address and correct some of the most challenging and longstanding veteran health care issues that our country has faced. The dedication of you and your staff members who work diligently to formulate policies that ensure we are taking care of our Nation's veterans is something that affects the lives of our members, and we are grateful for the ideas being put forth.

H.R. 1133 Veteran Transplant Coverage Act of 2017

AMVETS SUPPORTS H.R. 1133

H.R. 1133 authorizes the Secretary of Veterans Affairs to provide for an operation on a live donor for purposes of conducting a transplant procedure for a veteran, even if the live donor may not be eligible for health care from the VA.

AMVETS supports this legislation which will help ensure that the veteran is getting the lifesaving health care they have earned and deserve.

H.R. 2123 Veterans E–Health and Telemedicine Support (VETS) Act of 2017

AMVETS SUPPORTS H.R. 2123

The VETS Act allows a licensed VA health care professional to practice their health care profession at any location in any state, regardless of where the professional or patient is located, if the covered health care professional is using telemedicine to provide treatment. There is a reporting requirement due within the first year of enactment which will provide a variety of information including patient and health care professional satisfaction, access to telemedicine and potential budget savings due to reduction of travel reimbursements as a result of accessing care through telemedicine.

AMVETS applauds the introduction of this bill, and believes that in conjunction with VA's Proposed Rule posted on the Federal Register on October 2, 2017, Authority of Health Care Providers to Practice Telehealth, that veterans will soon benefit from greater access to a variety of health care, including mental health. Removing the arbitrary state barriers that have no relevance to telemedicine is long overdue. It is worth pointing out that while AMVETS is fully supportive of the use of telehealth, that the situation of each veteran needs to carefully be considered. For instance, some veterans clearly need to be seen in-person, but for interim checkups or counseling in between face-to-face appointments this is quite a valuable tool. For those that use telehealth for monitoring a long-term or chronic health condition, this is not only a time saver, but a cost saver as well. AMVETS looks forward to passage of this measure.

H.R. 2601 Veterans Increased Choice for Transplanted Organs and Recovery (VICTOR) Act of 2017

AMVETS SUPPORTS H.R. 2601

This bill amends the Veterans Access, Choice, and Accountability Act of 2014 to enhance access to organ transplants for veterans who live more than 100 miles from a VA operated transplant center by allowing them to get the medical care needed for the required organ transplant at a transplant center, operated by an approved entity under Choice, within 100 miles of their home.

AMVETS supports this legislation which will help ensure that the veteran is getting the lifesaving health care they have earned and deserve without the undue burden of having to travel over 100 miles for an organ transplant in addition to the myriad of preand post-transplant medical appointments required for a successful transplant and follow up.

H.R. 3642 Military Sexual Assault Victims Empowerment (SAVE) Act

AMVETS OPPOSES H.R. 3642

The SAVE Act establishes a three-year pilot program for veterans who are survivors of military sexual trauma (MST) so they may access private, non-Department of Veterans Affairs, medical and hospital treatment for physical and psychological injuries resulting from the assault. At the end of the pilot, participating veterans may request to continue receiving private sector care related to MST.

Five locations will be chosen in areas where sexual assault has been determined to be a substantial problem, and veterans participating may still receive VA health care for medical issues other than MST. A veteran is deemed eligible for the pilot if they qualify under section 1720D of title 38, United States Code Counseling and treatment for sexual trauma.

Every VA health care facility has an MST Coordinator and medical professionals who are knowledgeable about treating MST, in fact, all VA mental health and primary care providers must complete a mandatory training on MST. There are a variety of existing treatments available to the veteran including specialized outpatient

mental health services focusing on sexual trauma. Vet Centers also have specially trained sexual trauma counselors. Nationwide, VA has over twenty residential or inpatient programs that offer specialized MST treatment. The services can include cutting-edge treatment methodologies for a range of mental health problems associated with being an MST survivor. In addition, VA will often treat veterans for MST-related services even if the veteran is not eligible for VA health care

AMVETS is concerned with the open-ended access to private sector MST care in the five pilot areas and believes that veterans can be best served by receiving the renowned care that VA has long-worked to fine tune and provide to both genders who have experienced MST. AMVETS has a National Resolution on MST which states, in part, that AMVETS calls upon Congress to continue its oversight and hearings related to military sexual trauma care and benefits with the goal of improving VA and DoD collaboration and improving policies and practices for military sexual trauma care and disability compensation. We feel that the strengthening needs to occur within DoD and VA, and that having groups of veterans being treated in the private sector will lead to fragmented care for the veteran at a higher cost.

Draft to establish a permanent Veterans Choice Program, and for other purposes

AMVETS supports the discussion draft, and the consolidation of existing community programs into an established network of community VA providers.

Our concern with the draft is based on the premise of sending veterans into the community for care because of a shortage of health care providers, while not fixing long-term recruitment, hiring, and retainment for necessary staff, which would in essence solve many access to care issues.

AMVETS does not support using the Choice Program as a practicable option to address the capacity and patient care issues. Diverting funds into the community, instead of investing them within the VA system of care will quickly erode and eventually dismantle the VA health care system.

Currently over thirty percent of veterans receive community care. There is nothing that we have seen that shows that veterans who receive their care outside of VA have better health outcomes, or that it is a cost saving measure.

As of the due date for this statement for the record, AMVETS has not seen the amended draft bill, and therefore cannot provide a statement on the actual bill. We look forward to receiving the amended version in the near future.

Draft to direct the Secretary of Veterans Affairs to conduct a study on the

VETERANS CRISIS LINE

This draft initiates a study on VA's Veterans Crisis Line (VCL) to examine its effectiveness during the five-year period that began January 1, 2014. The study will analyze information on the number of veterans who began or did not begin VA mental health treatment after contacting the VCL, and of those who started treatment how many continued it. In addition to other analyzation, it will also determine whether receiving sustained mental health care affects suicidality, and whether veterans who were receiving VA mental health care utilized the VCL in a time of crisis. It will also study how many non-veterans call the VCL in the hopes of finding care for a veteran, and how many of those individuals received support in having the veteran initiate VA mental health care. Additionally, it will track how many veterans who contact the VCL tragically attempt or die by suicide.

AMVETS is pleased to support this draft measure, and we believe that five years of data, to include the times where the VCL was not operating optimally but where we hope they were still tracking data, can hold vital pieces of information in the visibility or knowledge of the Crisis Line, how veterans or those who care about them are triaged and end up in care (or not), and how many lives have potentially been saved based on facts. If we knew how to prevent a person's suicide, then we would not need to look into such data; but perhaps learning more can save more lives or offer a redirect into a new way of reaching those in their darkest days.

VA's legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act

At this time AMVETS offers no position on this proposal. There are number of Sections that we support, coupled with a number of Sections that cause us concern.

AMVETS supports the consolidation of existing community programs into one hopefully more manageable and streamlined program. We also wholeheartedly sup-

port the measures addressing improving personnel practices, and the fact that this reinvests into VA's system of care.

AMVETS does not support having service-connected disabled veterans who are currently qualified to receive medical care with no copay, to pay a copay for access to walk-in care. We also do not support the round down of certain cost of living adjustments. We cannot fund VA health care by instituting copays from veterans who by nature of their wounds do not pay for VA health care; or by rounding down their benefits. It is not their job to fund VA, and veterans should not have to sacrifice further.

In general, we are not comfortable with some language in the proposal that can be open to interpretation such as "not feasibly available," "impracticable or inadvisable," or a medical facility "not providing care that meets such quality and access standards as the Secretary shall develop." The latter is particularly distressing since a particular medical facility may be experiencing access issues due to not being properly staffed. Not fixing that inherent issue and sending a veteran out for community care creates a vicious circle, and in the end sets up that particular facility to fail.

We are concerned with not only the vagueness of some language, but that the discretion in implementing major portions are left up to the Secretary. In the end, massive changes to allowing more veterans to seek care in the private sector require specific language and concrete boundaries for many reasons. The primary reason would be budget allocations, the secondary yet equally important reason would be that loosely allowing veterans access into the private sector without clear delineations would systematically, over time, dismantle the VA health care system.

We hear that no one wants to privatize the VA health care system yet we are left wondering if we are looking at two different definitions. If you want to look at the definition literally, it explains that privatizing means to transfer from public or government control or ownership to private enterprise.

What we are concerned with is "the death by a thousand cuts" whereby it can easily be stated that allowing large numbers of veterans into the private sector while not fixing long-term recruitment, hiring, and retainment for necessary staff, which would in essence solve many access to care issues, is a very slow and painful way to bleed the VA health care system dry of funds, while lining the pockets of the private sector. Who benefits here? Not the veteran patient.

ASSOCIATION OF VA PSYCHOLOGIST LEADERS*

Association of VA Social Workers*

Nurses Organization of Veterans Affairs*

American Psychological Association

Veterans Healthcare Action Campaign

(*An independent organization, not representing the Department of Veterans Affairs)

Furnishing Mental Health Care to Veterans by Choice Program Providers

WASHINGTON, D.C. October 26, 2017

Chairman Roe, Ranking Member Walz, and Members of the Committee:

On behalf of our organizations, we thank you for the opportunity to submit this statement for the record on draft legislation to direct VA to furnish mental health care to Veterans by community providers participating in the Veterans Choice Program (VCP). This statement is in addition to our previous submittal that addressed different draft legislation on a Permanent VCP. We greatly appreciate your unwavering commitment to ensuring that Veterans receive the highest quality care.

The Veterans Health Administration (VHA), as many recent evaluations have documented, provides unrivaled mental health care. That care would be gravely undermined by this draft bill which allows Veterans to obtain mental health treatment with a VCP provider of up to eight visits per episode without any referral from the VHA. Funding for this care will be siphoned straight from VHA facility budgets, leading to incrementally fewer VHA mental health providers, and a consequent erosion and disappearance of the high quality VHA mental health services that Vet-

erans now receive. That alone would be calamitous. But it is the also the first step on a slippery slope to an unfeterred voucher system. As Secretary Shulkin testified in June 2017, "Just giving Veterans a card, a voucher, and let them go wherever they want to go. is appealing to some but it would lead to essentially the elimination of the VA system altogether."

Below we elaborate on the documented superiority and innovations of the kind of VHA mental health care that is not readily available in the community, including: (1) adherence and training procedures that ensure state-of-the art, evidence-based treatment, and (2) unique expertise in treating Veterans. All of this would be at risk—as would the benefits of VHA's integration of medical and mental health care—if funding is diverted from VHA to community care without VHA's referral and oversight.

VHA care is superior because it is integrated, monitored and delivered in one location.

The proposed legislation segregates and reduces coordination of Veterans' care, counter to VHA's best practice integrated model. It has no requirements for tracking whether non-VA providers are trained in or use evidence-based treatments, or how successful are the outcomes. The VHA is able to achieve better quality because, as a unified system, it has superior ability to implement and monitor adherence to assessment and treatment standards. As the Commission on Care Final Report recognized: "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"(page 28).

VHA expertise in treating Veterans with Post Traumatic Stress Disorder (PTSD) and depression is missing in the community.

More than 6,300 VHA mental health providers have received extensive training and supervision in the most effective evidence-based therapies (EBP) for PTSD—Prolonged Exposure and/or Cognitive Processing Therapy. More than 1,800 VA providers have received extensive training and supervision in one of three EBPs for depression. Veterans who received these EBPs in the VA have experienced clinically meaningful and robust improvement in their PTSD and depressive symptoms.

By contrast, RAND's Ready to Serve national study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or DoD, "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions" (page 21). Only 18% of Tricare and 6% of non-Tricare community therapists were trained in and used an EBP.

VHA MH patients are more likely to receive recommended psychiatric medication than are patients in the community.

Recent publications comparing the VHA to private sector care's medication treatment for mental disorders found that for all seven indicators, VHA performance was superior to that of the private sector by more than 30%. Another study found that only 1–12% of private sector patients treated with antidepressants are treated in a manner that is consistent with American Psychiatric Association guidelines (with care of ethnic minorities tending to be on the lower side of this range).

The VHA's approach to preventing suicides is more comprehensive than is commonly found in the community.

Each of the 150 VHA medical centers has one or more Suicide Prevention Coordinator (SPC) as dedicated positions. SPCs provide enhanced care coordination for Veterans identified at high risk for suicide and collaborate with VHA's integrated network of care providers and community partners to reduce suicide risk among vulnerable Veterans. VHA Suicide Prevention policies also include follow ups to missed appointments, safety planning, and wraparound services, and for high risk Veterans a medical record flagging and monitoring system that includes mandatory mental health appointments. VHA also uses predictive analytics to identify Veterans at risk for suicide and other adverse outcomes and offers enhanced care to these Veterans according to their needs. Some of these Veterans may not have been identified as at risk based on clinical signs. This novel big data approach which does not occur with Veterans seen in the community allows VHA to identify and help vulnerable Veterans before a crisis occurs.

Veterans with Serious Mental Illness (SMI) who use the VHA have greater life expectancy and reduced inpatient bed days of care.

Veterans with SMI conditions who receive VHA care live much longer on average than their counterparts in the U.S. population. Veterans with SMI who drop out of VHA health care but then resume have significantly lower rates of mortality than Veterans who do not return. Building on this success, VHA implemented the SMI Re-Engage Program, an outreach to Veterans with SMI who have a 12-month gap in VHA service utilization. For Veterans contacted between March 2012 and March 2016, 24% returned to VHA care within 4 months.

In the VHA's Intensive Community Mental Health Recovery (ICMHR) program, MH staff visit Veterans with SMI multiple times weekly to provide recovery oriented interventions, typically in the Veteran's place of residence, which ensures more routine follow up and alleviates the burden to present to a medical facility. Veterans enrolled in ICMHR services had 27 fewer bed days of care and 1.4 fewer admissions on average as compared to the year prior to admission to the program.

VHA's comprehensive and integrated health care response to military sexual trauma (MST) has no comparable program in the community.

When screened by a VHA healthcare provider, 1 in 4 women Veterans and 1 in 100 men report that they experienced MST. Because most servicemembers are men, they constitute 40% of all MST survivors seen in VHA. MST is associated with a wide range of mental and physical health conditions, as well as lasting impairment in occupational and life functioning.

Given that many survivors never talk about their MST experience unless asked directly, VHA's screening, sensitivity and attentive efforts are crucial ways to proactively reach survivors who might not otherwise seek out care. Each VHA facility has a dedicated MST coordinator position, mandatory MST training for primary and mental health care providers, free MST-related treatment and outreach efforts. All Veterans enrolled in the VHA are screened for experiences of MST, and tailored treatment plans are created for survivors in need of mental health care. Over 938,000 outpatient MST-related mental health visits were provided to Veterans with a positive MST screen in FY14. Comparable screening and treatment programs do not widely exist in the community, where providers are less likely to have experience or recognize that it is important to even ask Veterans about MST.

The VHA's evidence-based interdisciplinary approach to pain management, which is part of the VHA's care of patients with mental health and substance abuse problems, hardly exists outside of the VHA.

Approximately 50% of Veterans treated in Primary Care report one or more chronic pain complaints, disproportionately higher than American non-Veterans. CDC Guidelines specifically recommend avoiding the use of opioids in favor of cognitive behavioral psychotherapy, exercise therapy and non-opioid medications as first-line treatments for chronic pain. Instead of routinely triaging Veterans with chronic pain to specialists, the VHA introduced in 2009 a Stepped Care Model in which patients receive biopsychosocial chronic pain care first within VHA primary care. These interdisciplinary clinics collocate and integrate PCPs, psychologists, pharmacists and/or physical therapists to provide multi-modal pain care. Preliminary results show decreased self-reported pain, opioid risk and daily opioid use.

Interdisciplinary pain management continues to grow in the VHA but is very rare in the U.S. private sector where healthcare tends to be fragmented and truncated. VHA accounts for 40% of the U.S. interdisciplinary pain programs even though it serves 8% of the adult population. The importance of effective pain management, including behavioral interventions, is further underscored by the fact that pain is the most commonly identified risk factor when analyses are conducted after a Veteran has died from suicide.

No other healthcare system is as Veteran-centric and Veteran-sensitive as the VHA.

VHA care is Veteran-centric in many ways not found in general community settings. The VHA has hired 1100 Peer Specialists who are Veterans in successful recovery from mental health challenges and are integrated in programs as staff members providing mental health care. Peer specialists are uniquely suited to engage Veterans in ongoing care and to instill hope. Across the system, 31% of VHA employees are Veterans themselves. RAND's Ready to Serve report found that the Veteran and military cultural competency of VHA/DoD providers far outstripped that of community providers. VHA providers' cultural expertise comes not just from required trainings but also from a commitment to the mission of serving those who

served and from careers in a system that is by, for and about Veterans. Finally, the VHA has created a community of healing in which Veterans in therapy groups share experiences they have not revealed to anyone else in their lives.

The VHA is the main system of preparing our national healthcare workforce.

The VHA is involved in training 50% of all U.S. psychologists, 70% of all U.S. physicians, and 40 other healthcare professions. Significant reductions in the number of VHA attending supervisors would disrupt healthcare education nationally. Given the costs of establishing and maintaining training programs and residencies, the private sector will not be able to compensate for the loss of VHA training opportunities for the next generation of providers.

We recognize that when timely access to VHA services isn't feasible, the VHA should continue to purchase services from outside partners. Future efforts to reform the care of veterans must ensure that funding for high quality VHA mental health services be sustained and strengthened. We thank you again for this opportunity to provide input that describes the impact of allowing veterans to obtain mental health treatment with a VCP provider without any referral from the VHA.

Contacts:

Association of VA Psychologist Leaders president1@avapl.org
Association of VA Social Workers president@vasocialworkers.org
Nurses Organization of Veterans Affairs tmorris@vanurse.org
American Psychological Association hkelly@apa.org
Veterans Healthcare Action Campaign info@vhcac.org

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AMERICAN SOCIETY OF TRANSPLANT SURGEONS (ASTS), AMERICAN SOCIETY OF TRANSPLANTATION (AST), NATIONAL KIDNEY FOUNDATION, AAKP

October 20 2017

Representative John R. Carter
U.S. House of Representatives
2110 Rayburn House Office Building
Washington D.C. 20015

Re: Letter in Support of the Veterans Transplant Coverage Act of 2017

Dear Representative Carter,

The undersigned transplant patient, physician, and other provider organizations write in strong support of H.R. 1133, "The Veterans Transplant Coverage Act of 2017."

At this time, Department of Veterans Affairs (VA) policy limits veterans' access to life-saving transplants as it does not cover the medical expenses of non-veteran living donors. This policy means that if a veteran in need of a transplant has a living donor match, a lifesaving transplant may remain out of reach simply because of the non-veteran status of the donor.

The Veterans Transplant Coverage Act expands access to lifesaving transplant procedures for veterans by authorizing the VA to cover the costs of an operation on a living donor to carry out a transplant for an eligible veteran even if the living donor is not otherwise eligible for VA health care. Currently, other federal government health care programs cover live donors' health care needs. The Centers for Medicare and Medicaid Services (CMS) provides coverage of living donors for kidney transplants. We believe, at a minimum, that our nation's Veterans deserve the same access to care that Medicare beneficiaries receive.

The Veterans Transplant Coverage Act would help ensure that the men and women who have served our nation are given the same access to life-saving treatments that other American citizens have. Finally, we note that H.R. 1133 also authorizes the VA to cover live donor transplant operations at a VA or non-VA facility, increasing access to high quality medical care and transplantation.

We are pleased to support the Veterans Transplant Coverage Act of 2017 for our nation's veterans and those who give the gift of life to sustain their lives. Thank you for your leadership in advancing bipartisan legislation to improve transplantation care for veterans. If you have any questions, or if we can be of any assistance, please do not hesitate to contact any of our legislative representatives listed below.

AAKP Richard Knight rk.reslend@gmail.com

Paul T. Conway paulconway@cox.net
ASTS Peggy Tighe peggy.tighe@PowersLaw.com
AST Bill Applegate Bill.Applegate@bryancave.com
NKF Troy Zimmerman troyz@kidney.org

CONCERNED VETERANS OF AMERICA (CVA)

Draft Legislation House Veterans Affairs Community Care and Choice Reform Bill

A bill to reform the Department of Veterans Affairs (VA) community care programs and the Veteran Choice Program.

In 2014, in response to the VA wait list scandal, Congress created the Veterans Choice Program (VCP) as a temporary program to offer veterans the option to access private sector health care with their VA benefits if they live long distances from VA facilities or face long waits for care. The creation of the VCP was an important first step towards giving veterans who use the Veterans Health Administration (VHA) the ability to choose to access private sector providers through the VA if they felt that the VHA wasn't the best option for them at that time.

Unfortunately, the VCP was poorly implemented and, as currently structured, offers veterans at the VA limited health care choice. Additionally, the program recently faced a budget shortfall that had to be backfilled by Congress and is likely facing another budget shortfall before the end of the year. Accordingly, Congress needs to act to ensure that veterans who use the VCP do not experience a lapse in their care.

Concerned Veterans for America (CVA) has consistently advocated for increasing health care choice for veterans in the VA health care system and for better integrating the VHA with the private health care system. While the draft House Veterans Affairs Committee legislation contains positive reforms, Concerned Veterans for America encourages the committee to make the following modifications to improve the draft legislation:

1. Modify Section 101 to allow an eligible veteran to choose any primary care physician within their VA integrated care network regardless of whether they are at the VHA or a contracted community provider. Currently as written, under the proposed legislation a veteran can only choose a primary care provider (PCP) outside of the VHA if there is not one currently available at the VHA's facilities within their respective integrated care network. In CVA's opinion, this model does not properly empower veterans with more control over their health care and could potentially lead to some of the same problems we currently see with the VCP mainly that the VA would still have too much control as a gatekeeper to care outside of the VA. CVA strongly recommends modifying this section to conform with recommendation one from the 2016 Commission on Care that would allow eligible veterans to choose any PCP within the integrated network with available capacity. This would give veterans more health care options and flexibility. Coordination of care would also not be an issue since a PCP outside of the VHA would already be part of the integrated care network. In order to control costs and provide some incentive to stay within the VHA, CVA also supports implementing higher co-pays for non-service connected care for PCPs outside of the VHA if a veteran elects to go a community provider. This is similar to how TRICARE Prime operates in the Department of Defense.

2.Create an appeals process for veterans who feel they were wrongly denied referrals to specialty care outside of the VHA. This was proposed as part of Secretary Shulkin's initial Coordinated Access and Rewarding Experiences (CARE) plan. CVA believes this is essential to ensuring that veterans have the ability to have a third party settle a disagreement regarding referrals with their PCP.

3.Return the VA to a secondary payor status for veterans with other health insurance for non-service connected care in the community. Changing the VA permanently to a primary payor for non-service connected care will potentially increase up-front costs by billions of dollars and likely lead to future budgetary problems which will limit veterans use of choice. There are legitimate reimbursement issues that are causing veterans to receive unnecessary bills from community providers, but switching to primary payor is not the way to solve this problem. Other programs like TRICARE have demonstrated that there are better ways of reimbursing providers without switching to primary payor.

4.Authorize the pilot programs that were originally proposed as part of Secretary Shulkin's CARE plan to be implemented. The veteran population will be rapidly changing over the next decade. By 2030, there will be between 4 to 5 million fewer veterans and the VA's patient population will be more dispersed and have much different health care needs. With that considered, the VA should be continually testing new ways of delivering health care to our veterans and should also be testing new governance and reimbursement structures for the VHA that would better enable the VA to respond to changes in the veteran population.

Finally, CVA would encourage the House committee to consider and mark up this legislation in conjunction with the draft Asset and Infrastructure Review Act. The VA's infrastructure needs and its use of community care are inextricably linked and should be address concurrently with each other.

CVA applauds the House Veterans Affairs Committee for prioritizing this important piece of legislation and looks forward to continuing to work with the committee

to ensure that our veterans are empowered with more control over their health care at the VA.

Department of Veterans Affairs Coordinated Access and Rewarding Experiences (CARE) Plan

A proposal from the VA to consolidate and streamline the VA's community care and choice programs.

CVA believes that the CARE plan contains positive reforms that should be implemented. CVA supports establishing contracted urgent care clinics for veterans and believes that will increase access to certain types of medical care for veterans while also reducing demand at many VA medical centers. Additionally, CVA supports the proposal to improve the reimbursement process and the appeals process for veterans who feel that they were wrongly denied access to community care. However, as with the draft House Veterans Affairs Committee legislation, CVA supports adding to the CARE plan the ability for a veteran to choose a primary care physician outside of the VHA in the proposed integrated care networks. This is a commonsense measure that was proposed by the Commission on Care in 2016 and has been supported by members of the House committee in the past.

Draft Legislation Conducting a Study of the Veterans Crisis Line

A bill to direct the Secretary of Veterans Affairs to conduct a study of the effectiveness of the Veteran Crisis Line.

CVA supports efforts to ensure that the Veteran Crisis Line is operating as effectively as possible and is maximizing its ability to best serve veterans in crisis. Accordingly, CVA believes that it is appropriate to undertake this study and we applaud Rep. Banks for proposing this bill.

Concerned Veterans for America has no position on HR 1133, HR 2123, HR 2601, and HR 3642 at this time.

FLEET RESERVE ASSOCIATION (FRA)

The FRA

The Fleet Reserve Association (FRA) is the oldest and largest organization serving enlisted men and women in the active, reserve, and retired communities plus veterans of the Navy, Marine Corps, and Coast Guard. The Association is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) and entrusted to serve all veterans who seek its help.

FRA was started in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

The Association testifies regularly before the House and Senate Veterans' Affairs Committees, and the Association is actively involved in the Veterans Affairs Voluntary Services (VAVS) program. A member of the National Headquarters' staff serves as FRA's National Veterans Service Officer (NVSO) and as a representative on the VAVS National Advisory Committee (NAC). FRA's NVSO also oversees the Association's Veterans Service Officer Program and represents veterans throughout the claims process and before the Board of Veteran's Appeals.

FRA became a member of the Veterans Day National Committee in August 2007, joining 24 other nationally recognized Veterans Service Organizations (VSO) on this important committee that coordinates National Veterans' Day ceremonies at Arlington National Cemetery. The Association is a leading organization in The Military Coalition (TMC), a group of 33 nationally recognized military and veteran's organizations collectively representing the concerns of over five million members. FRA senior staff members also serve in a number of TMC leadership positions.

The Association's motto is "Loyalty, Protection, and Service."

Certification of Non-Receipt of Federal Funds

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

Introduction

Distinguished Chairman Phil Roe, Ranking Member Tim Walz and other members of the Committee, thank you for the opportunity to provide a statement regarding draft legislation to be discussed and reviewed at your October 24, 2017 hearing. At the FRA National Convention in Hunt Valley, Maryland, (September 19–24, 2017) the delegates unanimously approved FRA's 2018 Legislative Agenda. It calls for the FRA Legislative Team to "Monitor implementation of the Veterans Access, Choice and Accountability Act (VACAA) that provides a $10 billion fund to pay for non-VA care for veterans who live 40 or more miles from a VA facility or have been experiencing wait times for care of more than 30 days. VA has provided 'Choice Cards' to veterans who were enrolled in VA health care as of August 1, 2014, and to recently discharged combat veterans who enroll within the five-year window of eligibility."

The Association does not have any provisions in its Legislative Agenda pertaining to operations on live donors for purposes conducting transplant procedures for veterans or the VA regulation of state veteran's homes. Therefore: the FRA statement focuses on the VA Choice program and VA Telemedicine reform.

VA Choice Program

In FRA's recent survey (January/February 2017) nearly 81 percent of veterans see quality of VA health care benefits as "Very Important" (the highest rating). The past three years VA and specifically the Veterans Health Administration (VHA) have been embroiled in controversy and scandal. Since the Phoenix waiting list scandal was uncovered by Congress a robust debate has ensued on how to reform VHA to ensure it can provide timely, comprehensive and veteran-centric health care to veterans in need. In response to the scandal Congress passed the "Veterans Access, Choice and Accountability Act" (VACAA) that became law in 2014. FRA supported this legislation because the VA's first priority must be to ensure that all veterans currently waiting for treatment are provided timely access.

FRA supports the Independent Budget (IB) Framework for veteran's healthcare reform, and wanted the Choice program at the very least to be extended. The Association believes that the "Choice" program has merit, but will require significant oversight by this Committee to ensure it is an effective program that will benefit our disabled veterans. VA must ensure that Non-VA Care Coordination teams are adequately staffed and funded to be capable of handling the workload. Outsourced care has been available for many years but has not been well-planned or coordinated with VA care.

This law gives veterans who have waited more than 30 days for an appointment-or who live more than 40 miles from a VA medical facility-the choice to seek VA-funded care outside of the VA system. About 58 million medical appointments were scheduled by VA in fiscal 2016, an increase of almost six percent in less than two years. Almost a third of those appointments were scheduled with doctors working outside the VA system, in private clinics. 8,481 patients on VA lists have been waiting more than four months for appointment requests, a number that swelled to more than 10,000 in early 2016.

At a recent House Veterans Affairs Committee (HVAC) hearing VA Secretary Dr. Shulken claimed that VA community care appointments have increased by 61percent overall since Choice was created and, last year, 30 percent of all VA appointments were held in the community rather than in VA medical facilities.

On August 12, 2017, President Trump signed into law (Public Law 115–46) the FRA-supported "VA Choice and Quality Employment Act," (S.114) sponsored by Senator Dean Heller (NV). This legislation provides $2.1 billion to continue the Choice Program for six months while Congress works on other reforms to the Choice Program. It also authorized 28 major medical facility leases and enhances the recruitment, retention and training of the VA workforce.

Now that the funding short fall has been fixed, FRA is delighted to see this Committee's efforts to try to provide a transformational change of VA health care by creating an integrated network of VA and community health care providers, with the VA serving as the coordinator and primary care provider. The networks could make decisions about access to community care based on clinical determinations and veterans preferences, rather than subjective time and distance as is the current practice in the choice program.

FRA wants to note that the VA decision to use the Department of Defense (DoD) Electronic Health Record (EHR) Secretary of Veterans Affairs Dr. David J. Shulkin recently announced that the VA will dramatically reform this agency's Electronic Health Record (EHR) system by replacing the old antiquated system with same system used by the Department of Defense. This change is a shift from the VA's pre-

vious plan to develop its own system to digitize records. It will bring the agencies closer to sharing veterans' health information in an effort to solve a problem that has plagued the two departments for decades. "The health and safety of our Veterans is one of our highest national priorities." Shulkin said "Having a veteran's complete and accurate health record in a single common EHR system is critical to that care, and to improving patient safety." Secretary Shulkin claims that the software has a high level of cyber-security.

FRA has long sought to ensure adequate funding for DoD and VA health care resource sharing in delivering seamless, cost effective, quality services to personnel wounded in combat and other veterans and their families. The Association has repeatedly called for increased oversight in its Capitol Hill testimony to keep pushing both agencies to make progress on this issue.

Draft VA Choice Legislation

FRA appreciates the provision in the draft legislation that co-payments for an eligible veteran shall not exceed the co-payments required to be paid if services were provided at a VA facility. FRA also believes it is important that the ensures that providers within any contracted network are appropriately compensated in a timely basis, and that Congress will ensure appropriate funding accounts for community based care for veterans. Therefore, FRA supports the prompt pay provisions in the draft bill that provides payment within 45 days for paper clean claims and 30 days for an electronic clean claim. The Association also notes the provision in the draft legislation for in certain cases the VA to use a "value-based reimbursement model" to promote high-quality care. The switch to value-based reimbursement causes providers to change the way they bill for care. Instead of being paid by the number of visits and tests they order (fee-for-service), providers' payments will be based on the value of care they deliver (value-based care). The transition from a fee-for-service reimbursement system to one based on value is a significant oversight challenge.

FRA wants a VA health care program that is streamline and will integrate non-VA care into the broader VA health system, enhancing timely access to quality care, and focusing on a system that is easy to understand, simple to administer and meets the needs of veterans, community providers and VA staff. This program should improve collaboration and integration of Department of Defense (DoD)-VA–Community health care systems as part of a comprehensive, high-performing network of care. Our veterans deserve nothing less.

Veterans E–Health and Telemedicine Support

FRA supports the "Veterans E–Health and Telemedicine Support Act" (H.R. 2123), sponsored by Rep. Glenn Thompson (PA), that expands the current Department of Veteran Affairs (VA) state licensure exemption to allow credentialed health care professionals to work across state borders performing telemedicine without having to obtain a new state license.

This bill will help veterans struggling with mental health conditions, especially those in geographically remote areas. The bill will enable the VA to expand key treatment services, including behavioral health, which is critical considering the VA is facing increasing care demand and mounting provider shortages.

Under current law, VA health care professionals must be licensed in the state where the patient is treated in order to offer services. The state licensure requirement has limited the VA's ability to utilize telemedicine capabilities, which have been known as an effective mechanism for delivering a wide range of care services. The bill removes these barriers and allows the VA to provide treatment free of this restriction.

In 2011, Congress passed the Servicemembers Telemedicine & E–Health Portability Act, through which the Department of Defense (DoD) is now working to expand access to active duty service members through various existing programs. This current bill will enable the VA to implement the same reforms and provide greater access to care for our veterans.

Again we wish to thank the Committee for this opportunity to express the concerns and opinions of FRA members on these vital issues. Our leadership and Legislative Team stand ready to work with this Committee to improve benefits for all veterans who have served this great Nation.

GOT YOUR SIX

Statement for the Record

Prepared By
Lauren Augustine
Director of Government Relations

Bill Num.	Bill Name or Subject	Position
Draft	Draft legislation to establish permanent Veterans Choice Program	Support with recommendations.
Draft	Draft legislation to modify VA's authority to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions, and for other purposes	No position.
Draft	Draft proposal to establish the Veteran Coordinated Access and Rewarding Experiences (CARE) Act	Support with recommendations.
Draft	Draft legislation to require a study on the Veterans Crisis Line	No position.
HR 1133	Veterans Transplant Coverage Act of 2017	Support.
HR 2123	Veterans E–Health and Telemedicine Support Act of 2017	Support intent.
HR 2601	Veterans Increased Choice for Transplanted Organs and Recovery Act of 2017	Support intent.
HR 3642	Military Sexual Assault Victims Empowerment Act	Support intent.

Chairman Roe, Ranking Member Walz, and Distinguished Members of the Committee, on behalf of Got Your 6, I would like to extend our gratitude for the opportunity to share our views regarding several of these pieces of legislation.

The mission of Got Your 6 is to empower veterans to lead a resurgence of community across the country. Got Your 6 believes, and our research confirms, veterans are leaders, team builders, and problem solvers who have the unique potential to strengthen communities across the country. As a coalition, Got Your 6 works to integrate these perspectives into popular culture, engage veterans and civilians together to foster understanding, drive veteran empowerment policy, and empower veterans to lead in their communities.

Formed out of Hollywood as a movement to more accurately portray veterans in film and television, Got Your 6 has since gone on to lead the veteran empowerment movement by spearheading and publishing research, which proves veterans are civic assets, granting out more than $6 million dollars to our best-in-class nonprofit coalition partners, and leading an effort to change the national narrative around veterans as "broken heroes." Building on that success, and thanks to the direct request from our coalition partners, Got Your 6 was proud to launch a policy department in 2017 aimed at advocating on behalf of our direct-service nonprofit partners, building on the success of the veteran empowerment movement, and challenging the current messaging status quo in the halls of Congress.

The Got Your 6 policy framework includes advocating for legislation that:

1.supports efforts to change the current narrative of veterans as "broken heroes";

2.identifies common sense reform that does not detract from existing services but does increase efficiency or cost savings;

3.recognizes the entire veteran population, including the 13 million who do not use the Department of Veterans Affairs (VA) for their health care needs; and,

4.supports a strong VA that adequately meets the needs of those veterans who choose to use it.

The two major draft proposals aimed at addressing the future of care contracted outside the VA—referred to as non-VA care—include many overlapping provisions Got Your 6 has asked be included in a future non-VA care program. However, both bills also include fundamental differences in how the program should be set-up and managed, particularly as it relates to the establishment of networks of providers and the expansion of telemedicine. We encourage this Committee to reconcile the two proposals based on feedback from this hearing and present one, unified plan

that incorporates important provisions from each proposal that we as a community can all work towards becoming law.

On the general use of non-VA care, Got Your 6 believes veterans should receive care when and where they need it and by a provider that clinically best supports that need. Based on feedback from our coalition members, the top priorities for any non-VA care program should include: the ease of use for all parties, the consolidation of community care programs into a singular program, the quick resolution of provider payments and record sharing, and the exploration of expanding innovative public-private partnerships.

While both proposals include many provisions that meet or exceed those priorities, we found neither substantially addressed a pathway to expand the use of public-private partnerships or a call to leverage the best-in-class programs and networks that have been established to address gaps in VA care or to meet the needs of individuals currently not eligible for VA care. We believe many programs—like the Marcus Institute for Brain Health and Wounded Warrior Project's Warrior Care Networks—are complimentary of the work of VA, allow for innovative treatment options outside the current scope of VA options, and provide care to veterans with other than honorable (OTH) discharges and veterans' families, both groups of people frequently cited as underserved in the VA system. We encourage a continued conversation on and exploration of how these types of programs can be better understood and utilized to fill unmet needs at the VA.

Draft legislation to establish a permanent Veterans Choice Program

The draft legislation would establish a permanent Veterans Choice Program directing the establishment and management of the non-VA care options available to veterans utilizing the VA healthcare system.

Got Your 6 applauds the Committee for developing a comprehensive proposal that incorporates many of the stakeholder requests and report findings expressed since the creation of the existing Veterans Choice program. Generally, the language allows for significant flexibility in how the VA will implement specifics of a non-VA care program, which we support as the best way to empower the VA to create a program that will work better for veterans, VA employees, and the American taxpayer. The language also clearly supports the idea that veterans should receive care when and where they need it and by a provider that clinically best supports that need. Got Your 6 is particularly supportive of the following provisions:

Program eligibility The language makes clear the clinical needs of the veteran and the capabilities of the VA will be the key determining factors when deciding where a veteran can receive primary and specialty care. The language still maintains the VA's central role as the coordinator of such care, which we believe will allow for continued accountability and oversight of the VA while easing confusing and contradictory restrictions related to non-VA care.

Network creation The well-articulated network creation provisions allow for sufficient latitude to develop networks of non-VA providers that best align with market realities at a local level. We believe the creation of networks will help the VA better manage the overall system of non-VA care as opposed to a nation-wide system of individual provider agreements.

Prompt payment standard A lack of standardization for payment schedules and common anecdotal evidence of significantly delayed payments to providers have proven there is a need for greater attention to how community providers are able to submit and receive reimbursements. Got Your 6 strongly supports the strict requirements on how providers must submit claims and how soon after submission the VA must pay the claims, with accrued interest where applicable. These clearly defined responsibilities for all parties will better ensure a system that is fair and respectful of better business practices.

Consolidation of non-VA care programs While the existence of multiple programs is a well intentioned response from Congress to address specific challenges facing the VA or veterans using the VA, it easily leads to confusion for veterans, community providers, and VA employees navigating a complex system of options. Got Your 6 strongly supports the language in this legislation that intends to consolidate all existing non-VA care programs into one, easy-to-use program that takes into account the need for flexibility to address future regional or issue-based concerns.

Emphasis on electronic transfer of information The emphasis on the electronic transfer of information for health records and claims is encouraging and strongly supported as we continue to advocate for a 21st century VA. Got Your 6 encourages the VA to prioritize innovative technology and connected electronic platforms as a way to increase efficiency and decrease delays and errors in processing. Community

partners and veterans are increasingly expecting such capabilities and the VA should strive to exceed that expectation.

While the legislation is still in draft form, Got Your 6 encourages the consideration of the following:

Expansion of telemedicine authority The expanded use of telemedicine is widely held as a needed part of the solution to many of the VA's access constraints. We encourage the Committee to consider including the language presented in the draft proposal on the Veteran Coordinated Access and Rewarding Experiences Act, and the federal supremacy in particular, in the legislation as a part of the whole in addressing growth to VA's capacity and capability.

Protections from previously fired VA employees The language specific to what constitutes an eligible non-VA provider does not include restrictions on contracting with individual providers previously fired from the VA for poor performance, misconduct, or criminal charges. In the spirit of the recent efforts to establish greater accountability at the VA, we believe that once an individual is deemed an unacceptable provider for VA care they should not be eligible to provide contracted care either.

Consideration of appeals process It is imperative for oversight and accountability purposes there be a clearly defined, standard process to review any concerns related to the use and eligibility of non-VA care.

Annual market assessments The only concern we raise on this provision is the realistic ability to conduct such market assessments on an annual basis based on outcomes of similar assessments conducted by the VA.

Underscoring all of the thoughts on this draft legislation is a need for Congress, leadership across the VA enterprise, and engaged stakeholders to closely monitor the development and implementation of the program to ensure it is one the community stands behind. Successes and failures during early development and implementation will only compound if not resolved while the problem is in infancy. We know today's hearing is only one step in a long path to full implementation of a new non-VA care program and hope to see continued engagement with external partners.

Draft legislation to modify VA's authority to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions, and for other purposes

This draft legislation would modify VA's authority to enter into agreements with State homes, change the recording obligations for non-VA care, expand telemedicine authority, and establish a program to increase the number of graduate medical education residency positions within the VA.

Got Your 6 takes no position on this legislation. The draft includes many provisions Got Your 6 has spoken to under other proposals before the Committee today, including expansion of telemedicine and a change to the accounting procedures used by the VA when tracking non-VA care. Got Your 6 has no position on the agreements related to State homes and nursing care.

Draft legislation on the Veteran Coordinated Access and Rewarding Experiences (CARE) Act

The draft proposal would direct the establishment and management of non-VA care options available to veterans utilizing the VA healthcare system.

Got Your 6 appreciates the VA's proposal and is encouraged to see many similarities to the draft legislation making the Veterans Choice Program permanent, such as prompt payment standards and ending arbitrary eligibility requirements. However, we find the fundamental program development provisions vague and without clear enough guidelines to allow for sufficient oversight. Specifically, we have concerns with the following provisions:

Provider agreements The language establishing provider agreements is confusing with no clear indication there will be networks or a localized system to help reasonably manage provider agreements. As it reads, these provider agreements would be handled en masse, which seems difficult to maintain with any substantial accountability and oversight.

Enhanced-use leases While the language expanding enhanced-use lease authorities is a positive step towards increasing public-private partnerships, we find the scope presented extremely limited. It does not encourage or facilitate cooperation with organizations providing excellent services that do not meet the traditional parameters of enhanced-use leases and we would encourage a more innovative, open pathway for public-private partnerships.

Got Your 6 is supportive of the following provisions:

Expansion of telemedicine authority As stated in response to the draft legislation making the Veterans Choice Program permanent, we strongly support the language within this proposal that expands the VA's authority to provide telemedicine.

Recording obligations change Got Your 6 supports the provision requiring the cost of non-VA care be accounted for when a claim for payment is approved. We believe this change will allow the VA to have a better understanding of the real cost of non-VA care.

Walk-in care options Utilizing urgent care facilities is a comomnsense solution to increasing access to care while simultaneously reducing expensive and sometimes unnecessary emergency room visits. Got Your 6 supports the intent behind this provision and hopes to see access to urgent care options available for veterans under the new non-VA care program, but we find the specific language in this draft proposal too vague and encourage incorporating some additional parameters to better articulate the provision.

Enhancing federal agency partnerships Got Your 6 believes reducing bureaucratic barriers between VA and the Department of Defense (DoD) will result in quicker access to care with potential cost saving benefits. We hope to see more innovative and resource sharing opportunities, like the pilot program presented, identified to facilitate a more efficient government.

As previously stated, Got Your 6 encourages the VA and the House and Senate Veterans Affairs Committees to consider the best of both proposals and integrate stakeholder feedback to present one, unified plan we as a community can all support.

Draft legislation to require a study on the Veterans Crisis Line

The draft legislation would require a study on the efficacy of the Veterans Crisis Line.

Got Your 6 has no position on this draft legislation. While data on the efficacy of the Veterans Crisis Line (VCL) could be valuable information that would better inform how the VA is responding to the mental health care needs of veterans, we are concerned the information required in the study may not be feasible or ethical to collect. We are researching the matter further and welcome additional conversations on the subject.

H.R. 1133, Veterans Transplant Coverage Act of 2017

The Veterans Transplant Coverage Act would allow the VA to provide for an operation on a live organ donor, regardless of that individual's eligibility for VA care, including care necessary before and after the organ donation surgery.

Got Your 6 supports this legislation as it better empowers the VA to make decisions that best meet the clinical needs of veterans and reduces limitations to commonsense, and potentially lifesaving, use of eligible organ donors. However, we would encourage articulating more specific parameters around the VA's responsibility to provide care before and after the operation to non-veteran patients.

That support stated, Got Your 6 is concerned this legislation is short-term solution to providing necessary care for non-veterans. This legislation amends the current Choice program, which will be replaced in the near future with a new non-VA care program. As the future of non-VA care is debated and finalized, this bill should serve as a reminder to include sufficient flexibility to provide care to non-veterans when necessary to meet VA's responsibility, like treatments for live donor transplants or intro-fertilization.

H.R. 2123, Veterans E–Health and Telemedicine Support Act of 2017

The Veterans E–Health and Telemedicine Support Act would expand existing authorities for VA providers to practice telemedicine.

Got Your 6 supports the intent of the legislation and firmly supports the expansion of telemedicine capabilities at the VA as a innovative, commonsense solution to access and capacity issues for veterans seeking care at the VA. However, we would instead encourage the use of the proposed telemedicine expansion language presented in the draft proposal on the Veteran Coordinated Access and Rewarding Experiences (CARE) Act and its use of federal supremacy.

We also encourage the VA, and this Committee, to use an expansion of telemedicine as an opportunity to validate the need for and efficacy of expanded telemedicine capabilities for the medical field nationwide. Historically, the VA has been a driver of medical innovation for the country as a whole, we believe telemedicine is an op-

portunity for the VA to show how innovation and technology can be used to solve national medical concerns.

H.R. 2601, Veterans Increased Choice for Transplanted Organs and Recovery Act of 2017

The Veterans Increased Choice for Transplanted Organs and Recovery Act would amend the current Choice program to allow veterans to use non-VA care for organ transplantation if the veteran resides more than 100 miles from a VA transplant center.

Got Your 6 supports the intent of the legislation based on the belief veterans should receive care that best clinically meets their needs when and where they need it, including care related to organ transplants. However, we do not support the continuation of arbitrary eligibility standards, like distance from a facility. Additionally, given the implementation date presented, October 1, 2018, being closely aligned with the potential implementation of a future non-VA care program we believe the intent of this legislation would be better served by being included in overall conversations around the future of non-VA care.

H.R. 3642, Military Sexual Assault Victims Empowerment Act

The Military Sexual Assault Victims Empowerment Act would establish a pilot program for survivors of military sexual trauma (MST) to receive care at non-VA facilities.

Got Your 6 supports the intent of this legislation—veterans should receive the care that best clinically meets their needs—but have concerns with specifics of the language. First, the extreme geographic limitations this legislation creates severely limits the VA's ability to clinically meet the needs of all MST survivors and is not reflective of the intent of the language presented on the future of non-VA care. Second, the legislation also prohibits the VA from limiting the choice of non-VA providers, which does not account for legitimate limitations on available providers due to any number of issues including providers choosing not to participate with VA contracted care or current reimbursement eligibility for programs and providers. Instead, Got Your 6 would encourage the Committee and VA to include potential needs of all MST survivors in the framework and implementation of the future non-VA care program.

In conclusion, Got Your 6—through our 42 direct-impact, non-profit partners who collectively represent three million veterans and their families, as well as through our efforts to empower and challenge veterans to lead when they return home—are a new voice which represents all veterans, of all generations, of all backgrounds. We put veterans first and challenge them not to think of themselves as broken, but as the leaders our country is desperately searching for. The veteran empowerment movement is young, but it is already the voice of millions of veterans looking to challenge the dominating narrative of veterans in America.

We would like to thank this Committee for its leadership on veterans' issues and look forward to working together to empower all veterans.

HEALTH IT NOW

October 23, 2017

The Honorable Phil Roe
Chairman, House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

The Honorable Tim Walz
Ranking Member, House Committee on Veterans' Affairs
333 Cannon House Office Building
Washington, DC 20515

Dear Chairman Roe and Ranking Member Walz:

Health IT Now appreciates the Committee's attention to the important issue of ensuring access to high quality care for our nation's veterans. We agree that breaking down barriers to the utilization and nationwide scaling of the Department of Veterans Affairs' (VA) telehealth program is a way to accomplish this.

In order to ensure veterans have access to care when are where they need it, we have been strong supporter of the Veterans E–Health and Telemedicine Support (VETS) Act for a number of years. The statutory language included in the VETS

Act, and reiterated in the recent proposed rule issued by the VA, reflects the good faith efforts of many stakeholders to ensure an important balance is reached that veterans have access to care and proper channels are maintained to ensure patient safety. That is why we have supported the VETS Act and the VA's proposed rule.

We are concerned that the language included in the VA's proposed legislation, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act, does not maintain this important balance. We urge the VA to remove Section 301 of their proposed legislation and for the Committee to advance the VETS Act instead. There is broad stakeholder support for the VETS Act, illustrated by the attached letter signed by over two dozen organizations.

Thank you for your consideration and we look forward to working with you to pass the VETS Act.

Sincerely,

Joel White
Executive Director

IRAQ AND AFGHANISTAN VETERANS OF AMERICA (IAVA)

Statement of Tom Porter
Legislative Director

Chairman Roe, Ranking Member Walz, and Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 400,000 members, thank you for the opportunity to share our views on the legislation and legislative proposals being discussed today. I will focus our testimony on the proposals on community care and Choice program and the draft to address the Veterans Crisis Line.

Community Care and Choice Programs

The Veterans Choice, Accountability and Access Law of 2014, which was enacted in August 2014, was charged with providing a framework for designing the Veterans Health Administration (VHA) of the future. This legislation was introduced after the Phoenix VA scandal exposed similar problems with VA medical centers around the country. IAVA is proud of the work that we have done with our VSO partners, the VA, and Congress working to ensure that veterans have access to the timely and quality health care they deserve.

Since the 2014 law was passed, IAVA's primary position on this issue has remained unchanged: Reforming VHA into a truly 21st century health care system will require significant coordination between VA, the Administration, Congress, VSO partners, and the veterans we all serve. This coordination must be done in a bipartisan, veteran-centric manner that understands transformative change requires resources. It must focus on a holistic view of the future of VA health care, addressing how to best support and improve VA facilities and care while supplementing with support from the community. It is only in this way that we can work towards a veterans health care system that provides timely access to high-quality and comprehensive care. We will also stand by our brothers and sisters in the VSO community, especially Paralyzed Veterans of America (PVA) and Disabled American Veterans (DAV), whose members will be most impacted by any changes.

IAVA believes that in order for the VA community care programs, which includes Choice, to adequately assist in building this 21st century veterans healthcare system, certain components must be present in the next iteration of the Choice program. These components include a dynamic in which community providers are led by the VA primary care providers managing the veterans' care. Non-VA community care should be fully integrated to fill gaps and expand access, not displace VA.

Such a model can be beneficial to both VA and community providers, mentoring community providers to develop a cultural competency for the injuries that veterans present with and providing support to the VA so it can ensure all veterans seeking care are accessing it in a timely manner. Of note, a 2014 RAND report found that most community-based mental health providers are not well prepared to take care of the special needs of military veterans and their families.

Further, IAVA believes the 40-mile and 30-day standards are arbitrary access standards; Decisions about when and where veterans can receive medical treatment should be clinical between the veteran and his or her doctor.

Overall, IAVA believes that the VA provides a model of care that is uniquely positioned to treat the physical, psychological, social and economic aspects of a veterans

health. Such a model can benefit from the experience of the private sector, but cannot be replaced by the private sector as it is not positioned to replicate this unique model.

Such sentiments are reflected in IAVA's membership. According to our most recent member survey, 54 percent of respondents oppose full privatization of the VA.

Our latest member survey found that 82 percent of respondents are enrolled in VA health care. Ninety percent of those enrolled sought VA health care in the last year. Our members rely on VA health care, with 28 percent using VA health care exclusively, and 38 percent using it in combination with other health care.

While IAVA is supportive of improving the Choice Program, IAVA members have given the program very mixed reviews. Only 20 percent of IAVA member respondents have actually used the program. Of those that have used the program, 37 percent rated the Choice program as "above average" or "excellent," while a concerning 28 percent rated it as "below average" or "poor."

As more veterans transition from active duty and as we face the challenges of physical and mental injuries, we need to be assured that a first-rate system of care is in place.

IAVA appreciates the work that the House Veterans Affairs Committee (HVAC) has invested in the interest of improving the VA Choice Act through the draft legislation "to establish a permanent Veterans Choice Program," as well as the VA's work on its draft proposal, the "Veteran Coordinated Access and Rewarding Experiences (CARE) Act." These proposals are good starting points toward strengthening and consolidating the VA's community care programs and improving veterans' access to the care they deserve. While more work is still needed on these proposals, IAVA is encouraged by the directions that leaders within Congress and the VA have taken.

We are encouraged that both measures would end the arbitrary 30/40 rule for veterans' eligibility for access to community care programs. Any final legislation must ensure the veteran has timely access to quality care either within or outside the VA as a result of a decision made between the veteran and his or her VA primary care physician.

Also significant in both proposals is the consolidation of the various community care programs into one, which eliminates many confusing layers of duplicative bureaucracy, which have sown confusion amongst the veteran population.

We appreciate that both measures establish a standardized claims process and system of payments to ensure the VA remains on sound financial footing with its health care providers. However, If a provider finds it too difficult to do business with the VA and they discontinue that relationship because of those problems, veterans lose access to care. IAVA is concerned that with the VA now facing challenges of paying claims in a timely fashion, how will the Department keep to new stringent deadlines under the legislation of 30 or 45 days, depending on the method of submission?

Another key omission is how the VA will meet new technological and infrastructure needs to make these aggressive changes and enhance access to care. These needs should be significant, so we will look forward to seeing how the legislation addresses these needs as it progresses.

While the HVAC draft has no mention of how the new measures will be funded, the VA draft would round down cost-of living adjustments (COLA) a misguided provision that IAVA has stood with other VSOs to strongly oppose. We encourage the VA and Congress to look for better ways to fund VA benefits instead of reducing disability payments for those veterans most in need.

The VA must also take concrete and aggressive steps to focus more on the needs of our increasing population of women veterans, including supporting and implementing provisions in the Deborah Sampson Act (H.R. 2452) championed by IAVA and 16 of our fellow VSOs. Our #SheWhoBorneTheBattle legislative, media, and grassroots campaign champions this legislation to update VA programs and services and urges the change of its motto to be gender inclusive.

IAVA realizes that consolidating and improving the VA community care and Choice programs is a challenge, and that these draft measures represent only the beginning of this process, but working together we can strengthen the VA in order to provide the highest quality care for veterans. IAVA looks forward to continuing to work alongside this committee, Secretary Shulkin and our VSO partners to evaluate and implement changes necessary to best achieve this goal.

Veterans Crisis Line Study

IAVA has partnered with the Veterans Crisis Line since 2012 to both ensure our members are aware of the critical services the Crisis Line offers, as well as to provide crisis support to clients who are seeking support from IAVA's Rapid Response

Referral Program (RRRP). IAVA recognizes the life-saving services the VCL offers every day, and our RRRP program has referred nearly 200 clients to the VCL to date. It is a vital resource for our community, and we are committed to ensuring that it continues to fulfill its mission to provide 24/7, world class, suicide prevention and crisis intervention services to veterans, service members, and their family members.

IAVA supports the intent of the draft legislation "To direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line." VCL and programs like it must strive to collect data to continually assess and improve their impact. IAVA has been concerned that this is not happening to the extent that it can be. Section 2 of the Clay Hunt SAV Act, requiring a third party independent evaluation of VA mental health and suicide prevention programs, is intended to address this very concern. This legislation adds a level of specificity to such an assessment, prescribing specific data to analyze. However, the VCL has an added challenge in its self-assessments in that it must first and foremost preserve the anonymity of its callers while also assessing its impact. Thus, it is IAVA's belief that any legislation requiring VCL to record and report out data on its activity also ensure that the anonymous nature of the VCL is not compromised.

While we agree with the intent of this legislation, we believe that it might be too prescriptive in nature and could have unintended consequences. We also strongly believe that any legislation requiring further assessment of the VCL should involve a collaborative effort between VA, Congress, the VSO community, and researchers and focus not only on past data, but more importantly chart out how best to assess VCL in the future.

Again, IAVA appreciates the opportunity to express our views to this committee.

MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

CHAIRMAN ROE, RANKING MEMBER WALZ, and Members of the Committee, the Military Officers Association of America (MOAA) is pleased to present its views on pending legislation under consideration by the Committee.

MOAA does not receive any grants or contracts from the federal government.

EXECUTIVE SUMMARY

On behalf of the Military Officers Association of America, the largest military service organization representing the seven uniformed services, including active duty and Guard and Reserve members, retirees, veterans, and survivors and their families, MOAA thanks the committee for holding this very important hearing and for your continued support of our nation's servicemembers and veterans and their families.

MOAA offers our position on the following bills. MOAA takes no position on the remaining bills before the committee, as some are outside our scope of expertise.

- Draft legislation to establish a permanent Veterans Choice Program
- Veteran Coordinated Access and Rewarding Experiences (CARE) Act

DISCUSSION

Draft legislation to establish a permanent Veterans Choice Program-MOAA strongly supports consolidating all six of the VA's community care programs into one, as recommended in the June 30, 2016, independent Commission on Care report. This bill will accomplish that and prevent a confusing set of rules unique to each individual program, as well as provide the VA more flexibility in providing care.

MOAA also supports creating a more formalized network for community-based health care professions to become accustomed to working with veterans and their unique needs, as well as increasing partnerships with community clinics and hospitals. It is vital, however, that Congress maintain a strong oversight to ensure the VA retains existing special-emphasis resources and specialty care expertise such as spinal cord injury, blind rehabilitation, mental health, prosthetics, and similar foundational services. To date, the VA has not shared a list of expertise and resources it intends to retain, nor has it shared a methodology for how it will make such determinations in the future. It also has not shared the methodology it intends to use to perform the market assessments required in this bill. Transparency in this regard is essential to determining whether the permanent program will serve veterans' health care needs adequately.

MOAA offers the following legislative considerations to ensure the intended effect is achieved.

- Assignment of a patient-aligned care team or dedicated primary care provider should be made only after the VA determines a patient will actually be utilizing VHA services. As written, the draft legislation mandates that upon enrollment a dedicated primary care provider will be assigned. A Congressional Research Service report found in 2014 there were 9.1 million veterans enrolled in the VHA, while only 5.9 million veterans were patients within the VHA system [1]. Assigning primary care providers to veterans who are not utilizing the VHA to receive medical care would be inefficient and wasteful.
- The draft legislation sets forth three ways a veteran may receive medical services, depending upon clinical determinations: at a VA medical facility, by a regional network provider, or pursuant to a provider agreement. The language contained in the legislation pertaining to provider agreements is very broad and has few restrictions. The VA should only be able to enter into direct provider agreements for services not already covered by regional network providers or in locations where regional gaps exist. Duplicating a regional network with provider agreements may prove to be inefficient and could undermine the existing networks, confuse providers, and result in claims being sent to the wrong payer.
- All community providers should be required to meet some standards regarding scheduling, payment rates, and care provided. Absent such standards establishing reasonable performance expectations, the VA will be left attempting to enforce compliance without adequate legal authorities.
- Given the broad eligibility criteria, there is significant potential veterans will either become confused with the requirements or disagree with the determinations made by the VA. An appeals process must be included in the statutory language to establish a clear, fair, and expeditious process for veterans to dispute the VA's determination that they should or should not use care in the community.
- Language should be added to the legislation providing for service-connected disability compensation as a result of injuries incurred or aggravated by medical care by a community care provider, as set forth in 38 U.S.C. § 1151. Absent such a provision, veterans will be required to pursue recovery through the civil court system. Aside from the onerous burden civil legal action places on an individual, including retaining an attorney, years of litigation, and steep legal fees (some estimates place them at $30,000-$50,000 for a basic case and $100,000 for a complex case), veterans would be subjected to any number of additional legal hurdles. Some of these include capped recovery amounts due to tort reform legislation and potential mandatory arbitration if a health care provider requires it as a condition of rendering care. While the draft legislation leaves open the option a veteran may reject care in the community and choose to instead to be treated at a VHA facility, this places the veteran in the position of potentially not receiving timely care in exchange for preserving a legal right a decision that could have life-or-death implications, and a position in which a veteran should never be placed.

Veteran Coordinated Access and Rewarding Experiences (CARE) Act-MOAA reiterates all of the above-stated concerns, as they are relevant to this draft legislation as well. In addition, the following recommendations are offered.

- Walk-in Care Copayments: The draft legislation states if any eligible veteran utilizes walk-in care, the veteran must pay a copayment for those services. It does not differentiate between care sought for service-connected disabilities and non-service-connected disabilities. When a veteran seeks care at VHA facilities for a service-connected disability, there is no fee associated with that care. The same standards should be applied for care received in the community. Although the draft allows the Secretary to adjust those copayments based on a veteran's priority group, there is no assurance veterans seeking medical care for service-connected disabilities will not be required to pay. The legislation should make clear that veterans are not required to pay a copayment for any care received in a walk-in clinic for a service-connected disability. Because this co-payment exclusion would apply only to service-connected disabilities, and because walk-in care services are extremely limited in their type and scope, the potential that a veteran will overuse a walk-in clinic versus seeking primary care for a service-connected disability is very low.

[1] Congressional Research Service, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," June 3, 2014.

- Round-down of certain cost-of-living adjustments: While a round-down of cost-of-living adjustments for veterans benefits will not have a devastating financial impact on any individual veteran, the effects are cumulative and over a period of several years could yield significant reductions. The legislation as drafted provides that the round down would apply for 10 years (2018 through 2027) but no alternative funding source for these changes is apparent and the round-down will more than likely be extended for several 10 year periods thereafter leading to a lifetime of reduced benefits for veterans. Such a round down could lead to approximately $2,000 of lost benefits over the lifetime of a disabled veteran. It is unsettling that this reduction in benefits is proposed in the same bill that rescinds limitations on awards and bonuses paid to VA employees. This creates the appearance that cuts to veterans' benefits are being used to fund bonuses to VA employees. MOAA encourages the VA to continue, in earnest, all other potential funding options rather than to reduce veterans' benefits to pay for their own or other veterans' health care and VA employee bonuses.

MOAA thanks the committee for considering this important legislation and for your continued support of our veterans and their families.

MILITARY ORDER OF THE PURPLE HEART

SUBMITTED BY
ALEKS MOROSKY
NATIONAL LEGISLATIVE DIRECTOR

Chairman Roe, Ranking Member Walz, and Members of the Committee, on behalf of the Military Order of the Purple Heart (MOPH), whose membership is comprised entirely of combat wounded veterans, I thank you for inviting us to offer our views on today's pending legislation. The bills being discussed today deal with the future of the Veterans Choice Program, as well as several other important issues dealing with veterans' access to the health care that they have earned through their service, and we thank the Committee for bringing them forward.

Draft legislation, to establish a permanent VA Care in the Community Program, and for other purposes

MOPH strongly believes that veterans must have access to high quality health care that is timely, and within reasonable distances, in every instance. Since Department of Veterans Affairs (VA) facilities cannot always offer care to every veteran when and where they need it, it is critical that seamless, well-coordinated community care is available when necessary. Still, community care must be seen as a supplement to care provided at VA facilities; not a replacement. The necessity for a community care program must be balanced with the desire of many veterans who wish to continue to receive most, if not all, of their care at VA.

For the past three years, that balance has been primarily achieved by the Veterans Choice Program. While imperfect in many ways, the Choice Program was generally successful in easing the well-documented access problems from which VA suffered prior to its inception. Now, as the Choice Program nears its expiration, a permanent VA community care program must be authorized, so that veterans who currently receive care in the community under Choice do not experience any gaps in care. This creates an opportunity to improve upon the Choice program, and this draft legislation does so in many ways. MOPH supports the vast majority of the bill, and appreciates the urgency and thoughtfulness with which the Committee is addressing this important issue.

Of all the changes to the Choice Program envisioned by this bill, the one that would undoubtedly be most apparent to veterans is the elimination of the current 30-day/40-mile rule. Under the current program, veterans are only authorized to receive care in the community if it is determined that VA cannot provide an appointment within 30 days, or the veteran lives more than 40 miles from a VA facility. These standards are not only arbitrary; they often exclude certain veterans who would benefit from care in the community. This includes veterans who need an appointment in less than 30 days, and veterans who are unable to travel 40 miles due to their disabilities or other reasons. This legislation would do away with the 30-day/40-mile eligibility requirement, in favor of a clinical determination made by VA, in consultation with the veteran and their provider. With the understanding that VA would be required to remain the coordinator of all community care, MOPH strongly supports this change.

MOPH is pleased that the bill would require that only active users of VA health care, as opposed to all enrollees, will be assigned to either patient-aligned care teams (PACT) of the Department or primary care providers (PCP) in the community. This will prevent PACTs from being filled with enrollees who do not regularly use VA care, thus giving an accurate measure of capacity within VA when determining whether assignment to a community PCP is necessary.

We also support the provision of this bill that would allow the Secretary to exempt certain specialty care services from the primary care referral requirement. While we agree that specialty care ought to be granted based on PCP referrals in general, we believe this flexibility will allow veterans to continue to engage in direct scheduling for specialties that are appropriate, such as optometry and audiology, as they do now.

Other provision of the draft bill we support include the establishment of an appeal process for veterans who are not authorized community care but wish to be, prompt payment standards for community providers, annual capacity and commercial market assessments of each VA facility and Service Network, improvements to provider agreements, and the consolidation of existing community care programs into a single authority. All of these provisions would help to streamline the way VA provides care.

However, MOPH must oppose section 203 which would eliminate copayment offsets for veterans who carry other health insurance. Currently, when VA bills a veteran's health insurance for certain episodes of care, part of the money collected is used to offset any copayment for which the veteran would otherwise have been responsible. This policy incentivizes veterans to both share their insurance information with VA, and continue to carry other health insurance even if they receive most of their care at VA facilities. While we understand that the improvements contained in this bill will require additional funding, we do not believe that veterans should have to personally bear that burden with new out-of-pocket expenses. MOPH strongly urges the Committee to amend the bill to strike this provision.

VA legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act

MOPH appreciates VA's efforts in drafting its own bill to address the future of community care. This proposed legislation contains many provisions similar to those in the Committee's bill, but also has several key differences. We will primarily focus our comments on those provisions of the Care Act to that differ considerably from the Committee's draft bill.

Like the Committee's bill, the Care Act eliminates the 30-day/40-mile rule in favor of clinical determinations, which MOPH strongly supports. In those cases where such a determination would be made, we appreciate the concise nature of the text that reads, "The decision to receive such care or services from a non-Department entity or provider.shall be at the election of the veteran."

However, the Care Act establishes an additional eligibility trigger, whereby veterans would be referred to community care if the VA facility where they are enrolled does not meet quality or access standards, which are yet to be determined. While we generally agree with the principle that veterans should not be offered substandard care as the only option, we would like greater clarity on what those quality and access standards would be before offering our support for this provision. Furthermore, we strongly believe that known deficiencies at any VA facility should be corrected with the highest priority, and that community care should not be viewed as a substitute for remediation.

MOPH strongly supports the provision of the CARE Act that proposes establishing a walk-in community care benefit for active enrollees. We believe this would greatly improve convenience and health outcomes for veterans suffering from acute illnesses that do not require emergency room care. However, we would like the text to be amended to explicitly state that copays for walk-in care would be at the same rate as current VA copay amounts, rather than leaving those amounts to be determined by regulation.

We further support provisions unique to the CARE Act that would expand telehealth authorities, increase the number of graduate medical education residencies, provide reimbursement for continuing professional education requirements for advanced practice registered nurses, and improve collaboration with federal partners.

However, MOPH strongly opposes the provision of the CARE Act that would eliminate copayment offsets for veterans who carry other health insurance for reasons previously stated. Likewise, we vigorously oppose the provision that would attempt to generate offsets for community care by rounding down annual cost-of-living adjustments for veterans' and survivors' benefits. Veterans and their families rely on these modest increases to ensure their benefits keep pace with inflation. Their

payment rates should not be diminished in order to ensure that veterans receive the high quality care to which they are already entitled. MOPH opposes the inclusion of either of these provisions in any future drafts of VA community care legislation.

MOPH does support the provision that would place reasonable caps on the amounts that flight schools may charge under the Post-9/11 GI Bill, closing a loophole in current law.

H.R. 1133, the Veterans Transplant Coverage Act of 2017

MOPH supports this legislation, which would authorize VA to provide eligible veterans with organ transplants from live donors, in a VA facility or a non-Department facility under the Veterans Choice Program or a successor program, regardless of whether the donor is eligible for VA health care. VA would provide the donor with any care before and after the transplant that may be required as a result of the procedure, regardless of the donor's eligibility status.

Organ transplants are often life-saving operations. When a transplant from a live donor is a viable option, such as in the case of a kidney transplant, and a volunteer donor is identified, MOPH strongly believes that veterans should receive the transplants they need as quickly as possible. We wholeheartedly support this bill, which would remove current barriers to that process.

H.R. 2123, the Veterans E–Health and Telemedicine Support (VETS) Act of 2017

MOPH strongly supports this legislation, which would codify VA's authority to provide telemedicine across state lines. Currently, both the veteran and the VA provider must be physically located in a federal facility in order to conduct telehealth appointments. This legislation would eliminate that barrier, allowing veterans to get the telehealth care they need at their homes, workplaces, and other locations that are convenient for them. This would be particularly helpful for veterans who are homebound or live in highly rural areas. This legislation will allow VA to continue to expand its growing telehealth initiatives, leading to shorter wait times and greater access for all veterans.

H.R. 2601, the Veterans Increased Choice for Transplanted Organs and Recovery (VICTOR) Act of 2017

MOPH supports this bill's intent, which is to grant veterans with greater access to organ transplants through the Veterans Choice Program. As previously stated, organ transplants are often life-saving procedures, and should be provided as quickly as possible in all cases. However, we oppose the provision of this bill that would limit eligibility for non-VA transplants to veterans who live more than 100 miles from a VA transplant center. MOPH believes that the current 40-mile rule of the Veterans Choice Program is arbitrary and disqualifies many veterans who would benefit from care in the community. Likewise, we will not support attaching additional arbitrary distance requirements to any expansion of community care. If the 100-mile requirement were to be replaced with a provision determining eligibility based on clinical need, MOPH would fully support this legislation.

H.R. 3642, the Military Sexual Assault Victims Empowerment (SAVE) Act

MOPH supports the spirit of this legislation, which would establish a pilot program to allow Military Sexual Trauma (MST) victims to receive care in the community if they so choose, without the current 30-day/40-mile restrictions of the Veterans Choice Program. Such restrictions are arbitrary and often wrongfully exclusive for veterans seeking care for any reason. Furthermore, victims of MST have unique needs, and it is important to their recovery that they are able to receive care in an environment in which they are comfortable.

However, MOPH could only fully support this bill if it were amended to more explicitly state that VA would remain the coordinator of care for the program. Additionally, VA should be granted the resources to continue to improve care and services for MST survivors at VA facilities. While we appreciate this bill's intent, and would be most interested in the findings of the report it requires, MOPH certainly would not want the program it proposes to relieve VA of its responsibilities to coordinate care for the veterans who participate in the pilot, or be seen as a replacement for high quality MST treatment options within VA, in any instance.

Draft legislation, to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line

Although we appreciate the intent of this legislation to determine, and potentially identify ways to improve, the efficacy of the Veterans Crisis Line (VCL), MOPH must oppose it. The required study would contain multiple data points, to include

whether or not veterans who contact the VCL are already receiving VA mental health care at the time of the call, whether they begin and continue to receive VA care following the call, and whether or not they eventually die by suicide. While this data may be useful in theory, gathering it would require VCL responders to collect personally identifiable information from veterans in crisis during the call. This would not only run the risk of disrupting a suicide intervention in progress, it may steer veterans who wish to remain anonymous away from calling the VCL in the first place. While MOPH supports continued improvement to the VCL, we do not believe this bill offers the correct approach to achieve that goal.

Draft legislation, to amend title 38, United States Code, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs, and for other purposes.

MOPH supports this legislation, which would provide VA with greater flexibility when entering into agreements with State Veterans Homes, and create a program to fill graduate medical education residency positions within VA. Under this program, medical students would receive financial assistance with their education, in exchange for a period of obligated service as full-time VA employees, as determined by the Secretary.

The ability of VA to meet veterans' demand for medical care is contingent on its ability to continuously recruit medical professionals. Accordingly, VA must have the programs and funding in place to attract those employees. This bill would assist in accomplishing that goal.

Similar to H.R. 2123, this bill would also authorize VA medical professionals to provide telehealth services to veterans across state lines, irrespective of whether the veteran or the provider are physically located in a federally-owned facility. MOPH fully supports this provision.

Chairman Roe, Ranking Member Walz, this concludes my statement. Once again, I thank you for inviting me to submit our views, and I would be happy to answer any questions for the record that you or any other Members of the Committee may have.

Disclosure of Federal Grants and Contracts:

The Military Order of the Purple Heart (MILITARY ORDER OF THE PURPLE HEART) does not currently receive, nor has MILITARY ORDER OF THE PURPLE HEART ever received any federal money for grants or contracts other than the routine allocation of office space and associated resources at government facilities for outreach and direct veteran assistance services through its Department of Veterans' Affairs accredited National Service Officer Program.

The National Alliance on Mental Illness (NAMI)

Submitted by:
Emily Blair
Manager-Military, Veterans & Policy

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee, thank you for affording NAMI, the National Alliance on Mental Illness, the opportunity to submit a statement for the record on the Committee's draft legislation to establish a permanent Veterans Choice Program and the Department of Veterans Affairs' (VA's) legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act.

NAMI is the nation's largest grassroots mental health organization, dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has over 900 affiliates and more than 200,000 grassroots leaders and advocates across the United States-all committed to raising awareness and building a community of hope for all of those in need, including our men and women in uniform, veterans, and military families.

Veterans Choice Pilot Program

NAMI applauds Congress, and this Committee specifically, for working swiftly and in a bi-partisan way to implement the original Veterans Choice Program legislation. Veterans were not receiving the timely access to care that America had promised, and Congress worked expeditiously to draft a policy framework with the

intent of creating an unmatched system of care. However, there are many lessons learned from the initial three-year Choice pilot program, which presents opportunities for us to work together to develop improvements for a permanent solution.

While increased access should continue to be at the forefront of this discussion, NAMI remains concerned about ensuring high-quality of care standards for mental health care and substance use treatment delivered within the walls of VA and through Choice providers in the community. Additionally, the need for providers to have a satisfactory level of military cultural competency is crucial, especially when delivering mental health care services. If a clinician doesn't establish a positive rapport with a veteran from the initial interaction, or a veteran feels judged by his or her military experiences-we know this often leads to disengaging in treatment. VA must work to ensure this key need is met among all VA and contracted community clinicians.

Draft Legislation to establish a permanent Veterans Choice Program

Title I–Improved Access to Care in the Community

Sec. 101. Establishment of Veterans Choice Program.

NAMI agrees that giving the Secretary authority to establish regional networks of providers in Veterans Integrated Service Networks (VISNs) and enter into contractual agreements for the operation of these networks, is a positive step to increase capacity and access to care. The establishment of provider networks would also enable a built-in quality measurement tool to ensure all providers participating in the Choice Program meet a satisfactory level of care and cultural competency.

Additionally, after regional provider networks are established, it could create an opportunity for VA to implement a tiered system and develop incentives, such as the policy outlined in the draft legislation-charging the Secretary to utilize value-based reimbursement models for providers, in order to better meet the specific health care needs of veterans. NAMI suggests the insertion of legislative language in the final bill which would require providers to utilize only evidence-based therapies for treating post-traumatic stress disorder (PTSD) and other mental health conditions as a stipulation for reimbursement. This will ensure veterans have access to the best treatments, VA is spending Choice program dollars wisely and will begin to make a concerted effort at the reduction of suicides among veterans.

While we understand the positive intent, NAMI strongly disagrees with the proposal which would restrict the Secretary in providing specialty hospital care or medical services, to include mental health care and substance use treatment, unless a referral for these specific services is made by the veteran's primary care provider. Research shows that requiring a referral from a primary care provider only acts as a barrier to care. Concerning behavioral health care specifically, we know that referral patterns illustrate a high number of drop-offs, often resulting in a lack of treatment for the veterans who need this care the most. It is imperative to meet the veteran when he or she has a need for mental health care and develop a system of care which allows veterans to seek a consultation and treatment without navigating an often-burdensome referral process.

NAMI does agree that primary care providers have an integral role in behavioral health care, however would suggest a slightly different approach. Recognizing that earlier intervention and treatment produces better mental health outcomes, coupled with the provider shortage in the behavioral health care field at VA and across America-utilizing primary care providers is necessary. Instead of involving PCPs in the referral process, NAMI suggests VA move towards broad integration of mental health care services in the primary care setting. This could be achieved by providing additional training to PCPs within the Department and in the regional provider networks by the adoption and wide dissemination of a pilot program developed by Dr. Sheila A.M. Rauch, PhD, a clinical psychologist at the Atlanta VA Medical Center (VAMC).

Dr. Rauch's program provides training for PCPs to 1) properly administer a PTSD screening tool to veterans, and 2) deliver 6 sessions of Prolonged Exposure (PE) Therapy, an evidence-based treatment for PTSD, to veterans in the primary care setting. Her data illustrates a significant drop in veterans screening positive for PTSD after receiving this treatment. In the case a veteran still screens positive for PTSD after receiving this treatment, the model had a mechanism in place for a direct referral to a mental health provider to assess and deliver more intensive sessions of Cognitive Behavioral Therapy (CBT).

VA's Legislative Proposal: The Veteran Coordinated Access and Rewarding Experiences (CARE) Act

Title I–Developing an Integrated High-Performance Network

Sec.101. Improving VA's Partnerships with Community Entities and Providers to Increase Access to Care Through Veterans Care Agreements

Although VA's proposal utilizes a different approach than the Committee's, NAMI sees benefits and disadvantages to each proposal. Authorizing the Secretary to increase access through Veterans Care Agreements-instead of creating regional provider networks-could be a way in which VA could contract to purchase reliable, high-quality care. However, NAMI believes in this case it would be too restrictive for providing increased access to care. NAMI underscores the importance of only entering into contractual agreements and reimbursing providers, community-based clinics and networks that utilize evidence-based therapies.

Title II–Streamlining Community Care Programs and Eligibility

Sec. 201–221. Subtitles A, B, C

NAMI agrees for the need to improve flexibility in the Choice Fund and to consolidate all existing Community Care programs and authorities into one program with a single set of eligibility criteria. One of the primary complaints NAMI receives from veterans on the current programs for accessing care outside of the walls of VA-including Choice, Community Care and Patient-Centered Community Care (PC3)-is the confusion regarding the eligibility and set of restrictions each program contains. Combining all of these programs for accessing care through community providers into one, streamlined program will make great strides in mitigating confusion and will expedite getting veterans into the care they need.

Rural Veterans

The Committee's discussion draft and VA's legislative proposal (CARE) each contain a section on giving the Secretary increased authority to negotiate a higher rate with providers, health care clinics or networks, and hospitals who serve eligible veterans residing in "highly rural areas." The definition that is used in each proposal would define the term "highly rural area" as a specific area in a county that has fewer than seven individuals per square mile in residence. NAMI believes this definition and criteria set-forth is much too specific for many reasons; the primary reason is illustrated by VA's recently released state-by-state report on the suicide rate among U.S. veterans utilizing 2014 as a sample year.[1]

Observing the top 10 rural states by population in the U.S., the suicide rate among veterans ranges between 45.7% (45 per 100,000) to 68.6% (68 per 100,000). Five of the 10 rural states reporting rates of veteran suicide over 50% (50 per 100,000). NAMI would encourage the Committee and VA to expand their definitions of rural veterans to simply "rural areas and states." In many rural areas and states, there are very few mental health professionals for hundreds of miles. Using Montana as a specific example due to the state currently having the highest rate of veteran suicides in the country, when examining the state's most recent Suicide Mortality Review Report illustrated that over half of Montana's veteran suicides during the reporting period, occurred in Montana's six most populous counties.[2] VA and Congress needs to ensure all rural veterans are able to receive timely access to high-quality mental health care.

Another solution to serve veterans in rural states that NAMI proposes is for VA to increase their utilization of telemedicine and telepsychiatry. Further, NAMI is supportive of H.R.2123, the Veterans E–Health and Telemedicine Support Act of 2017 or the VETS Act of 2017. We believe this legislation will allow for an increase in high-quality mental health providers to deliver care to veterans in rural settings.

Addressing the unmet Suicide Prevention needs of America's Veterans

In developing a permanent Veterans Choice/CARE Program, it was NAMI's desire to see specific language outlined in each proposal regarding the suicide prevention needs of America's veterans that are currently not being met. Recognizing that only 6 of the 20 veterans who die by suicide each day are under the care of VA,[3] it is clear that while the Department provides excellent mental health care in most cases, VA cannot go it alone.

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[1] Suicide Among Veterans and Other Americans, 2001–2014: Suicide Data by State. VA Office of Suicide Prevention. https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheets-VA–States.pdf

[2] 2016 Montana Suicide Mortality Review Report. Page 49. http://www.sprc.org/sites/default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf

[3] Suicide Among Veterans and Other Americans, 2001–2014. VA Office of Suicide Prevention. https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf

VA and Congress must work together with non-profit and advocacy organization partners to 1) better identify the predictive indicators and characteristics of the approximately 14 veterans not engaged in VA care, 2) recognize and detect the gaps in care which currently exist and 3) give the Secretary express guidance and authority to use existing VA Choice funds to contract with community and non-profit mental health networks and clinics to provide expedited access to evidence-based mental health care services. The Secretary should be provided with guidance to expedite the credentialing process for these community-based clinics to ensure they are delivering evidence-based therapies with same-day access to care, and can demonstrate effective clinical outcomes in the veterans they serve.

Conclusion

NAMI is grateful to Secretary Shulkin, Congress and this Committee for the continued focus on improving the access and quality of mental health care and substance use treatment for America's veterans. We wish to express our gratitude to the Committee for the invitation to submit a statement for the record to provide feedback on these legislative proposals, and the opportunity to weigh-in on the future of the Veterans Choice Program-an incredibly important program to veterans with mental health care needs.

It is a devastating tragedy that our nation continues to lose an average of 20 veterans each day to suicide. This is an issue of personal importance to me, the organization I represent and our membership. We continue to commit our organization to working shoulder-to-shoulder with Congress, VA, and our Veterans Service Organization (VSO) partners to achieve our shared goal of the reduction and elimination of suicide among veterans in America.

NATIONAL GUARD ASSOCIATION OF THE UNITED STATES (NGAUS)

Dear Chairman Roe, Ranking Member Walz, and other distinguished members of the House Veterans' Affairs Committee:

Introduction:

On behalf of the over 45,000 members of the National Guard Association of the United States (NGAUS) and the nearly 500,000 soldiers and airmen of the National Guard, we deeply appreciate this opportunity to share with you our thoughts on the legislation designed to reform the Veterans Choice Program for the record. We also thank you for your continued oversight to ensure accountability and improve Department of Veterans Affairs (VA) services to veterans and their families.

Since our inception in 1878, NGAUS has sought to ensure benefit eligibility and equity for the men and women of the National Guard. We are grateful for this Committee's work earlier this year in passing the Harry W. Colmery Veterans Educational Assistance Act, which was the most significant expansion of G.I. Bill benefits since the passage of the Post-9/11 G.I. Bill in 2008. Not only did that vitally important bill expand eligibility and increase educational benefits for all servicemembers, it also corrected a serious benefit inequity and provided access to educational assistance for Guardsmen and Reservists who serve under U.S.C. Title 10, Section 12304(a) and 12304(b) orders. With this legislation to reform the Veterans Choice Program, you have again proposed much needed changes to increase benefits equity and access to health care for our veterans of the National Guard.

Veteran Eligibility:

We greatly appreciate the opportunity to share our thoughts with you on your bipartisan effort to ensure the stability of the Veterans Choice Program for our veterans and their families. Currently, the program provides eligible veterans access to care through a comprehensive network of community-based providers and augments VA's ability to provide specialty inpatient and outpatient health care services to veterans. This access is critical for veterans who face wait times longer than 30 days for medical and mental health care or for whom a regular VA medical center is inaccessible. As you know, National Guard veterans face unique challenges in obtaining access to health care because, unlike the Active Component, access to health care is dependent on duty status and geographic location. Due to this Committee's collaborative efforts, we believe this legislation will mitigate those factors and continue to build upon the successful VA-centric model of increasing access to health care for our veterans.

We support the proposed provisions that permanently establish the Veterans Choice Program. The proposals aim to create a system that better delineates the cir-

cumstances where veterans can receive primary and specialty health care. This legislation does not take VA out of the equation. In fact, it puts the VA in the center of an apparatus that is targeted toward ensuring veterans receive access to health care. Only in cases where the VA is unable to assign their own primary health care provider will a veteran have the flexibility to choose a primary provider within their community from the contracted provider networks established by the VA. In cases where specialty care is required for a veteran, VA would also have priority to provide that care. We believe accountability and access to health care will increase because of these reasons and by requiring VA to continually evaluate on an annual basis whether there is capacity for veterans to be assigned to a VA primary care provider.

We are also pleased that this legislation eliminates arbitrary distance and wait time criteria for veterans to qualify for community-based health care from providers, especially when VA is unable to provide those services. By eliminating these provisions, it is better ensured that veterans are granted access to health care based on their individual medical needs and not where they live and/or how long they have waited for care. Community providers eligible under this new system include Medicare providers, Federally Qualified Health Center (FQHC) providers, Department of Defense providers, Indian Health Service (HIS) providers, academic affiliate providers, or any other health care provider that meets the criteria established by the VA Secretary.

We also support the proposed increased safeguards to protect veterans and their health records. Secure and confidential exchange of medical records between VA and private health care providers is essential. Under this legislation, medical records exchange will be required to adhere to HIPPA standards and health services undertaken by community-based providers will be added to a veterans' electronic health record through a system designed to do so. Additionally, in cases where copayments are required to be made by a veteran, we support the better defined and targeted limitations that would be put in place both on the amount and when a veteran is required to pay.

Access to Behavioral Health Treatment:

We would also like to convey our continued concern with the high rate of suicides throughout the military, especially among Reserve Component servicemembers. We greatly appreciate the efforts made by this Committee to try to improve the quality and access to behavioral health services for our servicemembers and veterans, but much more still needs to be done. NGAUS is eager to continue our work with this Committee to support and amplify numerous initiatives to provide increased resources for our members to more easily receive care within this legislation. As you know, veterans of the National Guard and Reserves face unique challenges when it comes to behavioral health care, especially compared to their Active Component counterparts.

While National Guard and Reserve servicemembers undergo annual health assessments to identify medical issues, any follow-up treatment is done at the servicemember's expense with a civilian medical provider unless they are within 180 days of a scheduled deployment. While TRICARE Reserve Select is an option for all members of the National Guard, the majority of servicemembers do not opt to enroll because it is prohibitively expensive. In fact, 25 percent of National Guardsmen (approximately 114,000 service members) do not have any sort of health insurance, which is a serious readiness issue in and of itself. NGAUS continues to support innovative solutions to increase treatment availability and access to VA medical facilities for our members.

For these reasons, we strongly support S. 1566, the CARE for Reservists Act of 2017, which is sponsored by Senator Jon Tester. This legislation was introduced in July and would expand eligibility for readjustment counseling at VA Veterans Centers to members of the National Guard and Reserves, including access to outpatient care from a certified mental health care provider should a Veterans Center individualized assessment determine that such care is necessary to facilitate successful readjustment to civilian life. Additionally, the bill would direct the VA, in consultation with the Department of Defense, to furnish mental health services for members of the National Guard and Reserves and allow the VA to provide mental health treatment for members of the National Guard and Reserves who served in classified missions.

Overall, we strongly believe the VA is uniquely positioned, in terms of its mission and infrastructure, to help close this gap in mental and behavioral health services for members of the National Guard and Reserves. The VA, through its Veteran Centers and health clinics around the country, plays a vital role in providing mental and behavioral care for those that come in and out of military life on a monthly

basis. As such, we believe it is essential to continue to expand mental health services, especially at the community level, in order to deliver evidence-based care to veterans whenever and wherever they are located.

Conclusion:

Thank you again for allowing NGAUS to submit written testimony to this Committee and for developing the legislation to reform the Veterans Choice Program. We urge your colleagues in the House to support this crucial legislation that will provide increased access to health care for our veterans and their families. We look forward to continuing our work together and cannot thank you enough for your steadfast leadership in advocating for the men and women of the National Guard.

Nurses Organization of Veterans Affairs* (NOVA)

ASSOCIATION OF VA PSYCHOLOGIST LEADERS*

ASSOCIATION OF VA SOCIAL WORKERS*

VETERANS HEALTHCARE ACTION CAMPAIGN

(*An independent organization, not representing the Department of Veterans Affairs)

Chairman Roe, Ranking Member Walz and Members of the Committee:

On behalf of our organizations, we would like to thank you for the opportunity to submit a statement for the record on the Veterans Choice Program redesign. We appreciate your leadership on this issue and the strong bipartisan spirit of collaboration to provide high quality healthcare for our nations' veterans.

We believe the current draft discussion language has several positive aspects for how to use community resources to supplement gaps in the provision of care. It also contains language that, as written, could potentially be harmful to the Veterans Health Administration (VHA) and the veterans who depend on it. The bill could accelerate a one directional flow of veterans' specialty hospital care and medical services out of the VHA and into the community. Choice care would be reimbursed first and the VHA would be forced to make do with remaining funds, thus draining VHA of staffing resources, and privatizing care over time. We provide examples of key aspects below.

Language that enhances the provision of care to veterans:

1. Right of First Refusal with Primary Care. The bill's most beneficial aspect is affording the Secretary the right of first refusal when a veteran establishes primary care. It allows local facilities the flexibility to determine whether they have a capacity of available health care professionals. If they do, the facility automatically becomes the care provider. This provision assures stability and predictability to VHA facilities in self-managing their primary care staffing and services.

2. Reappraisal of Capacity. After a veteran establishes primary care in the community, the bill authorizes the Secretary to conduct an annual reappraisal to determine whether the local VHA can resume being the provider for that veteran. This incentivizes facilities who have inadequate staffing to develop robust capacity. We have concern that directing a veteran's care back will be difficult to accomplish without explicit language that indicates the VHA can be newly established as the PCP if it has capacity at the point of reappraisal.

3. VHA as Care Coordinator and Case Manager. The bill identifies VHA staff to be the assigned as case manager of VA-community care coordination. This is a useful structure, and one that we have mentioned in previous testimony, but requires a significant increase in staffing. The bill doesn't recommend any additional funding for this role, so the net offset would be a reduction in staff that provides health care. Supplemental VHA allocations are warranted.

Language that erodes the VHA by diverting funds to the community:

1. Specialty Care Referral and Cost Control. Although the bill provides the Secretary a right of first refusal for primary care, a weaker prerogative exists for specialty care. Once a veteran receives primary care at a non-VA facility, ensuing referrals for specialty hospital care or medical services can easily bypass the VHA. The Secretary should be authorized to have the right of first refusal to provide specialty hospital care and medical services when it has the capacity to do so.

The language indicates that Choice providers only have to "consult" with the Secretary on specialty hospital care or medical services referrals. There is no process for VHA review and authorization of services. It is important to have an explicit requirement for Choice providers to "refer" back to VHA, and that VHA be required to oversee and control the provision of healthcare.

2. Demand/Supply Gaps. Although the bill allows local VHAs to define whether they have a shortage of available health care professionals, it does nothing to remedy shortages. Its' Annual Capacity and Commercial Market Assessments makes no mention of identifying the supplemental allocations and resources that are needed to address human capital and infrastructure gaps. Nor does it show how money flowing to Choice providers are impacting local facility staffing and services. We strongly affirm that strengthening and improving the VHA should go hand in hand with any Veterans Choice Program redesign. Without adequate funding, VHA shortages will be inevitable and services slowly eroded.

Language that undermines provision of quality care to veterans:

1. Double Standards for Timeliness and Quality of Care. The bill requires the Secretary to publically report every month the average wait time at VHA facilities. However, it does not require that Choice wait time data be obtained and published. Timeliness of Choice services—as well as all other aspects of performance, screenings and on-going training requirements—should be reported and held to the same high standards of VHA providers. Otherwise, care provided via Choice would be held to a lower standard than the VHA. This is a disservice to veterans. Finally, Choice providers should be required to continuously learn about the extent and quality of services the VHA provides, just as the VHA must do about the community.

2. PCP Referrals and Wait Times. At present, Choice wait time data are not published, therefore the Secretary is not able to use wait times in determining community providers' availability. A local VHA should be restricted from providing the veteran a list of available PCPs' until it first verifies that the providers on the list are more available than the VHA. It is well established that there exists and continues to be a growing scarcity of primary care physicians in the community.

3. Care Coordination via Medical Records. The bill gives network providers unlimited time to provide medical records to the VHA, and explicitly says they will be paid whether or not their records are late. There should be a penalty for undermining care coordination in this manner. Providers should be held accountable for any delay in care.

Once again, the Nurses Organization of Veterans Affairs, the Association of VA Psychologist Leaders, the Association of VA Social Workers and Veterans Healthcare Action Campaign thank the Committee for the opportunity to submit testimony on this critical topic. As health care professionals providing care and services to veterans across the country, we would be happy to assist with language in the final bill to accommodate any of the issues mentioned in our statement.

Contacts:

Nurses Organization of Veterans Affairs tmorris@vanurse.org
Association of VA Psychologist Leaders president1@avapl.org
Association of VA Social Workers president@vasocialworkers.org
Veterans Healthcare Action Campaign info@vhcac.org

PARALYZED VETERANS OF AMERICA (PVA)

Chairman Roe, Ranking Member Walz, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to provide comments on these critically important bills being considered before the Committee today. Since the establishment of the Veterans Choice program in 2014, VA has struggled with ever-changing requirements enacted by Congress to the program and significant new demand for these services. The uncertain nature of the Choice program over that time period caused unnecessary complications in the implementation of the program. However, the Department of Veterans Affairs (VA), with assistance from its community partners and the third party administrators, has made great strides to improve the program. The draft bills being considered today lead to the next logical step of solidifying this program once and for all. That being said, concerns still remain.

Draft Bill to Make the Veterans Choice Program Permanent

Draft "Veteran Coordinated Access & Rewarding Experiences (CARE) Act"

Given the similar nature of the two primary draft bills being considered regarding future of the Choice program, we will address the provisions of both bills together in our statement. We would like to say up front that we do not explicitly oppose either draft bill. However, we do believe that the bill presented by this Committee provides a much better path forward for the implementation of the Choice program. It is also important to understand that some of the provisions in both bills mirror one another.

Before the Committee takes steps to reform the delivery of veterans' health care in the community, it is important to affirm that specialized services are part of the core mission and responsibility of VA. As the Department continues the trend toward greater utilization of community care, Congress and the Administration must be cognizant of the impact those decisions will have on veterans who need the level of complex care that, more often than not, only VA can deliver. This includes VA's decision to continue concentrating all of its energy on expanding the Choice Program balanced against the need to demonstrate how it plans to make its own services more competitive with the private sector-a key component of the proposed high-performing network.

In recent months, VA has indicated that, along with improving the delivery of care in the community to veterans, it plans to concentrate on expanding and improving what it considers "foundational services." However, we have yet to see any indication of how this concept is defined. Moreover, we are troubled that VA is inclined to have local facilities determine what should be defined as foundational based on local markets. The Secretary has indicated that it considers spinal cord injury and disease (SCI/D) care and blinded care foundational services. However, he must make that policy unequivocally clear to all networks and all facilities. Additionally, we do not believe foundational services end with just those areas; there are many areas of service within VA that inform the principle of veteran-centric care. We appreciate the fact that the Secretary has committed to expanding SCI/D nurse staffing by approximately 1,000 new positions. Guidance has been directed towards the field to set aside approximately five percent of funds from special use funds to be used to augment foundational services. Unfortunately, we are not certain that the steps to set aside those funds are actually pointed towards strengthening those foundational services. These concerns about foundational services cannot be dismissed simply in the interest of focusing attention on more community care.

As we have stated repeatedly, any legislation designed to reform VA health care must incorporate or match the attributes that make VA's specialized services strong. For example, VA utilizes outcome-based standards of care across the SCI/D system, which, in turn, allows us to measure and scrutinize the quality of care provided. The system is governed by comprehensive policies laid out in Veterans Health Administration (VHA) Directive 1176 and the corresponding handbook governing procedures. These authorities require VA to track the SCI/D population in a variety of ways, specifically capturing data on outcomes. When individual facilities are lagging behind, the evidence is not just anecdotal. VA's facilities are also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission. When the entire system is questioned, Congress can commission an independent assessment, similar to the one carried out as part of the original Choice legislation. VA officials can also be called to testify about the conditions of care in VHA facilities.

Congress should examine more closely how VA will monitor the quality of care veterans are receiving in the community. This question goes beyond a plan for care coordination. If VA is unprepared to retain ownership of responsibility for care delivered in the private sector, Congress will be helpless in conducting adequate oversight. Moreover, it places a spotlight on one of the fundamental principles of both bill that presumably dictates access to community care-VA facilities not meeting an undefined quality standard. Clear comparisons need to be made between the VA and the local community when decisions about choice are made to ensure that unbiased decisions are made.

With this in mind, PVA strongly supports the concept of developing a high-performing integrated health care network that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. The Committee's draft proposal clearly considers this concept at the center of its bill. The VA has emphasized all along that it would like to evolve into a dynamic, high-performing network model. And yet, the proposed CARE Act does not address the need for a high-performing network at all. VA apparently be-

lieves it has the authority to establish such a network without Congressional approval. We disagree. Absent a clear plan with the design of a fully-integrated health care network, we defer to the concepts proposed in the Committee draft bill as the best path forward.

PVA believes, like many stakeholders and members of Congress, that the definition of an integrated VA network is one that utilizes private providers to supplement, not supplant, the VA health care system. Unfettered choice of provider granted to all veterans is not a realistic or financially viable basis for a healthy VA health care system capable of sustaining critical, veteran-centric, specialized services. In fact, at the end of the Committee round table held earlier this month, Chairman Roe emphasized that the notion of unfettered choice is a false choice. He explained that the only people who get unfettered choice in their health care in America are those who pay completely out of pocket. Otherwise, all other people seeking health care do so through variously defined types of managed care. This is a critical point as some continue to advocate for unfettered choice within VA. It is cost-prohibitive and, in many cases, leads to fractured care as veterans attempt to navigate the private health care system without managed care coordination.

We believe that the design and development of VA's network must be locally driven using national guidance, and it must reflect the demographics and availability of resources within that area. VA has taken the first steps toward this goal by conducting its pilot market assessments using three individual VHA facilities and their surrounding health care markets. Unfortunately, none of the stakeholders, particularly in the VSO community, have seen the findings and methodology developed from these test markets. If that methodology does not include a component that considers the actual wants and needs of veterans in the given community (market), then we believe it is a flawed process.

Our philosophy is that the development of VA's network of providers should be locally driven, contemplating demographics, demand and availability of resources within that particular area. It is more, though, than just filling access gaps. Quality, both within VA and in the community, is inextricable from this analysis. It should be a critical factor in determining whether VA should continue to offer a service or if it should capitalize on segments of the community that are already delivering that service with excellent results. Similarly, just because VA is offering poor quality in a particular service line does not automatically mean there is a second choice available in the community. VA is obligated to raise the quality in its own house in those circumstances. Moreover, the Committee bill requires that the VA publish its wait times on a monthly basis seemingly as a measure of quality and as a means to determine potential access to community care. We recommend that wait time data for all facilities with each health care market, to include VA and private providers, should be provided to afford veterans a clearer perspective. A well-balanced network that supplements service gaps in VA's system sets a natural boundary for the network. It is efficient and preserves VA core competencies and specialized services such as spinal cord injury and disorder care.

PVA supports the Secretary's plan to move the Department away from the current 30-day/40-mile eligibility standards in favor of a case-by-case clinical determination. The Committee's draft bill targets the same desired end goal. Access decisions dictated by arbitrary wait times and geographic distances have no comparable industry practices in the private sector. This change would shift the organizational mindset and focus of VA to clinical outcomes instead of catering to arbitrary metrics governing access to care in the community. We have consistently advocated for this proposition before Congress and the administration, stating that eligibility and access to care in the community should be a clinically-based decision made between a veteran and his or her doctor. Establishing appropriate eligibility standards will be an integral part of a sustainable network.

We do remain concerned that the Committee draft bill sets up a scenario all but asking the VA to fail by requiring an annual capacity assessment of each VISN and VA medical center. The administrative burden of doing this on an annual basis will almost certainly lead to bad information and incomplete data. These assessments should be spread out to be done less frequently. Considering that it took months for VA to complete three pilot market assessments, we cannot see how VA will effectively accomplish this task. Fortunately, in discussions with the Committee, there is clearly an openness to modifying this requirement to better align with the capabilities of the VA to complete these important assessments on a recurring basis. It would also align expectation with what is currently being debated in the context of the "Asset and Infrastructure Review Act."

VA will be able to make greater strides, especially in rural areas, if given the ability to bring more community providers into the fold with flexible provider agreements. The current requirement that providers enter into agreements with VA gov-

erned by the federal acquisition regulation (FAR) system has suffocated VA's attempts to expand access to care in a timely manner. Smaller health care provider organizations otherwise disposed to serve the veteran population are especially resistant to engaging in the laborious FAR process. And yet they remain vital to filling the gaps in health care services in certain areas.

The CARE proposal focuses a great deal of attention on the need for provider agreements establishing the authority for Veterans Care Agreements. We are pleased to see that the proposed Committee bill also provides for the authority to enter into Veterans Care Agreements. PVA, along with our partners in The Independent Budget-DAV and VFW-have strongly supported the need to give VA this authority over the last two years. These agreements are critical to filling gaps that may be left by an integrated network.

One area of this debate that has received very little attention is that of Native American veterans and the Indian Health Service (IHS). The VA CARE Act does not explicitly address the existing agreements with IHS and tribal governments. Due to the unique relationship that exists between VA and IHS and tribal governments, we urge the Committee to revise the draft language in its bill so it does not consider IHS and tribal health programs (THPs) as part of the core provider network. This request was made explicitly clear by tribal governments during consultations with VA in 2015 and 2016. IHS and THPs must be allowed to continue to set up agreements directly with VA as part of the government-to-government relationships. According to the VA's 2016 Tribal Consultation Report tribes have uniformly opposed any proposal to consolidate IHS and THPs into a standard community care program.

VA responded to the tribes' concerns stating that they will "ensure VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA." It is our understanding that VA intends to hold these agreements harmless from the impact of the CARE Act. However, VA has not provided any details on how IHS and THPs will be treated in their proposal should the national IHS–VA Reimbursement Agreement expire on June 30, 2019, as it is currently scheduled to do. It appears THPs and IHS would be relegated to community provider status which would disrupt the care currently being provided to 9,000 unique Native American veterans among the 99 tribes who had finalized agreements at the end of 2016. PVA urges Congress and VA to ensure the legislation put forward dutifully fulfills the federal trust responsibility to provide access to health care eligible native veterans.

PVA, along with our partners in the VSO community, continue to advocate for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care. This is consistent with current health care trends, and greater utilization could provide a relief valve to VA emergency services, the Choice Program, and the system as a whole. VA previously proposed in its Plan to Consolidate Community Care Programs a more common sense determination of what constitutes reimbursable emergency and urgent care, thereby expanding access, but it came with the imposition of cost-sharing for otherwise exempt veterans. We strongly oppose co-payments for veterans who are currently exempt. Using co-payments as a means to discourage inappropriate use of emergency care by service-connected veterans is not an acceptable method of incentivizing behavior. Unfortunately, the VA's proposed CARE Act retains the possibility of all eligible veterans having a co-payment requirement to access "walk-in care," albeit with the Secretary having discretion to limit the co-payment requirements based on Priority Group. What the CARE Act fails to do is exempt all veterans who currently are not required to pay any co-payments from paying when they access "walk-in care." Any final legislation should affirm this exemption unequivocally.

While there was the promise of an urgent care benefit from the VA's originally proposed community care plan, the proposal has evolved to provide access to community walk-in care clinics within the community care network. It remains unclear whether this is a departure from urgent care in favor of retail minute clinics, and whether it has also curtailed the number of eligible providers to those who are within the community care network. Given the disparity in quality and scope of care provided between urgent care and retail minute clinics, we would encourage this committee to seek further clarification from VA. We would also encourage the Committee to add an urgent care component to its own draft proposal or to whatever final version of this legislation is passed.

PVA continues to have serious concerns about the funding mechanism for community care going forward. The Independent Budget, as well as many of our partners in the VSO community, have advocated for moving all funding authorities for the Choice program (and other community care programs) into the discretionary ac-

counts of the VA managed under the Medical and Community Care account. The Committee draft bill clearly makes this necessary change. Unfortunately, the CARE Act is unclear at best on how it addresses this question. Our interpretation of the VA's proposal is it retains the mandatory funding stream for community care. This is a wholly unacceptable proposition. Every member of this Committee and all stakeholders in this debate know that this program should not be funded through a mandatory funding mechanism. And yet, the VA insists on carrying this bad practice forward, presumably at the urging of the Office of Management and Budget (OMB), which should have no say in this matter. The Committee should without question enact the provisions included in its draft bill that would ensure proper alignment of funding authorities in the discretionary budget of the VA.

Additionally, as long as the VA continues to propose a mandatory funding proposal, we will have to deal with the unacceptable mandatory pay-for issue that the Administration continues to bring forward. A reasonable debate can be had on the merits of rounding down the cost-of-living adjustment (COLA) or on the amount that should be provided for flight school training under the provisions of the Post-9/11 GI Bill. What is not acceptable in this debate is the notion that veterans benefit reductions (benefits for service connected disabled veterans in the case of the COLA in particular) should be used to pay for access to health care, to include for non-service connected disabled veterans, in the community. The American public will not accept Congress reducing any type of veterans benefit simply because the Administration and Congress are unwilling to properly fund the expansion of health care services in the community.

Finally, PVA believes that the Committee and VA need to seriously consider the consequences for veterans when they are injured during the course of their treatment in the community. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability or health problem is incurred. Under 38 U.S.C. § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility or as a result of care delivered by a VA provider. When PVA questioned VA as to whether these protections are conferred to veterans being treated in the community, VA officials confirmed in writing that this protection, as a matter of law, does not attach to the veteran in such circumstances. If medical malpractice occurs during outsourced care, the veteran must pursue standard legal remedies instead of VA's non-adversarial process. Adding insult to literal injury, veterans who prevail in a private action are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. These include treating the resulting injuries as service-connected conditions, such as a botched spinal surgery resulting in paralysis where the veteran did not provide adequately-informed consent. It also includes access to adaptive housing and adaptive automobile equipment benefits should the veteran require these features. Furthermore, the limits on these monetary damages vary from state to state leading to disparate results for similarly-situated veterans. The disparity in outcomes and the different processes by which they are achieved are unacceptable. This Committee and Congress must ensure that veterans are treated equally and that these protections follow the veteran into the community.

Ultimately, we believe the House draft proposal is a much better proposal for the future of the VA's community care program. It more adequately addresses longstanding concerns the VSO community has expressed about how to provide access to community care and how to ensure proper coordination of care. The mechanics of how it expects the VA to operate an integrated community care network are clearer. It places the proper focus on how community care should be funded going forward, recognizing that this will still be a difficult problem to overcome. The draft CARE Act leaves too many unanswered questions. The VA claims that it has a plan currently being reviewed by the White House and OMB to implement a future community care program. However, it has chosen not to share that plan with any key stakeholders. Without a clear plan for how VA intends to execute the delivery of community care for veterans, and given the clearly unrestricted authorities the draft CARE Act provides that could allow VA to go in any number of directions for delivery of those services, including a very significant expansion into the community, we believe the Committee should move to advance its own proposal incorporating key aspects of the VA draft into the final bill.

H.R. 1133, the "Veterans Transplant Coverage Act of 2017″

PVA supports H.R. 1133, the "Veterans Transplant Coverage Act." This legislation gives VA the authority to provide organ transplants to veterans from a live donor

regardless of veteran status of the donor or the facility they are in. Under the current Choice program, veterans in need of organ transplants are denied due to the program's eligibility requirement. If a living donor is not a veteran, the transplant coverage is denied if the surgery is not performed at a VA facility. However, due to the very access problems that prompted the Choice program-long distance travel, inaccessible transportation, etc.-these veterans are unable to receive the care they so desperately need. Whether or not a veteran receives a necessary organ transplant should not depend on who or where the donor is.

H.R. 2123, the "Veterans E–Health and Telemedicine Support (VETS) Act of 2017"

PVA supports H.R. 2123, the "Veterans E–Health and Telemedicine Support (VETS) Act of 2017." This bill would improve access to telemedicine services from the Department of Veterans Affairs. Under current law, VA may only provide at home telehealth to a veteran if the physician and veteran are in the same state. This requirement can be a particularly troubling barrier for veterans who have specific medical or mental health needs, have moved, or live in rural communities without providers. This bill would alleviate some of these pressures by waiving the instate requirement, allowing VA health professionals to operate across state lines.

H.R. 2601, the "Veterans Increased Choice for Transplanted Organs and Recovery (VICTOR) Act of 2017"

PVA supports the intent of H.R. 2601, the "Veterans Increased Choice for Transplanted Organs and Recover Act of 2017." This bill would amend the existing Choice Program to allow veterans who live more than 100 miles from one of VA's fourteen transplant centers to seek care at federally certified, non-VA facilities. This legislation would seemingly improve access for veterans in need of organ transplants. However, it does not address the barriers to care for those veterans who live less than 100 miles of a transplant center. As we have seen over the lifetime of the Choice Program, arbitrary distance and time measurements can complicate an already confusing community care system. Much as the discussion about the future of community care in the VA has trended towards decision-making based on clinical need, we would like to see access to transplant services in non-VA facilities be based on clinical need and quality of care rather than an arbitrary mileage standard.

H.R. 3642, the "Military Sexual Assault Victims Empowerment (SAVE) Act"

PVA supports the intent of H.R. 3642, the "Military Sexual Assault Victims Empowerment (SAVE) Act." This legislation would establish a three year pilot program to furnish non-department medical care to eligible military sexual assault survivors in five locations. PVA believes Congress must enable VA to provide timely, high-quality care for veterans struggling with military sexual trauma (MST). However, it is unclear how this legislation as written will achieve that end.

The bill states the Secretary may not restrict which community provider a veteran chooses to receive care from. We would argue that such a suggestion is misleading to veterans as the participating provider must accept the payment rates of any contract the provider is already in or the rates pursuant to section 1703 of title 38, United States Code. A veteran's choice of private provider will be unimpeded provided their chosen provider accepts the established rates. It is with this in mind that we point out VA already has the authority to contract for care in the community for the treatment of MST. It is unclear what the proposed pilot would make available that is not already.

We are not convinced that the current state of VA care and contract authorities necessitates this pilot. While VA does still struggles to increase its capacity, and provide timely access to care, they are not in isolation. The same barriers to care, wait times and provider shortages, often exist in the private sector. Further, this bill makes no mention of how or if the care will be coordinated with VA. MST survivors often have multiple comorbidities and need access to services such as primary care, substance abuse treatment, housing, disability benefits and travel assistance. MST coordinators are available at every VA medical center to help veterans to access these services.

Currently all VA mental health and primary care providers must complete mandatory trainings on MST and trauma-related disorders as specified by VHA Directive 2012–004. These issues may not be commonly found in the community. There

is no assurance that private providers have any such specialized training in evidence-based treatments for MST.

Draft Bill Regarding State Homes and Other Purposes

PVA generally supports the draft bill addressing state homes and other purposes. Section 1 of this proposal seeks to modify the authority of VA to enter into agreements with state homes by striking contract authority under 1720(c)(1) and relying solely on "agreements." These agreements could be entered into without the requirement that the Secretary use competitive procedures to select the party. Further it would stipulate that the partnering state home would not be subject to any law to which providers of services and suppliers are not subject to under Medicare and Medicaid programs. PVA supports the efforts to make available to veterans the long term services and supports they need and that VA be able to do so in a timely manner.

Section 3 seeks to encourage individuals to fill graduate medical education residency positions that were established by the Choice Act. The Secretary would be charged to carry out a program of educational assistance to recruit applicants. While PVA supports such intent the legislation as written is not clear what the education assistance would look like; whether it be loan forgiveness, competitive compensation, or other incentives. Similarly, there is little illumination as to how the length of the period of obligated service is to be determined.

PVA believes VA must be adequately resourced to attract the best and brightest medical professionals. There is a current and worsening provider shortage in the United States and VA must take steps to see that the veterans community be the least affected by this trend. By providing competitive incentives in exchange for a period of service, VA would become a reasonable choice for residency. Competitive incentives and loan assistance for residents can cultivate a culture of commitment by those unburdened by debt and revive areas too long stressed by continuous shortages.

Lastly, Section 4 appears to be duplicative of the intent of H.R. 2123, the "VETS Act of 2017." PVA supports the expansion of the use of telemedicine regardless of the state patient and physician are located in and would encourage the Committee to consider either of these provisions to accomplish the desired end.

Draft Legislation Regarding the Veterans Crisis Line

PVA generally supports the intent of the draft legislation that would require greater reporting and analytics of the Veterans Crisis Line (VCL). The information required by the legislation could prove invaluable in analyzing the function and efficacy of the VCL and the patterns of veterans who reach out to the VCL. However, we have a serious concern about this effort. We wonder how the Committee believes that this information that would allow individual veterans to be tracked for data collection purposes can be obtained from a veteran, who is in crisis, without potentially upsetting them further? Exactly what does the Committee believe the reaction of a veteran in crisis would be if the VCL representative asked for his or her name and last four numbers of the Social Security number in order to open up the "log" for tracking the data about that individual? That would almost certainly exacerbate the situation.

Furthermore, the bill can be interpreted as though it would blame VA in instances where veterans commit suicide. But it does not address the circumstances of the nearly 70 percent of veterans who commit suicide who never touch VA in any way. We are more interested in knowing why those veterans do not come to VA; or where are they going for help if not VA; and what is the efficacy of that support in the community. This bill certainly is well-intentioned. The information that it seeks could certainly be valuable, but at what risk. The Committee should be very careful as it pursues the information that this draft bill seeks.

Mr. Chairman and Ranking Member Walz, we would once again like to thank you for the opportunity to share our thoughts on these critical measures. The impact of this legislation could set the course for health care delivery in the VA for many years to come, so it is important that we get this right. We cannot simply rush to a final conclusion just to claim victory. We look forward to working with each of you, the members of this Committee, and the respective staffs to ensure that VA is best positioned to deliver on the promise of the timely, quality health care in the most appropriate setting.

Thank you again. We would be happy to take any questions for the record that you may have.

RESERVE OFFICERS ASSOCIATION (ROA)

Dear Chairman Roe and Ranking Member Walz:

The Reserve Officers Association of the United States represents all seven of our nation's uni-formed services, both non-commissioned and commissioned officers in the Reserve and Guard Compo-nents. Under our 1950 Congressional charter, our purpose is to promote the development and exe-cution of policies that will provide adequate national defense. We do so by developing and offering exper-tise on the use and resourcing of America's Reserve and Guard Components.

The association is pleased to provide this letter of support for legislation to establish a permanent Veterans Choice program. We appreciate the continued bipartisan leadership of the committee, the dedication of the Members and the hard work of the professional staff, all who are devoted to en-hancing and improving the VA community care system. Additionally, we thank the committee for allowing ROA to improve and enhance the bill through offered technical corrections.

In particular, we thank the committee for adding legislative language granting the VA Secretary greater flexibility in giving priority for specialty care to VA medical facilities and for giving veter-ans more community care options. Specifically, once a veteran is enrollment in VHA care the VA will assign them a primary care provider. If the VA cannot assign that veteran to a VA primary care provider because of a shortage of healthcare personnel, the veteran may select a community primary care provider from a list of available networks. Factors such as the burden of travel, geography, envi-ronmental factors, the veteran's medical condition, and any recommendations from the primary care provider will all be considered.

While the bill is not a "pathway to privatization" it also does not take away VA benefits from the veterans. We believe this important bill ultimately benefits all veterans because it provides flexibil-ity and options which are not currently available.

Thank you again for your strong efforts to improve health care choices and flexibility for our military community, especially members of the Reserves and National Guard. Please have your staff call John Rothrock, ROA's legislative director, at 202–646–7713 or e-mail at jrothrock@roa.org with any questions or issues you would like to discuss.

Sincerely,

Jeffrey E. Phillips
Maj. Gen., USA (Ret.)
Executive Director

UNIVERSITY OF CALIFORNIA, RIVERSIDE

October 23, 2017

The Honorable Phil Roe, MD
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

The Honorable Tim Walz
Ranking Member
House Committee on Veterans Affairs
333 Cannon House Office Building
Washington, DC 20515

Dear Chairman Roe and Ranking Member Walz:

On behalf of the University of California, Riverside (UCR) School of Medicine, I want to thank you both for your strong support of Graduate Medical Education (GME) at the U.S. Department of Veterans Affairs (VA). The 1500 new GME slots that were created in the Veterans Access, Choice and Accountability Act of 2014 ("Choice Act") have been a boon to Inland Southern California, which is a medically-underserved region with a high population of low-income and minority veterans. The Choice Act has allowed the UCR to have an academic affiliation with the VA Loma Linda Healthcare System ("Loma Linda") and to apply for new GME slots to treat veterans in Community Based Outpatient Clinics (CBOCs).

You may know UCR has a new School of Medicine, which graduated its first class of medical students this spring. Our School is the first public medical school on the West Coast in over 40 years and it is desperately needed to address the physician shortage we face. But the new medical school is not enough-we must also have local GME opportunities for our graduates if we are to retain them in Inland Southern California. As you work to craft a Choice Act 2.0, and in response to recent draft legislation, UCR would like to offer the following comments for the record:

Sec. 3 Program to Fill Graduate Medical Education Residency Position of Department of Veterans Affairs

- The draft legislation proposes the VA would cover the cost of a medical resident in exchange for a post-residency service contract that is to-be-determined. However, this offers no incentive to the resident whose bottom line would be no different if that resident accepted any other position. VA academic affiliates could benefit from this proposal, but residents would not. As a result, medical students from poorly-performing for-profit medical schools overseas may be more inclined to accept residency positions under the proposed program. In order to maximize benefit to the residents and the VA, UCR strongly encourages the Committee consider a student loan forgiveness program instead in exchange for VA service obligation. The Indian Health Service runs a similar program.
- It is unclear, as the draft legislation is written, if this new program would apply to all of the unfilled GME slots from the Choice Act. If so, UCR asks you to revisit this proposal. New medical schools, like UCR's, are still in the process of building our clinical faculty and GME programs. The Choice Act initially allowed for five years for academic affiliates to fill all of the 1500 GME slots and, last year, Congress passed legislation that extended that time period to ten years. The additional five years will be critical for new medical schools like UCR and we hope to continue to apply for new slots.

Sec. 4 Practice of Health Care Professional of the Department of Veterans Affairs Providing Treatment, Including Treatment Via Telemedicine

- The draft legislation proposes that VA healthcare professional may provide healthcare to veterans, including telemedicine, "at any location in any State regardless of where in a State the covered health care professional or the patient is located." It is unclear if medical residents are included in the definition of "covered health care professional" and UCR encourages they be so included. As you know, medical residents play a critical role in veterans' health care. Furthermore, this new program would benefit veterans in rural communities where private facilities exist, but VA facilities do not, such as the communities surrounding Joshua Tree and Twentynine Palms in San Bernardino County, and it would have tremendous impact on rural telemedicine.
- UCR supports efforts that would allow VA health care provides to give care to veterans across state lines through, especially through telemedicine. This would greatly ease the burden on disabled veterans who could be treated from the comfort of their own home.
- UCR also supports streamlining the process for adding non-VA facilities to the approved mix of clinical locations through "sole source leasing authority." This would allow clinics like UCR's new medical clinic in downtown Riverside to host pop-up clinics for veterans. UCR believes this is necessary as the City of Riverside has a high homeless and low-income veterans population and the nearest VA CBOC in Riverside County is a one-hour commute by public transportation followed by a 1.5 mile walk-very difficult for a disabled veteran.
- UCR encourages the Committee to consider including indirect cost or overhead payments in addition to clinical treatment costs. New medical schools like UCR's that do not have a longstanding academic affiliation with a VA healthcare system and that do not have joint faculty appointments struggle to make these new GME programs financially viable due to the lack of overhead reimbursement from the VA. This disadvantages new medical schools, many of which are being set up to serve rural communities and areas with physician shortages.
- UCR also supports the proposed report on the effectiveness of the use of telemedicine.

Not Included

- UCR strongly encourages the Committee to support housing reimbursement for residents in VA GME programs in rural areas. This would allow the VA and its residents to better serve rural communities. For example, UCR's residents would like to serve the CBOC in Blythe, California, which is located 165 miles

or 2.5 hours from campus and is 98 miles or 1.5 hours from Indio, California, which is the nearest major city on the I–10 freeway. For residency accreditation purposes and personal health reasons, residents cannot drive back and forth to Blythe-they must be housed locally.

Again, I want to thank you for your support of VA GME programs and for the opportunity to comment. I am grateful for the Choice Act programs and am excited about positive changes that we can make through Choice 2.0. The spirit of the draft legislation is positive and it provides a strong starting point. I hope you find my comments to be constructive and helpful as you make positive changes to the Choice GME program to more effectively benefit residents and veterans.

Sincerely,

Deborah Deas, MD, MPH
Mark and Pam Rubin Dean of the School of Medicine
CEO for Clinical Affairs
University of California, Riverside
CC: The Honorable Mark Takano

UNIVERSITY OF PITTSBURGH

STATEMENT OF DR. ABHINAV HUMAR
CHIEF, DIVISION OF ABDOMINAL TRANSPLANTATION SURGERY
UNIVERSITY OF PITTSBURGH
ON
"LEGISLATIVE HEARING: H.R. 2601 VETERANS INCREASED CHOICE FOR TRANSPLANTED ORGANS AND RECOVERY ACT OF 2017"

OCTOBER 24, 2017

Chairman Roe and Ranking Member Walz,

Thank you for the opportunity to provide testimony regarding Representative Neal Dunn's legislation: H.R. 2601 Veterans Increased Choice for Transplanted Organs and Recovery Act of 2017 or, the VICTOR Act. I am grateful to Dr. Dunn for offering this legislation and offer my strong support for it. It is my hope that the House and Senate Veterans Affairs Committees will support this legislation and include it in legislation that continues to allow veterans to receive care in the community.

A bit of background on myself: My name is Abhinav Humar, MD. I am currently employed by the University of Pittsburgh where I am a professor of transplantation surgery as well as the chief of the abdominal transplantation surgery division and Director of the Thomas E Starzl Transplant Institute. I specialize in intestinal, kidney, liver and pancreas transplants with a specialized focus on living donor liver transplant and pediatric kidney transplants. I have been published over 300 times in various medical journals and publications on topics related to organ transplant medicine. My curriculum vitae has been submitted with this testimony.

In my capacity as a transplant surgeon, I have performed numerous transplants on veterans at the Veterans Affairs (VA) Pittsburgh Healthcare System and this is where I first learned of the VA's policies pertaining to veterans seeking an organ transplant, either kidney or liver transplants. There are currently 6 VA transplant centers (VATC) that perform liver transplants and they are: Portland, Madison, Houston, Nashville, Richmond and Pittsburgh. A veteran must travel to one of those six facilities to receive a transplant. The Veterans Access, Choice and Accountability Act of 2014[1] (hereinafter "Choice Act") does not apply to organ transplant surgery and therefore the veteran is not eligible to receive a transplant in a non-VA medical facility regardless of the distance that a veteran must travel to a VATC.

As a physician, the standard that I apply is the best medical interest of the patient or veteran. Is it in the best medical interest of the veteran to travel a significant distance to receive a transplant? The medical research that has been conducted on this topic clearly indicates that VA's current policy that requires a veteran to travel to a VATC to get care, regardless of distance, is not in the best medical interest of the veteran. A 2014 study published in the Journal of the American Medical Association states, "Among VA patients meeting eligibility criteria for liver transplantation, greater distance from a VATC or any transplant center was associated with lower likelihood of being waitlisted, receiving a liver transplant, and greater

[1] Public Law 113–146

likelihood of death."[2] In other words, the farther a veteran is from a transplant center the less likely they are to get a transplant and the more likely they are to die. There is no rational basis, based upon medical research, that would justify the VA forcing a veteran to travel a significant distance to receive a liver transplant from a VATC when a civilian transplant center exists closer to the veteran's home.

Dr. Dunn's legislation is straight forward and common sense in my opinion. It amends the Choice Act to explicitly cover organ transplants and applies a distance metric of 100 miles or greater from a VATC. If the veteran lives 100 miles or more from a VATC, the veteran can then choose whether they want to travel to a VATC for treatment or seek care at a civilian transplant center closer to their home.

The primary reason to support Dr. Dunn's bill is that it is in the best medical interest of the veteran. Allowing a veteran to receive an organ transplant at a transplant center closer to their home increases the chance that the veteran will receive an organ and increases their chance of survival. It will reduce the travel requirements for a veteran who must travel to the assigned VATC for the transplant operation as well as preand post-operation care. It will increase the opportunities for the veteran's family to be present to support their recovery. It will allow veterans to avoid the prolonged in-patient care that is associated with being medically cleared for extended travel following the transplant operation. It is simply a veteran friendly bill that will improve the quality of care for veterans who require organ transplants.

The system that VA currently has in place is problematic because it artificially inflates the demand for organs in certain regions but supply remains constant. Currently, the Organ Procurement & Transplantation Network[3], which is administered by the Health Resources and Services Administration divides the United States into 11 regions. Using livers as an example, the VA forces all veterans in the United States into the 5 regions where the 6 VATCs that conduct liver transplants are located even though the veterans may not live in those regions and therefore the veteran population does not get the opportunity to benefit from the total supply of organs within the United States.

To illustrate this problem, I will use an example of a veteran located in Panama City, FL, who needs a liver transplant. VA assigns him or her to the Pittsburgh VATC which performs the most liver transplants of the 6 VATCs. Florida is in Region 3[4] and in 2016 there were 1,392 livers donated. The 2017 liver waitlist for Region 3 consists of 1,269 people waiting to receive a matching liver. To put it simply, if you live in Region 3 and you need a liver, there is a healthy supply of donated livers as compared to demand and you have very good chance of getting one. However, the veteran in Florida does not get to benefit from that robust supply. Instead, VA assigns them to the Pittsburgh VATC which is located in Region 2[5]. Region 2, in 2016 had 1,172 livers donated and the 2017 liver waitlist for Region 2 consists of 2,058 people waiting to receive a matching liver. As you probably noticed, there are significantly more people in Region 2 who need a liver than livers donated and VA is making that problem worse by forcing veterans into the region which inflates demand. This requirement is not good for the veteran and it is not good for a civilian who needs a liver transplant because it diminishes every patient's chance to receive a matching liver.

H.R. 2601 is legislation that puts the best medical interest of the veteran first. It allows the veteran to receive lifesaving care closer to home while also allowing all veterans who need an organ transplant to benefit from the total supply of organs within the United States and not just the organ supplies in the regions where VA has located the VATCs. I hope you will support Dr. Dunn's legislation and include it in the upcoming legislation that is to replace the Choice Act. Thank you for the opportunity to submit this testimony.

VIETNAM VETERANS OF AMERICA (VVA)

Submitted by
Rick Weidman

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[2] Goldberg, David S., "Association of Distance From a Transplant Center with Access to Waitlist Placement, Receipt of Liver Transplantation and Survival Among US Veterans." Journal of the American Medical Association 311.12 (2014) 1234–1243.

[3] https://optn.transplant.hrsa.gov/members/regions/

[4] Region 3 Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi and Puerto Rico. https://optn.transplant.hrsa.gov/members/regions/region-3/

[5] Region 2 Delaware, DC, Maryland, New Jersey, Pennsylvania, West Virginia and Northern Virginia. https://optn.transplant.hrsa.gov/members/regions/region-2/

Executive Director for Policy & Government Affairs

Regarding

Draft legislation to amend title 38, United States Code, to establish a permanent Veterans Choice Program, and for other purposes; Draft legislation to amend title 38, United States Code, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs, and for other purposes; H.R. 1133, Veterans Transplant Coverage Act of 2017; H.R. 2123, VETS Act of 2017; H.R. 2601, VICTOR Act of 2017; H R. 3642, Military SAVE Act; VA Draft legislation Veteran Coordinated Access & Rewarding Experiences (CARE) Act; Draft legislation to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line and Draft legislation direct the Secretary of Veterans Affairs to furnish mental health care to veterans at community or non-profit mental health providers participating in the Veterans Choice Program

October 24, 2017

Amended

Good morning, Chairman Roe and other distinguished members of the Committee. Vietnam Veterans of America (VVA) is pleased to provide our Statement for the Record sharing our views concerning pending legislation before this committee.

Draft legislation to amend title 38, United States Code, to establish a permanent Veterans Choice Program, and for other purposes.

This draft legislation makes a number of changes and improvements to the VA health care system. The Veterans Choice Program established in Section 101 is generally in line with the Secretary's plan and vision. VVA supports the elimination of the arbitrary 30 day and 40 mile requirements. Eligibility based on clinical need simplifies the process for both provider and veteran, making it a much more veteran centric program.

Additionally, the consolidation of care authorities and the authorization of veterans care agreements are two big legislative asks that the Secretary has been highlighting for over two years. These changes not only increase access to care but help streamline the process for a successful implementation and transition.

VVA has no objection to Section 202 of the draft legislation which authorizes the Secretary to reimburse for emergency ambulance services if the request was made as a result of a sudden onset of a medical condition where a prudent layperson who possesses an average knowledge of health and medicine would have reasonably expected that a delay in seeking immediate medical attention would have been life threatening or could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in jeopardy and the individual is transported to the closest most appropriate medical facility.

While we support the draft legislation, VVA would like to note that a priority of any legislation should be to restore the capacity of the Veterans Health Administration. We understand that VHA is struggling to fill 14,000 clinical positions. Additionally, purchasing care in the community, while necessary, should not be the focus of transforming VHA, rather preserving the health care system built to address the maladies of wartime veterans, should be. We oppose any pretense of privatization of the VA health care system.

Draft legislation to amend title 38, United States Code, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs, and for other purposes.

Section 1 would modify the authority to enter into agreements with State Homes to provide nursing home care. Importantly, these agreements are excluded from certain Federal contracting provisions, making it a much faster and more fluid process. This will allow the Secretary to provide quality, appropriate, care in a timely manner.

Section 2 provides authority for the Secretary to record obligations for care at non-Department facilities on the date the claim is approved for payment rather than the date the hospital care was authorized.

Section 3 authorizes a program to fill graduate medical education residency positions through educational assistance. This program would require individuals who are accepted to incur obligated service as a full-time employee of the Department in a clinical practice of the participant or in another health care position as deter-

mined by the Secretary, commensurate with the agreement. If, in the case the participant breaches the contract or fails to complete the period of service, they become liable to pay back an amount determined by the Secretary.

Section 4 authorizes, at the discretion of the Secretary, covered health care professionals who are providing telemedicine to be able to do so in any location in any State regardless of the location of the provider or the patient. This is a change the VA has been asking for and would remove the barrier to care that currently exists and would greatly increase access, especially in rural areas.

VVA supports this legislation.

H.R. 1133, Veterans Transplant Coverage Act of 2017, introduced by Congressman John Carter, (R–TX–31), to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide for an operation on a live donor for purposes of conducting a transplant procedure for a veteran, and for other purposes.

According to the Health Resource Services Administration (HRSA), the demand for organs far outweighs the number of donors. Living donations offer another choice and extends the supply of organs. Of the 28,954 organ transplants performed in the U.S. in 2013, over one-fifth (5,989) were living donor transplants.

While VVA has no objection to the bill, as it provides another avenue for veterans who receive transplants in the VA, the bill does not address potential liability issues for the Department concerning operating on someone who is not eligible for VA health care. Additionally, we note that VA would need sufficient appropriations to carry out this legislation.

H.R. 2123, VETS Act of 2017, introduced by Congressman Glenn Thompson (R–PA–5), to amend title 38, United States Code, to improve the ability of health care professionals to treat veterans through the use of telemedicine, and for other purposes.

This section authorizes a covered health care professional of the Department to furnish telemedicine at any location in any State regardless of where in a State the covered health care professional or the patient is located.

This section requires a report on Telemedicine one year after the date of enactment. The report would include several elements to include satisfaction of veterans with services, satisfaction of health care providers, the effect of telemedicine on the ability of veterans to access health care, frequency of use, wait times, use by veterans of in-person and any reduction. This assessment would also include types of appointments that were provided during the year preceding the report, number of appointments during the year, disaggregated by VISN and finally, savings.

The authority provided by this legislation regarding furnishing telemedicine at any location in any State regardless of where in a State the covered health care professional or the patient is located removes a formidable barrier and is something VA has been asking for in order to improve access to health care through telemedicine.

VVA supports this legislation as long as there are strict oversight policies in place to ensure quality care and coordination of care is conducted in the best interest of the veteran.

H.R. 2601, VICTOR Act of 2017, introduced by Congressman Neal Dunn (R–FL–2), to amend the Veterans Access, Choice, and Accountability Act of 2014 to improve the access of veterans to organ transplants, and for other purposes.

This legislation would authorize transplants under the Veterans Choice Program at a non-Department transplant center if the veteran resides more than 100 miles from a Department transplant center. The Secretary would enter into an agreement with the non-Department transplant center.

VVA has no objection to this legislation.

H.R. 3642, Military SAVE Act, introduced by Congressman Andy Barr (R–KY–6), to direct the Secretary of Veterans Affairs to carry out a pilot program to improve the access to private health care for veterans who are survivors of military sexual trauma.

Section 2 of the bill establishes a pilot program to be carried out for a three-year period, at no more than five locations, to furnish hospital care and medical services to eligible veterans at non-Department health care providers to treat physical and psychological injuries or illnesses as a result of sexual assault, battery of a sexual nature, or sexual harassment.

The eligible veteran chooses the health care provider without restriction from the Secretary.

The Department must collect data in the form of a survey for each veteran, whether they elect to participate in the pilot program or not, to assess the health care treatment furnished to the veteran under 1720D of title 38. The survey includes a number of elements that would be garnered from the survey. The surveys will be taken when the veteran elects to participate in the program or as soon as practicable if the veteran does not choose to participate. The survey would be conducted during every six month period while the pilot program is going on and then upon completion of the pilot program. In addition to the survey the legislation requires four questionnaires be given to the participants of the pilot program. A VA researcher would be assigned to the pilot program to ensure integrity of information.

There is a report required that includes several elements that are designed to assess such things as sleeping better, taking fewer or more medications, have a lower rate of suicidal thoughts or suicides. The report is to include whether eligible veterans who participated in the pilot, as compared to eligible veterans who did not participate fared in the evaluation.

VVA has some concerns with the legislation. The first concern is that the legislation allows the veteran to choose the non-Department provider and restricts the Secretary from intervening in that choice, while not addressing the certification and/or qualifications of non-Department agencies and/or individual providers. We believe this opens the veterans up to possibly choosing providers who are not qualified, and therefore experiencing poor quality health care, and may endanger the veteran. The second concern we have is with the questionnaires. Directing that the Secretary use the four that are listed in the legislation is very prescriptive. Some flexibility should be given to the Secretary to ensure that appropriate information and data are being collected. In addition, VVA believes that the Columbia-Suicide Rating Scale should not be used as the sole determinant for a veteran's suicide risk.

VA Draft legislation Veteran Coordinated Access & Rewarding Experiences (CARE) Act, to amend title 38, United States Code, to improve veterans' health care benefits and for other purposes.

The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 required the Department to provide Congress a plan to consolidate care programs and improve access to care for veterans. VA submitted that plan to the Committees on October 30, 2015.

The path forward for this endeavor as outlined in the plan included streamlining eligibility, addressing referrals and authorizations to the community, developing highperforming networks, improving care coordination and medical records management, and improving billing, claims, and purchasing care. VVA is pleased to see VA put forth a draft that is generally in line with the plan. However, VA cannot move forward with this transformation unless they are given the legislative authority necessary to implement the changes.

This draft legislation asks for the authority to engage in Veterans Care Agreements with eligible entities or providers. These Agreements would not be subject to any provision of law governing Federal contracts for acquisition. This would allow for a faster, easier and more streamlined process for VA to increase access to quality care for veterans. VVA believes this authority is a priority and we urge the Committee to act on this request.

Sections 111through 114 all address the issue of paying providers in a timely and efficient manner. VVA supports these sections under Subtitle B of Title I, of the draft.

Title III, Subtitle A, Section 301, authorizes a covered health care professional of the Department to furnish telemedicine at any location in any State regardless of where in a State the covered health care professional or the patient is located. This is at the discretion of the Secretary. Additionally, this section adds language on Supremacy over States. VA serves a large population of rural veterans who often times forgo needed medical treatment due to a variety of barriers that rural veterans face. VVA is pleased that this change to the delivery of telemedicine was included in the draft and fully supports its implementation.

Title IV, Section 401, authorizes a pilot program for VA and Department of Defense (DoD) sharing of health care resources without billing. The program will run for two years in no more than five sites that would be jointly identified by the Secretaries. VVA fully supports collaborations with other Federal entities as long as veterans' timely access to quality health care does not take a back seat to other beneficiaries.

Title V, Section 501 and 502 modify the termination date of the Choice Program to September 30, 2018, and, authorizes appropriations and appropriates $4 billion

in mandatory funds from the Treasury to the VA Choice fund, respectively. VVA does not support mandatory funding for VA health care. The original funding of Section 802 of the Choice Act of $10 billion in emergency funding was supposed to be temporary. While we understand that mandatory funding may be necessary to bridge the gap while VA is implementing the transition plan, we fully expect a return to full discretionary funding of VA health care.

Section 503 is a pay-for and authorizes round-downs of certain cost-of-living adjustments from 2018 through 2027. VVA is vehemently opposed to this section. We do not support taking money from veterans to pay for their own benefits. This is a disservice to all veterans and we call on Congress to find another source of funding.

H.R. (no number), introduced by Congressman Jim Banks, (R–IN–03), to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line. VVA thanks the Congressman from Indiana for putting forth this important legislation. However, as recently as June 2017, our organization called for a comprehensive evaluation of the VCL, which we feel is sorely needed. This evaluation is important and a needed effort to ensure the efficacy of the hot line. However, we cannot support the bill as written. We have several concerns with the some of the elements in the bill. Having said that, we would like to work with the Congressman and the Committee to improve the bill and ensure that the essential data called for in this study can be gathered in a less invasive, but more effective manner.

H.R. (no number), introduced by Congressman Mike Gallagher (R–WI–8), would direct the Secretary of Veterans Affairs to furnish mental health care to veterans at community or non-profit mental health providers participating in the Veterans Choice Program.

Section 2 of this draft legislation would require the Secretary to furnish eligible veterans mental health care to a community or non-profit mental health care provider, regardless of whether or not the veteran has a referral for the treatment. The sessions would be limited to eight with the Secretary having approval to extend that number pending approval of a treatment plan. However, the eligibility of the veteran to receive covered medical services would be determined by the community or non-profit provider. Additionally, a toll-free hotline, to a community or non-profit provider must be maintained by the VA. An initial report and final report would be required that lists several elements to include recommendations by the Secretary regarding extension or making permanent the authority.

VVA has serious concerns with this legislation and hence cannot support it. First, there is no mention of any coordination of care; in fact, a veteran does not even have to have a referral. Seriously? This distorts the VA's role in navigating a veteran's health care, and would likely lead to poor quality and care management for the veteran.

Second, if enacted, would result in total confusion for the veteran because it gives the community or non-profit mental health provider the authority to determine the eligibility of a veteran to receive covered medical services. This is neither sensible nor necessary.

In addition, this legislation has privatization written all over it. Not only does it take fundamental authority away from the Secretary, it puts it in the hands of non-VA entities. It seems that the mental well-being and appropriate care of the veteran will take a back seat by extending the concept of choice.

Third, yet another toll-free hotline is redundant and unnecessary, given that the VA already has established a Veterans Crisis Line (VCL).

Finally, we would like to emphasize that the Veterans Health Administration provides superior mental health care for veterans. We would prefer to see Dr. Shulkin's vaunted CARE plan initiated, monitored, and tweaked where necessary. But we are adamant that primary care and mental health care must remain the province of the VHA.

VVA thanks you for this opportunity to provide our Statement for the Record supporting our nation's veterans and their families.

WOUNDED WARRIOR PROJECT

Chairman Roe, Ranking Member Walz, and Members of the Committee:

Thank you for inviting Wounded Warrior Project ("WWP") to offer our views on legislation currently under consideration by the Committee. WWP brings perspectives based on our first-hand experiences working directly with warriors who have sustained wounds, injuries, and illnesses since 9/11, and their families, through more than twenty comprehensive programs and services, as well as from our partnerships and collaboration with other community organizations who share our commitment to addressing the needs of wounded warriors and filling gaps in government care. We offer the following statement to assist the Committee in its review of pending legislation.

Draft Legislation to establish a permanent Veterans Choice Program & Draft Legislation entitled the "Veteran Coordinated Access & Rewarding Experiences (CARE) Act"

As our community moves forward to forge a long-term replacement for the Veterans Choice Program, we must recognize that those who have put their lives in harm's way deserve the best possible care, regardless of whether that care is delivered by the Department of Veterans Affairs (VA) or community providers. VA provides exceptional care for veterans and should be given the resources it requires to continue improving health care quality and availability, but leveraging non-VA care to expand options and improve outcomes for veterans is a necessary part of meeting them where they are and where they want to go in their recovery. As such, WWP supports a strong integrated health system that provides timely access to optimal care a position based on feedback from warriors that provides unique insight to the needs of the post-9/11 generation of warriors we serve.

Since 2010, WWP has performed a comprehensive annual survey of our warriors to help the organization identify trends among this community, to compare their outcomes with those of other military and veteran populations, and to measure the impact and mix of WWP programs and services all in an effort to determine how we can better serve veterans, service members, and their families. Our forthcoming 2017 Wounded Warrior Project Survey is based on the results of 34,822 completed surveys and weighted to produce estimates representative of the 2017 WWP population, which stood at 106,821 as of October 3, 2017.

While the final report is being prepared, we are pleased to share several data points from our study that illustrate recent trends in the community and focal points for emerging veteran-focused public policy. Among the most salient points for the Committee to consider are the following:

- **Growing enrollment in VA health care:** Up three percentage points from the 2016 estimate, 73.6% of warriors are enrolled for Veterans Health Administration (VHA) benefits and services. This represents a three-year increasing trend.
- While approximately forty percent of our nation's veterans are enrolled for VHA care, this survey indicates that wounded veterans who served on or after 9/11 are more likely to use VA health care than other segments of the overall U.S. veteran population.
- **Use of VA primary care:** More than two-thirds (69.0%) of responding warriors with VA health insurance use VA as their primary health care provider. These veterans may have other insurance in addition to VA coverage.
- Among warriors that do not use VA as their primary health care provider, the leading reasons why were difficulty accessing VA (43.5%), too much trouble or red tape (43.4%), and bad prior experiences at VA (43.4%).
- **Effects of physical health and mental health problems on activities:** Over 80% of warriors report that they were less productive than they would have liked because of their physical health or emotional problems. More than 8 in 10 warriors (82.2%) said that their physical health limited them in the kind of work or other activities they could perform in the past four weeks. More than 8 in 10 (83.9%) indicated that they were less productive than they would have liked because of emotional problems.
- Body weight: In 2017, the average body mass index (BMI) for our warriors was 30.7, slightly above the cut-off for obesity, which is 30.0. More than 8 in 10 (86.7%) warriors reported a BMI exceeding the cut-off for being overweight.
- **Mental health care services Access/Resources:** Among warriors, 51.7% had visited a professional to get help with issues such as stress, emotional, alcohol, drug, or family problems in the past three months, but access to care remains an issue. More than one-third of warriors (34.1%) had difficulty getting mental health care, or did not get the care they needed.
- VA scheduling: Over one-third of warriors (34.8%) indicated that conflicts between their personal schedules and hours of operation of the VA sites were the

reason they had difficulty getting mental health care the most frequently cited reason in the survey.

- Geography: There was a slight decrease from the 2016 estimate in the percentage of warriors mentioning a lack of resources in their geographic area as reason for difficulties in getting mental health care (24.7%, compared to 26.0% in 2016).
- Specialists: Warriors seeking mental health care from a specialist such as a psychiatrist, psychologist, social worker, or counselor averaged 5.7 visits (3.0 mean) over a 3month period.
- Encouraging trends: While 34.8% of warriors indicated scheduling conflicts with VA as an impediment to receiving care, that percentage has declined from 37.5% in 2015 and 36.4% in 2016. Similarly, the percentage of those citing difficulty in scheduling appointments has decreased from 31.5% in 2015, to 30.9% in 2016, to 29.3% in 2017.
- **VA top-cited resource for mental health care:** Wounded warriors utilize various resources and tools to help address their mental health issues. VA was the most frequently cited resource (70.6%), continuing its trend as the most commonly used resource (66.1% in 2016).
- Quality: In addition to being the most frequently used resource, VA care was also cited as the most effective (20.3%); talking to another OEF/OIF/OND veteran (14.9%) was second; prescription medicine was third (10.8%); and service dogs/pets/other animals was fourth (9.0%).
- **Physical health care services Access:** More than 4 in 10 warriors (42.7%) had difficulty getting health care for physical injuries or problems in the past 12 months, or they put off getting care, or did not get the physical health care they thought they needed.
- Scheduling: The most frequently cited reason was difficulty in scheduling appointments (39.1%).
- Encouraging trend Access: Similar to trends seen in mental health care access, difficulty in scheduling appointments was at its lowest point in three years, as the frequency has fallen from 42.4% in 2015, to 40.3% in 2016, to 39.1% in 2017.
- Discouraging trend Specialists: The percentage of veterans reporting that VA requirements make it difficult to get referrals to specialty treatment for physical problems has been growing since 2015. That percentage has risen from 29.6% in 2015, to 30.9% in 2016, to 31.1% in 2017.

While the 2017 Wounded Warrior Project Survey did not ask any questions related to the Veterans Choice Program or attempt to create control groups to assess the program usage or effectiveness, trends indicating improved access to care may reflect positive outcomes from the Veterans Choice Program. There is no doubt that veterans across the country have benefitted from the two pillars of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113–146) investing in VA's internal capacity to meet rising demand for care, and improving access to community-based care to expand that capacity even further.

The 2017 Wounded Warrior Project survey clearly shows that the veterans we serve most frequently look to VA for care, but that difficulty scheduling appointments whether due to bureaucratic morass or conflicts with VA hours of operation remain an impediment to care. Taken together, these points provide a compelling reason to continue making investments in VA-based care while recognizing that there are still limits in VA's capacity to meet demand for care. We urge the Committee to address pending legislation with an eye towards strengthening and modernizing VA-based health care and integrating community-based care to ensure timely and convenient access for all enrolled veterans.

Moreover, WWP urges the Committee to consider the pending legislation as a vehicle to improving collaboration between VA and the nonprofit community and ensuring that VA has the requisite authorities to partner with private and nonprofit organizations to deliver care in new and innovative ways. As these organizations are often able to operate nimbly and with fewer restraints, several have become adept at identifying gaps in care, developing new and effective treatment strategies, and ultimately testing current ideas and practices for scalability in the future so that more veterans have access the best possible health care.

At WWP, we have seen first-hand how our community can work together to deliver effective care in the present and build the foundation for even better care in the future. In January 2016, WWP, Emory University, Massachusetts General Hospital, University of California at Los Angeles, and Rush University Medical Center officially started accepting wounded service members for a first-of-its kind mental health program, Warrior Care NetworkT. Warrior Care Network represents a three-

year, $100 million commitment made by Wounded Warrior Project and its partner academic medical centers (AMCs) to build a more systematic and evidence-based approach to post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) treatment, but that partnership extends even further.

While AMCs provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, a Memorandum of Agreement (MOA) between WWP and VA has been structured to further expand the continuum of care for the veterans we treat. The MOA generates cooperation and collaboration on several levels while emphasizing objectives consistent with several principles of a strong, integrated health system including the need to improve access and timely care, provide care and support networks at the local level, and increase the number of community-based providers competent in caring for veterans.

To date, more than 2,300 wounded veterans across the country have received care through the Warrior Care Network, and we hope to reach thousands more in the years ahead. We believe that partnerships such as the Warrior Care Network embody the spirit of collaboration envisioned by community care integration, and we encourage the Committee to embrace legislative solutions that empower VA to identify and partner with organizations that are striving to build better models of care for the future.

In closing, we commend the Committee for prioritizing the need to replace the Veterans Choice Program with a carefully designed system that is accessible and efficient for veterans, accommodating and inviting for providers, and built to ensure a strong and stable integrated system of care for those who have bravely served our county. While WWP does not currently endorse either of the community care bills before the Committee today, we are encouraged by the inclusive nature that both VA and Congress have used in crafting their proposals for a long-term replacement for the Veterans Choice Program. We are eager to engage with Congressional stakeholders as these deliberations continue, and wish to make our resources available to help increase understanding of the profile and particular needs of post-9/11 wounded veterans, or how WWP and others are finding new and innovative ways to serve this population.

NATIONAL INDIAN HEALTH BOARD

VINTON HAWLEY, CHAIRMAN

DRAFT LEGISLATION RELATED TO THE VETERANS CHOICE PROGRAM

THE DEPARTMENT OF VETERANS AFFAIRS' (VA'S) LEGISLATIVE PROPOSAL, THE VETERAN COORDINATED ACCESS AND REWARDING EXPERIENCES (CARE) ACT

On behalf of the National Indian Health Board [1] (NIHB) and the 567 federally recognized Tribes we serve, I offer this testimony for the record for the legislative hearing held on October 24, 2017. NIHB appreciates the opportunity to provide input on VA priorities for American Indian and Alaska Native (AI/AN) Veterans in Tribal communities across Indian Country, as well as the many non-Indian veterans in our communities for whom Tribally operated health care may be the only realistic choice. Today we will offer comments on draft legislation related to the Veterans' CHOICE program and the Department of Veterans Affairs' (VA) legislative proposal the Veteran Coordinated Access and Rewarding Experiences (CARE) Act.

The federal government's trust responsibility to provide health care to all AI/ANs extends across all departments and agencies of the United States and includes VA. And yet, although AI/ANs serve in the U.S. military at higher rates than any other race, they are underrepresented among Veterans who access the services and benefits they have earned. AI/AN Veterans are also more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other

[1] Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

races.[2] Unfortunately, many AI/AN Veterans do not have faith and trust in the VA after past experiences and delays in enrollment, denial of care, or lack of access to VA services.

The Indian Health Service (IHS) is a federal health care program designed to provide health care to over 2.2 million AI/ANs. It is an agency with a similar mission and purpose to the U.S. Department of Veterans Affairs (VA) and other federal health programs with the exception of the following differences: (1) American Indians and Alaska Natives have treaty rights for the provision of health care; (2) IHS is severely underfunded in comparison to other federal health care programs (for example, in 2015 the VA medical spending per patient was $8,760 compared to $3,136 IHS medical spending per patient); and (3) unlike other federal mandatory health programs, IHS is subject to sequestration and funded through discretionary funds, which are not increased with population growth, inflation, or new technology.

Indian health system and memoranda of agreements with the VA

Section 813 of the Indian Health Care Improvement Act (IHCIA) authorizes Tribes and Tribal organizations to provide health care services to non-beneficiaries.[3] As a result, many Tribes and Tribal organizations already serve non-IHS-eligible beneficiaries, many of whom are Veterans. In addition, section 405(c) of the IHCIA, as added by the 2010 Affordable Care Act (ACA), requires the VA to reimburse IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either the VA or from IHS.[4] In 2014, the Veterans Access, Choice and Accountability Act (Choice Act) established an additional mechanism for the VA to work with Tribal health programs to serve Veterans. However, the Choice Act provides lower reimbursement rates and is more burdensome for Tribal health systems to implement. There is also a general preexisting authority in 38 U.S.C. 8153 for the VA to enter into "sharing agreements" to purchase care, and at times the VA and Tribes have used this authority to enter into agreements.

The Tribal memoranda of understanding (MOUs) between the VA and the Indian Health Service, Tribes and urban Indian health care providers authorized under the Indian Health Care Improvement Act are ideal mechanisms for the federal government to preserve and build on the existing excellent relationships that the VA has with IHS and Tribal Health Programs. To date, the VA has over 100 agreements with the IHS, Tribes, and Tribal Organization entered into under the authority of section 405 of the IHCIA.

The first of these MOUs was completed in 2012 well before the Choice Act was enacted. Between 2012 and 2017 the VA reimbursed $50 million to IHS and Tribal facilities, serving over 5,000 eligible veterans nationwide. This is just a fraction of one percent of the VA's annual budget. NIHB and Tribes have continuously gone on record supporting the continuation of the current MOU system. The MOU agreements promote access to culturally competent exceptional health care for Veterans near home, including services provided in rural and medically underserved communities. IHS and THPs are federally funded programs carrying out federal responsibilities alongside the Veterans Health Administration. IHS and, therefore, THPs are not contractors, procurement sources, or outside, private vendors. The MOUs are crucial to the delivery of quality health care not only to Native American Veterans, but to thousands of non-Native Veterans as well.

Though the legislation considered at the legislative hearing includes the Choice Act, we think this is a critical opportunity for Congress to reaffirm its intent for the Indian health system to continue to use the MOU agreements as authorized by section 405 of the IHCIA. NIHB therefore strongly recommends that the current bill be reframed in such a manner so as to reaffirm and maintain the current IHCIA Section 405 agreements between VA and IHS and Tribal Health Programs (THPs). The current national reimbursement agreements expire in 2019, but will hopefully be renewed.

With these thoughts in mind, NIHB recommends that the bill be modified to include Tribes and Tribal organizations, along with IHS, and that it also reaffirm Congress' intent to maintain existing MOUs with IHS and Tribal providers entered into under Section 405 of the IHCIA, and that it further make plain that nothing in the new enactment amends or limits in any manner the authorities set forth in Section 405. NIHB further recommends that provision be made to make clear that reimbursements under Section 405 agreements shall be at not less than the cost-

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[2] United States Department of Veterans Affairs, American Indian and Alaska Native Service Members and Veterans

[3] 25 U.S.C. § 1680c. IHS may also serve non-AI/ANs with the consent of the tribes being served by the IHS directly operated health care program.

[4] U.S.C. § 1645(c)

based rates IHS annually publishes in the Federal Register. See, e.g. DHSS Indian Health Service—Reimbursement Rates for Calendar Year 2017, 82 Fed. Reg. 5585 (Jan. 18, 2017).

Above all, it is critically important that the new enactment not undermine or substitute for the continuation of MOUs that are already in place. Care under IHCIA Section 405 MOU's is both veteran centric and community centric because is permits our Veterans to receive care in their own communities. It also takes advantage of existing systems that the VA could not possibly match, in areas where the private sector cannot address the need. [5]

Network Provider Clarification

The House bill includes IHS as a "network provider." It is necessary that legislative language also include Tribes/ Tribal Organizations and Urban Indian Health Organizations, so they may participate if they so choose. This will ensure that the whole Indian health system is clearly included as available providers. Additionally, legislative language should reflect that becoming a network provider in the Choice program is optional for Indian health providers.

Value Based Reimbursement Models

We also note that the draft bill would encourage the use of a "value-based" provider system. While we understand that this undefined term may make practical sense in other areas, the Indian health system should be exempted from such a system. Imposing value-based standards on Tribal health care systems is simply unworkable. Moreover, the existing system of annually-published IHS rates already reflects a value-based methodology because it is developed based on an analysis of actual costs. For Tribal facilities to have to engage about new "value-based" quality measures would mean taking away extremely scarce resources from patient care. Tribes already report to the federal government on Government Performance and Results Act (GPRA) for quality of care and adding additional quality standards may just impose additional burdens. In short, the Indian health system already utilizes quality measures through GPRA and other means, so to add another layer would be duplicative and burdensome, and would siphon off already sparse resources from patient care. Therefore, we request that the Indian health system is specifically exempted from the requirement under the value-based reimbursement.

Clarification on Contracted Rates

This proposed legislation and the Choice Act does not pay at the agreed upon Office of Management & Budget (OMB) rate, which is cost based and was included in the initial reimbursement agreement between the VA and IHS. Each Federal program that reimburses IHS and Tribes for health care (Medicare and Medicaid) does so at these rates. The current reimbursement structure is based on average costs calculated by an independent professional cost report preparer engaged by the IHS utilizing costs from audited financial statements and workload statistics maintained by the IHS in its National Database Warehouse. The calculated rates, which are calculated on a "per visit" or "per encounter" basis, are reviewed by the Centers for Medicare & Medicaid Services (CMS) and the OMB and, once approved, are published in the Federal Register for the purpose of reimbursing all IHS facilities for medical care, including Medicare, Medicaid, and others.

IHS and THPs utilize robust, established provider networks that round out the services provided directly to AI/AN Veterans. These networks are critical in providing care to Veterans living in rural and remote areas. NIHB strongly opposes the standard rate and any reduction in the rate because of the circumstances that AI/ANs face with regards to physical health and social determinants of health. Any reduction in reimbursement will further exacerbate the conditions that the Indian Health System faces.

Therefore, we recommend adding language to Section 101(d) of this draft legislation that would read:

"(G) Nothing in this section shall impact reimbursement rates or other provisions of agreements entered into by the Veterans' Administration and the Indian health service, Tribal Health Programs, or Urban Indian Health programs as authorized by 25 U.S.C. § 1645."

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[5] Finally, we note that the MOU has not been implemented for urban Indian health programs even though such programs are explicitly included in the 2010 agreement between VA and IHS. AI/AN Veterans may prefer to use an urban Indian health program instead of a VA facility. The participation of urban Indian health programs in the VA's community care network partnerships is important toward improving the quality of health care received by AI/AN Veterans.

VA's Legislative Proposal

Section 303 "Improving Graduate Medical Education and Resiliency"

NIHB appreciates the inclusion of IHS and Tribal health programs in Section 303 "Improving Graduate Medical Education and Resiliency." In order to ensure the whole Indian health system is represented, we believe that it is appropriate to include Urban Indian Health Programs as part of the legislative language. Therefore, we recommend that the proposal be amended to read:

"(2) A facility operated by an Indian tribe or a tribal organization, or an Urban Indian organization as those terms are defined in Section 4 by the Indian Health Care Improvement Act (25 U.S.C. 1603).

Section 221 of the VA's legislative proposal includes consolidating existing programs. Again, we would recommend adding legislative language that would ensure that MOUs between the VA and Indian health system are not impacted. Therefore, we recommend the following language be added to this section:

"Nothing in this section shall impact reimbursement rates or other provisions of agreements entered into by the Veterans' Administration and the Indian health service, Tribal Health Programs, or Urban Indian Health programs as authorized by 25 U.S.C. § 1645."

Additional Recommended Legislative Changes

Reimbursement for Purchased/Referred Care Services: NIHB also believes that this is an opportune time to include other technical corrections for AI/AN veterans. As discussed above, the VA–IHS MOU has proven to successfully facilitate patient care and provide the least administrative burden for VA, IHS, and THPs. Unfortunately, 25 U.S.C. § 1645 has not be fully implemented. The current national agreement and, by default, all THP agreements do not include reimbursement for Purchased/Referred Care (PRC) services. IHCIA provided a broad directive to reimburse IHS and THPs for care provided to AI/AN veterans and this includes specialty and referral care provided through IHS and THPs.

IHS and THPs utilize robust, established provider networks that round out the services provided directly to AI/AN veterans. These networks are critical in providing care to veterans living in rural and remote areas. Given the minimal amount of funding supporting IHS and THPs reimbursement agreements, including PRC services seems realistic as we work together to improve access to quality care for veterans across the country.

As VA, IHS, and THPs work to build greater partnerships, we must work to address issues with regard to coordination of care. Failing to adequately coordinate care is magnified by VA's unwillingness to reimburse referral services. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must been seen within the VA system before a referral can be secured. This means the VA is paying for the same services twice, first for those primary care services provided to the veteran in the IHS or THP facilities, and then again when the patient goes back to the VA for the same primary care services to receive a VA referral. This is a not a good use of federal funding, nor is it navigable for veterans. As stated previously, the Indian Health Care Improvement Act provides the authority for this reimbursement and the VA needs to adhere to the law. Therefore, we recommend legislative language be included in this bill that would direct the Veterans Administration to include the reimbursement of Purchased/Referred Care to IHS and THPs for services provided to AI/AN veterans.

Exemption for AI/AN Veterans from Co-pays and deductibles: As discussed above, the federal government has a unique trust responsibility AI/ANs Veterans, like all AI/ANs. In recognition of this, AI/ANs do not have copays or deductibles for services received at an Indian health facility. Additionally, this was recognized in the ACA, which includes language at Section 1402 to exempt all AI/ANs under 300% of the federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace and all AI/ANs are exempted from copays and deductibles if they have a referral from the from an IHS or THP. Like IHS and the marketplace, the VA is another means by which the federal government upholds its trust responsibility to AI/ANs. The Veterans' Administration should similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the federal trust responsibility. We believe that this legislation is an ideal opportunity for Congress to reaffirm this responsibility and include statutory language that would ensure that AI/ANs receiving services at the VA are similarly treated.

Conclusion

Thank you again for the opportunity to offer testimony on this important legislation. As noted above, the United States has a unique trust responsibility to provide health services for all AI/ANs, including AI/AN Veterans. While the Indian health system is the primary way AI/ANs receive health services, this federal trust responsibility also includes other federal providers including the VA. In recognition of this fact, the IHS–VA MOU outlines the need for collaboration between the two agencies in order to provide AI/AN Veterans and other Veterans with the best possible care. We believe that further modifications to both the House draft legislation and the VA's Legislative proposal are needed before the legislation can move forward in order to ensure that the current IHS–VA MOU is preserved and that the federal trust responsibility for health is fully honored by the VA.

We would welcome the opportunity to discuss these or other comments as this legislation moves through the legislative process.

Questions For The Record

POST–HEARING QUESTIONS FOR ADRIAN M. ATIZADO
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR

Question 1: The draft bill, which would direct the Department of Veterans Affairs (VA) to provide mental health care to veterans at non-profit or community providers and bypass VA's care coordination role, was added to the agenda late last week and did not give witnesses sufficient time to review and prepare testimony that reflects the views of their organizations.

Q. Does DAV support this bill? If not, what are DAV's concerns?

Response: Thank you for the opportunity to comment on this draft legislation. The bill seeks to increase access for veterans in distress who require immediate attention for mental health conditions. While we appreciate this intent, DAV does not support this bill. DAV believes that mental health treatments for war-related or military sexual trauma (MST) are foundational services that VA cannot contract out to community providers without significantly impairing the quality and continuity of services rendered to enrolled veterans.

As we understand it, this draft legislation would authorize same-day mental health care services from non-VA providers participating in the CHOICE program without a VA referral as part of VA's comprehensive program for suicide prevention. If enacted, veterans could self-refer or use a VA referral service to identify CHOICE providers available for same-day care and could remain under this provider's care for as many as eight visits (and more if authorized). Providers would have to verify veterans' eligibility for such care through VA and VA would pay providers under the same schedule as negotiated for CHOICE. VA would simply act as a payer for eligible veterans and would not restrict veterans' choice of a provider.

DAV acknowledges that veterans occasionally require immediate access to care that VA cannot provide, but believes that the CHOICE program and the emergency benefit already in law address this problem while maintaining VA's role as primary care coordinator. Unfortunately this bill, if enacted, would leave VA providers out of the care process entirely-DAV believes to the veteran's detriment. Under the legislation, VA would be unable to deter veterans' use of outside services even if the veteran is already being treated for a mental health condition within VA. VA may not be asked to work with the provider to identify VA treatment modalities that might be appropriate or share patient information that might inform therapy. It would not allow VA to establish referral patterns based on the development of a trusted relationship between certain CHOICE providers and VA, nor would it allow VA to recommend providers that it believes are more proficient and knowledgeable in providing evidence-based treatment for mental health conditions such as PTSD and depression. It is also unclear if the veteran would have to be in crisis in order to receive care or just choose not to wait. In short, it would not allow VA providers to coordinate services or collaborate on an appropriate care plan for the veteran.

VA has developed an integrated system of health care provision for veterans with mental health conditions that is unrivaled in the private sector. Starting with primary care, VA trains providers to identify prevalent conditions among veterans including post-traumatic stress, traumatic brain injury, anxiety, depression, MST, substance use disorders and suicidal ideation. Mental health providers are included on primary care teams to provide immediate screening and referral for veterans who screen positive for any condition. VA has identified suicide prevention and MST coordinators at each medical center. Using a new algorithm, VA has even begun to

"flag" veterans at risk of suicide in order to monitor and manage their care. Flagged veterans must attend appointments to manage their mental health conditions. Suicide prevention coordinators routinely follow up to ensure that these patients do not miss scheduled appointments and to follow up on their care afterward.

The highly integrated and coordinated approach VA uses to address veterans' needs has worked. VA has clearly demonstrated that veterans engaged in VA care are at far lower risk of committing suicide than veterans who are not. Veterans under VA care for chronic mental health conditions are even likely to add years to their expected life span.

VA does this in large part by coordinating care with all care providers through its electronic health record system-it is this tool that collates all of the disparate pieces of care together serving as a common database for all VA providers and ensuring care continuity for the veteran. VA also offers a number of "wrap around services" that can be supported through case management and care coordination to veterans that are at high risk for adverse outcomes. This important tool can help to ensure that veterans receive timely access to necessary care and services. VA is now beginning to implement a new database to manage its patient care programs that will make it easier to share this information with outside providers.

When a veteran is in crisis or at risk, VA can also make a continuum of resources available-programs that address veterans at risk of homelessness, substance use disorders, and programs that assist with learning or relearning independent life and vocational skills. VA can often help with transportation and, in some circumstances, with child care, to ease veterans' access to care. VA can even help stabilize veterans' families through its vet centers and some of its homeless programs. Few, if any, private sector providers have the ability to offer this array of services in a comprehensive and holistic way.

There is also a largely unanswered question of availability of expertise and capacity within the private sector. Studies done by the RAND corporation and others found that outside providers are not routinely trained in evidence-based practices. Care outcomes, including use of recommended medications, are far lower. Capacity in professionals trained to deliver the evidence-based care this draft bill calls for may also be severely limited. While VA has trained more than 6,000 providers in these treatment protocols for PTSD and 1,800 for depression, RAND found that fewer than 18% of TRICARE providers and 6% of non-TRICARE providers had received training on any evidence-based practices.

In addition, this draft bill threatens to undermine VA's programs. While CHOICE funding has previously been earmarked, VA has asked for the ability to move funding between its own programs and those funded under CHOICE. If veterans are allowed unfettered access to any CHOICE provider available to see them for a mental health condition, resources-mostly providers-may be drawn away from VA programs compromising the access to and integrity of these highly specialized programs. Additionally, VA would have no ability to control these costs.

Mr. Chairman, the current state of VA's mental health programs is the product of a wealth of education from years of clinical experience with our nation's veterans that make them culturally attuned and effective. The Independent Assessment of VA programs required under Sec. 201 of Public Law 113–146 indicates that VA mental health providers are operating at a high level of productivity. Programs are specialized to meet the needs of veterans and VA uses evidence-based practices to ensure care results in the best possible outcomes. Most importantly, VA's programs save our veterans' lives. While VA is certainly not perfect, it is able to provide far more comprehensive services than the private sector. VA's mental health care system sets the gold standard for which other mental health providers strive. For these reasons, we are unable to support a bill that is likely to result in inferior care for our veterans.

We appreciate Mr. Gallagher's attempt to work through some of the most important problems we have with this bill, but suggesting that the differences between VA and CHOICE programs can be resolved by requiring medical records to be exchanged between CHOICE providers is not realistic.

We would appreciate Congress backing away from this draft bill. At the very least, Congress should require a much greater understanding of its impacts, including its costs, that are sure to accrue to VA should it be enacted.

Thank you for this opportunity to our views on this draft bill.

Question 2: Mr. Atizado, in your testimony regarding the Minority's draft language, you indicated DAV generally supported the intent of the section that would provide VA with new authorities to incentivize medical students to fill the 1,500 GME slots created under VACAA. However, you indicated alternative incentives

should be considered. Would you care to elaborate on what those alternatives are in your opinion?

Response: This Committee is to be commended for working to improve ill and injured veterans' limited access to the VA health care system by expanding use of academic affiliations, federal and state partners, and community providers. DAV believes VA is the veterans' first choice for health care and this Committee bears the responsibility of improving VA's capacity to directly provide veteran-centric care, making VA health care more accessible.

We believe this requires, at a minimum, reforming how VA buys care in the community, how the Department modernizes its aging infrastructure and align its real property assets, and how the agency is able to hire, train and retain medical professionals and effectively manage its workforce.

The Veterans Health Administration (VHA) has serious and long-standing challenges with its workforce. A multipronged approach is required and should include such things as addressing VHA's limited human resources (HR) capacity, providing VHA the resources and authority to directly hire, pay competitively in local markets, and have an attractive work environment. The relationship VA has with U.S. medical schools and teaching hospitals, in which veterans gain access to high quality care and ensure the next generation of clinicians acquire those competencies needed to care for veterans and all patients, offers the Department the opportunity to recruit and hire. VA is the largest training site for physicians, and funds approximately 10 percent of national graduate medical education (GME) costs annually.

While we support the intent of creating new incentives to bring clinicians into the VA health care system such as that proposed in the draft bill to incentivize medical students to fill the 1,500 GME residency positions created by Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014, we recommend the Committee expand its vision to include other federal programs for the VA to improve recruitment of physicians during residency training at the VA. For example, the VA can partner with the Uniformed Services University of the Health Sciences (USUHS) and the U.S. Public Health Service (PHS). USUHS medical school graduates each year are assigned to shortage areas as PHS officers. With VA financial support, new participants in this program could be commissioned into the PHS, attend USUHS, and agree to serve seven years with VA post-GME residency. We believe VA, USUHS and PHS are close to an agreement but will require funding for these positions.

The Health Professions Scholarship Program (HPSP) has been a critical source of trained health care professionals entering the U.S. military. The HPSP offers future and current medical school students up to four years of paid medical education and living stipend, in exchange for service as a commissioned medical department officer. The military service obligation is generally one-for-one for every service-paid year of schooling, with a minimum of two years for primary care physicians and three years for physician specialists. Fulfillment of the obligation begins only after postgraduate training is completed.

Other recruitment options could include loan repayment programs and scholarships similar to that offered by the National Health Service Corps (NHSC). Its Students to Service (S2S) loan repayment program is offered when medical students choose their specialty and residency training by providing up to $120,000 to repay student loans during medical residency and in return physicians commit to a 3-year service obligation in certain medical shortage areas after their training is complete. The NHSC scholarship program pays tuition, fees, other educational costs, and provides a living stipend in return for a commitment to work at least 2 years at certain medically underserved community.

As you are aware, DAV provided testimony for the record on September 26, 2017 in support of the discussion draft to, among other things, make certain improvements in the Health Professionals Educational Assistance Program of the VA. Similar to the options listed above, this draft bill would use scholarships to address shortages and vacancies and require service obligations for 18 months for each school year the scholarship was awarded. Loan repayment would be used, alone or in tandem with the scholarship above, for specifically targeted medical specialties particularly difficult for VA to recruit or retain.

Of immediate concern is the effect Public Law 114–198, the Comprehensive Addiction and Recovery Act of 2016 has had on VA facilities ability to recruit and retain clinicians. This law linked VA's Recruitment, Relocation and Retention (3R) Incentives under the same spending cap as Performance Awards. It is our understanding that this change resulted in a nearly 30 percent cut in FY 2016, compared to FY 2015, in individual performance based awards and the cut in 2017 is even greater. As you are aware, the 3R Incentives are used by VA facilities to "bump-up" VA sala-

ries in order to be competitive with what their private sector counterparts offer the best and brightest clinicians. Notwithstanding VA's disadvantages including tens of thousands of VA clinical vacancies, the complexity of federal hiring and the relatively low salaries VA is authorized to offer, DAV recommends the removal of the 3Rs from the spending cap and redress the funding loss for the 3Rs for FY 2017 and for FY 2018.

Material Submitted For The Record

JAVA

Original Investigation

Association of Distance From a Transplant Center With Access to Waitlist Placement, Receipt of Liver Transplantation, and Survival Among US Veterans

David S. Goldberg, MD, MSCE; Benjamin French, PhD; Kimberly A. Forde, MD, MHS; Peter W. Groeneveld, MD, MS; Therese Bittermann; Lisa Backus, MD, PhD; Scott D. Halpern, MD, PhD; David E. Kaplan, MD, MSc

IMPORTANCE Centralization of specialized health care services such as organ transplantation and bariatric surgery is advocated to improve quality, increase efficiency, and reduce cost. The effect of increased travel on access and outcomes from these services is not fully understood.

OBJECTIVE To evaluate the association between distance from a Veterans Affairs (VA) transplant center (VATC) and access to being waitlisted for liver transplantation, actually having a liver transplant, and mortality.

DESIGN, SETTING, AND PARTICIPANTS Retrospective study of veterans meeting liver transplantation eligibility criteria from January 1, 2003, until December 31, 2010, using data from the Veterans Health Administration's integrated, national, electronic medical record linked to Organ Procurement and Transplantation Network data.

MAIN OUTCOMES AND MEASURES The primary outcome was being waitlisted for transplantation at a VATC. Secondary outcomes included being waitlisted at any transplant center, undergoing a transplantation, and survival.

RESULTS From 2003-2010, 50 637 veterans were classified as potentially eligible for transplant; 2895 (6%) were waitlisted and 1418 of those were waitlisted (49%) at 1 of the 5 VATCs. Of 3417 veterans receiving care at a VA hospital located within 100 miles from a VATC, 244 (7.1%) were waitlisted at a VATC and 372 (10.9%) at any transplant center (VATC and non-VATCs). Of 47 219 veterans receiving care at a VA hospital located more than 100 miles from a VATC, 1174 (2.5%) were waitlisted at a VATC and 2523 (5.3%) at any transplant center (VATC and non-VATCs). In multivariable models, increasing distance to closest VATC was associated with significantly lower odds of being waitlisted at a VATC (odds ratio [OR], 0.91 [95% CI, 0.89-0.93] for each doubling in distance) or any transplant center (OR, 0.94 [95% CI, 0.92-0.96] for each doubling in distance). For example, a veteran living 25 miles from a VATC would have a 7.4% (95% CI, 6.6%-8.1%) adjusted probability of being waitlisted, whereas a veteran 100 miles from a VATC would have a 6.2% (95% CI, 5.7%-6.6%) adjusted probability. In adjusted models, increasing distance from a VATC was associated with significantly lower transplantation rates (subhazard ratio, 0.97; 95% CI, 0.95-0.98 for each doubling in distance). There was significantly increased mortality among waitlisted veterans from the time of first hepatic decompensation event in multivariable survival models (hazard ratio, 1.03; 95% CI, 1.01-1.04 for each doubling in distance). For example, a waitlisted veteran living 25 miles from a VATC would have a 62.9% (95% CI, 59.1%-66.1%) 5-year adjusted probability of survival from first hepatic decompensation event compared with a 59.8% (95% CI, 56.3%-63.1%) 5-year adjusted probability of survival for a veteran living 100 miles from a VATC.

CONCLUSIONS AND RELEVANCE Among VA patients meeting eligibility criteria for liver transplantation, greater distance from a VATC or any transplant center was associated with lower likelihood of being waitlisted, receiving a liver transplant, and greater likelihood of death. The relationship between these findings and centralizing specialized care deserves further investigation.

Centralization of specialized health care services is used to control costs, concentrate expertise, and minimize regional differences in quality of care. Such efforts are common in national health systems. In the United States, insurers regionalize care by contracting with centers of excellence for services like bariatric surgery, cardiac interventions, and treatment for some cancers.1-3 Although efficient, centralization may offset any gains in care delivery by increasing the distance between

patients and hospitals.2,4-9 Prior studies relating geography to health care access found less access for rural patients and for those patients living far away from hospitals delivering specialized services.2,5,10-12 Few studies have examined specialized care restricted to a limited number of centers. Previous studies of access to care were limited by not knowing the total population in need of care.2,12,13 Organ transplantation is a highly specialized service requiring concentrated medical and surgical expertise, resulting in de facto centralization in metropolitan regions.14 Veterans with Veterans Health Administration (VHA) benefits receive care at 1 of 128 Veterans Affairs (VA) hospitals or associated community-based clinics. Within the VA, liver transplantation is offered at only 5 VA transplant centers (VATCs) located in Houston, Texas (since 2008); Nashville, Tennessee; Pittsburgh, Pennsylvania; Portland, Oregon; and Richmond, Virginia. Veterans with secondary insurance (ie, Medicare) may obtain care at either a VATC or non-VATC. Patients at the VA lacking other health insurance generally receive care at a VATC except in rare emergencies (ie, fulminant hepatic failure).

Liver transplantation in the VA system serves as a model to study the association between distance and access to centralized medical resources. We tested the hypothesis that increasing distance between a patient and a liver transplant center (ie, VATC) is associated with a lower likelihood of being waitlisted for transplantation, a lower likelihood of getting a liver transplant, and an increased risk for mortality.

Methods

We evaluated liver transplantation in the VA between January 1, 2003, and September 20, 2012. January 1, 2003, was selected as the start date because it was about 1 year after the implementation of the current model for end-stage liver disease (MELD) allocation system. MELD shifted liver transplantation priority away from wait time to illness severity.15-17

The study was approved by the institutional review boards at the Philadelphia VA Medical Center and the University of Pennsylvania, which included a waiver of informed consent.

Veterans Eligible for Waitlisting at a VATC

Any veteran with VHA health benefits who used the VA health system was eligible for inclusion. We queried the VHA's Corporate Data Warehouse18 to identify transplant-eligible veterans meeting the following minimal waitlisting criteria established by the American Association for the Study of Liver Diseases: cirrhosis with a complication of liver disease (ascites, variceal bleeding, or hepatic encephalopathy) or hepatocellular carcinoma.19,20 Transplant-eligible veterans were identified using a validated International Classification of Diseases, Ninth Revision, coding algorithm.21,22 Weexcluded veterans aged 70 years or older (only 4 veterans aged ?70 years were waitlisted at a VATC from 20032010) with malignancies precluding transplantation or having the human immunodeficiency virus (eTable 1 in Supplement).20 We only included veterans with incident decompensated cirrhosis from January 1, 2003, until December 31, 2010, to ensure sufficient follow-up for outcomes assessment. Veterans Affairs physicians may not directly refer veterans who have secondary insurance to non-VA transplant facilities. They may, however, inform patients of their ability to refer themselves for non-VA health care. The VA does not reimburse veterans for co-pays or deductibles related to non-VA care.

We restricted our cohort to veterans who were active users of VA outpatient care to ensure the ability to be referred for liver transplantation in the VA system. We defined active users as patients who were seen in VA outpatient clinics for at least 2 physician or clinician outpatient visits in the 365 days following the first decompensation event or hepatocellular carcinoma event (including the index visit if outpatient). Twovisits were required based on previous studies evaluating use of VA care,23,24 and the assumption that to complete testing prior to referral to a VATC, a veteran must have at least 2 outpatient visits. Veterans were assigned to a local VA medical hospital using Corporate Data Warehouse data, which identified the VA medical hospital where a patient received his or her medical care. Patients receiving care at more than 1 VAfacility were assigned to the first hospital where he or she met the coding algorithm criteria for having decompensated cirrhosis, hepatocellular carcinoma, or both.

Identification of Waitlisted Veterans

We cross-referenced Social Security numbers of all waitlisted liver transplant candidates from 2003-2012 using the Organ Procurement and Transplantation Network (OPTN) database25 linked with the VA Corporate Data Warehouse. Among the 110 US liver transplant centers, the waitlists of only 5 (the VATCs) were solely composed of patients with VA insurance, and these transplant centers could be discriminated based on the distribution of zip codes of the waitlisted patients at each center.

Statistical Analysis

Access to Waitlisting

In our primary analysis, we evaluated the relationship between a transplant-eligible veteran's distance from the local VA hospital to a VATC and being placed on the waitlist for a liver transplant at a VATC. Secondarily, we evaluated the association between distance to a VATC and being placed on the waitlist at any transplant center (VATC and non-VATC) to determine whether access to a local non-VATC mitigates this relationship between distance and waitlisting. We chose a binary waitlisting outcome because access to transplantation once waitlisted is based on severity of illness not waiting time unlike kidney transplantation.

Distance was modeled as a continuous variable. The relationship between distance and waitlisting was not linear so distance was linearized by log transformation in the log 2 base scale.26 In a secondary analysis, distance was modeled as a categorical variable with 5 categories. To our knowledge, no prior regionalization study has modeled the effect of distance with the conditions we studied. Thus, we created 5 distance categories having broad ranges to prevent identification of individual hospitals (ie, no hospital was 100 miles from a VATC, but hospitals were 90 or 110 miles, thus 100 miles was a cutoff not associated with a specific VA hospital) that were based on the observed relationships between certain distance and waitlisting outcomes upon initial evaluation of the data (to convert miles to kilometers, multiply by 1.6). Because these categories were defined after examination of the data, these analyses should be considered post hoc

We assumed that veterans receiving care at a VA within 100 miles of a VATC would live at home after discharge from the transplant hospitalization given that travel times for these veterans would be less than 90 minutes. Thus, the first distance cut point was selected to be 100 miles. Distances longer than 100 miles were categorized relative to travel times or mode of transportation to a VATC (ie, necessity to travel by plane for those living >500 miles from a VATC). Privacy regulations precluded our access to a veteran's home address. Consequently, the shortest distance in miles was measured between the VA medical hospital where the patient received routine care and the closest VATC or non-VA transplant facility.

Regression analyses were performed using generalized estimating equation models with a logit link, an exchangeable correlation structure, and a robust variance estimator to account for patient clustering within VA hospitals27 using Stata version 13.0 (StataCorp). Models were adjusted for age at the time of hepatic decompensation without inclusion of other patient-level covariates. We did not have access to other patientlevel covariates because the VA data use agreement only authorized identification of date and age at the time of hepatic decompensation. The following data were captured for all patients with hepatitis C at a given VA hospital and were adjusted to account for hospital characteristics that may be associated with waitlisting independently of distance: (1) age (median); (2) socioeconomic status estimated by the proportion of patients who are below the federal poverty level; (3) race/ethnicity (proportion self-reported as white); and (4) mental illness (proportion with anxiety, bipolar disorder, depression, posttraumatic stress disorder, and/or schizophrenia). Hospital-level measurements of these covariates were obtained from the VA Clinical Case Registry: Hepatitis C, which is a national VA registry of all patients with hepatitis C because such measurements are not available among other data for the entire VA population.28-30 We assumed the distribution of these covariates mimicked the broader chronic liver population at each VA medical hospital.

Transplantation

The distance to a transplant center may affect the likelihood of receiving a liver transplant. For example, patients living closer to a transplant center might have increased access to transplantation because they can reach the center in the narrow time window of an organ offer, or by virtue of proximity, serve more readily as a backup recipient. To evaluate this, we analyzed all waitlisted veterans, and modeled deaths while waitlisted as identified by OPTN coding or within 90 days of being removed from the list. Deaths were identified from the Social Security Death Master File found within OPTN. Pretransplant deaths were modeled as competing risks31,32 because death while on the waitlist serves as a competing risk to transplantation.

We fit competing risk Cox regression models with transplantation as the outcome and all other waitlist removals (ie, condition improved) other than death (modeled as the competing risk) as censoring events.31,32 The exposure was distance from a patient's home VA hospital to a VATC. Covariates included sex, race/ethnicity, age, laboratory MELD score,16,17 and albumin measured when waitlisted, diagnosis, and hepatocellular carcinoma (binary yes or no as to whether a patient was receiving additional waitlist priority for hepatocellular carcinoma33). We tested for interactions between distance and being waitlisted at a VATC to determine if the probability of being waitlisted is directly influenced by distance. We used a robust

standard error estimator to adjust for the clustering of veterans within VA hospitals.34,35

Survival

The relationship between mortality and distance to a VATC among all waitlisted veterans was modeled with Cox regression. Time from the first hepatic decompensation event to death or a censoring event (eg, condition improved) was modeled with the exposure variable being distance from the patient's home hospital to a VATC. Follow-up began at the date of first hepatic decompensation event to account for the time a patient first became eligible for transplant, which may have been associated with delays in being waitlisted as a function of distance. We adjusted the model for covariates available in OPTN (sex, race/ethnicity, age, laboratory MELD score,16,17 albumin level measured when waitlisted, diagnosis, and hepatocellular carcinoma) and insurance status at the time of waitlisting. Residential-level poverty was adjusted for using OPTN zip code data.36 Death dates were ascertained as specified above. We used a robust variance estimator to adjust for clustering within VA hospitals.34 The proportional hazard assumption was tested for using Schoenfeld residuals.

Sensitivity Analyses

Although veterans with decompensated cirrhosis met minimal clinical criteria for being waitlisted, a MELD score of 15 or greater may better determine eligibility.37 In a preplanned sensitivity analysis, we restricted our cohort to veterans having MELD scores of 15 or higher following the diagnosis of decompensated cirrhosis, hepatocellular carcinoma, or both. The influence of a patient's base hospital having advanced liver care available (defined by being located within 20 miles of any transplant center, being affiliated with an academic liver transplant center, and having a clinician specialized in hepatology) was modeled by a distance x advanced liver care interaction analysis. Availability of secondary insurance status (defined as none, Medicaid, secondary non-Medicaid, or Medicaid plus secondary non-Medicaid) was modeled as a covariate for the 45 792 (90.4%) of the cohort who had this information available in the VA Corporate Data Warehouse (10% had missing data or insurance status reported as unknown).

Table 1. Demographics of Veterans Receiving Outpatient Veterans Affairs (VA) Medical Care Prior to Being Waitlisted for Liver Transplantation

	No. (%) of Veterans Waitlisted at Transplant Center[a]		
	VA Center (n = 1418)	Other Center (n = 1477)	*P* Value[b]
Age, median (IQR), y	56 (52-60)	57 (53-60)	.08
Male sex	1378 (97.2)	1402 (94.9)	.002
Race/ethnicity			
White	1101 (77.6)	1093 (74.0)	
Black	152 (10.7)	171 (11.6)	
Hispanic	138 (9.7)	180 (12.2)	.09
Asian	6 (0.4)	13 (0.9)	
Other[c]	20 (1.4)	21 (1.5)	
Primary etiology			
Hepatitis C virus	909 (64.1)	879 (59.5)	
Alcohol	222 (15.7)	209 (14.2)	
Hepatitis B virus	19 (1.3)	27 (2.8)	
NASH or cryptogenic	112 (7.9)	128 (8.7)	.003
Cholestatic	25 (1.8)	49 (3.3)	
Autoimmune	24 (1.7)	28 (1.9)	
Other[d]	107 (7.6)	157 (10.6)	
Poverty category, %[e]			
0-4.9	87 (6.1)	116 (7.9)	
5-9.9	267 (18.8)	325 (22.0)	
10-14.9	308 (21.7)	333 (22.6)	
15-19.9	250 (17.6)	251 (17.0)	
20-24.9	178 (12.6)	160 (10.8)	.04
25-29.9	110 (7.8)	91 (6.2)	
≥30.0	176 (12.4)	149 (10.1)	
Missing	42 (3.0)	52 (3.5)	

Abbreviations: IQR, interquartile range; NASH, nonalcoholic steatohepatitis.

a Unless otherwise indicated.

b Derived from the ?2 test for categorical variables and the Wilcoxon rank sum test for the continuous variables.

c Other race/ethnicity included multiracial, Pacific Islander, and individuals who responded as other.

d Included metabolic liver diseases, acute liver failure, polycystic liver disease, and all other diagnoses.

e Defined as the proportion of people residing in the zip code who are living below the federal poverty level. Patient-level zip code data were only available for the 2895 waitlisted veterans registered with the Organ Procurement and Transplantation Network.

Statistical significance was defined as $P < .05$ using 2-sided tests. The final multivariable models also include variables with biological plausibility for the association with the outcome, even if the P value was above the prespecified P value threshold (ie, diagnosis). All analyses used Stata version 13.0 (StataCorp), including the xtgee module.

Results

Among all veterans in the United States having VHA health benefits and using VHA medical care, 79 899 had incident decompensated cirrhosis or hepatocellular carcinoma (ofany stage) and used VA outpatient services from 2003-2010. Although hepatocellular carcinoma stage could not be ascertained, which affects transplant eligibility,38 results were unchanged when patients with hepatocellular carcinoma were excluded. Of the 79 899 veterans, 29 262 were excluded (18 041 were aged ?70 years and 11 221 were <70 years, but had a malignancy precluding transplantation). This left a total analytic cohort of 50 637. Overall, 2895 (5.7%) veterans meeting our predefined criteria of using VA outpatient care were waitlisted (1418 [49.0%] ata VATC and 1477 [51.0%] at a non-VATC). Waitlisted veterans had significantly more

VA clinician visits than veterans who were not waitlisted, but there were no differences based on distance to a VATC. Demographic characteristics are listed in Table 1 (additional clinical data in eTable 2 in Supplement).

Validation of Distance

Our method of measuring distance was validated by analyzing the cohort of veterans waitlisted at the Pittsburgh VATC (eTable 3 in Supplement). Because the home zip codes of waitlisted veterans is provided in OPTN data, the distance from the centroid of a respective veteran's home zip code to the Pittsburgh VATC was compared with the measured distance from that veteran's local VA hospital to the Pittsburgh VATC. The median distance between these 2 measured distances was 18.7 miles (interquartile range, 5.3-55.7 miles), with nearly 90% of such veterans who were categorized as being within 100 miles based on distance from a local VA hospital remaining in that category when using home zip code as the measure (eTable 3 in Supplement).

Multivariable Regression Results

In multivariable models, increasing distance to a VATC was associated with significantly lower odds of being waitlisted either at a VATC or any transplant center (Table 2). The odds ratio (OR) in the multivariable generalized estimating equation model evaluating distance and waitlisting at a VATC was 0.91 (95% CI, 0.89-0.93, P < .001; Table 2). For example, a veteran living 25 miles from a VATC would have a 7.4% (95% CI, 6.6%-8.1%) adjusted probability of being waitlisted, whereas a veteran 100 miles from a VATC would have a 6.2% (95% CI, 5.7%-6.6%) adjusted probability. The OR signifies a 9% lower odds of being waitlisted at a VATC between 2 populations whose distance from a local VA hospital to a VATC differs by a multiplicative factor of 2. Veterans Affairs hospital academic affiliation or an advanced liver care center was neither a significant covariate nor an effect modifier. Similar results were obtained when we excluded veterans with hepatocellular carcinoma or those with a MELD score of less than 15. Even though veterans with secondary non-Medicaid insurance were significantly more likely to be waitlisted at a VATC (OR, 1.60; 95% CI, 1.43-1.81) or any transplant center (OR, 2.22; 95% CI, 2.04-2.41), secondary insurance status did not confound the relationship between distance and waitlisting with unchanged ORs for distance with inclusion of this insurance variable. Increasing distance from a local VA hospital to the closest transplant center (VA or nonVA) was also associated with a lower odds of being waitlisted overall (OR, 0.94 [95% CI, 0.92-0.96] for log 2 base distance variable in multivariable generalized estimated equation model, P = .004; Table 3). Similar results were seen when distance was modeled as a categorical variable (eTables 4 and 5 in Supplement).

Table 2. Association Between Distance From Veterans Affairs (VA) Center to VA Transplant Center (VATC) and Being Waitlisted for Transplantation Among Veterans With Decompensated Cirrhosis or Hepatocellular Carcinoma

	Being Waitlisted at a VATC		Being Waitlisted at Any Transplant Center	
	Multivariable OR (95% CI)[a]	*P* Value	Multivariable OR (95% CI)[a]	*P* Value
Distance[b]	0.91 (0.89-0.93)	<.001	0.94 (0.92-0.96)	.004
Age at first hepatic decompensation event per 1-year increments	0.97 (0.96-0.97)	<.001	0.97 (0.96-0.97)	<.001
Racial/ethnic composition of VA center[c]				
76%-100% White (n = 3461)	1 [Reference]	.14[d]	1 [Reference]	.76[d]
51%-75% White (n = 22 026)	0.97 (0.71-1.32)		1.12 (0.87-1.43)	
26%-50% White (n = 21 107)	0.80 (0.58-1.09)		1.02 (0.80-1.31)	
0%-25% White (n = 4403)	1.03 (0.68-1.57)		1.04 (0.74-1.46)	
Median center age[a]	1.10 (0.98-1.57)	.08	1.13 (1.03-1.23)	.006

a Center-specific covariates of proportion of veterans with mental illness and percentage of veterans with a low socioeconomic status excluded from final model for listing at VATC because they were not significant in univariable or multivariable models (P > .50) and were not confounders of the relationship between distance and waitlisting. None of the variables were collinear and the models were not overfit due to a large number of outcomes relative to the number of covariates examined.

b The odds ratio (OR) for distance corresponds to the difference in the odds of being waitlisted between 2 populations whose distance from a local VA center to a VATC differs by a multiplicative factor of 2.

c The number within each racial/ethnic category represents the total number of transplant-eligible veterans receiving care at a VA center with that specific racial/ethnic composition. The waitlisting rate at a VATC is 2.6% (89/3461) for 76%-100% white, 3.0% (670/22 026) for 51%-75% white, 2.6% (539/21 107) for 26%-50% white, and 3.0% (120/1043) for 0%-25% white. The waitlisting rate at any transplant center was 4.7% (163/3461) for 76%-100% white, 5.9% (1296/22 026) for 51%-75% white, 5.8% (1213/21 107) for 26%-50% white, and 5.5% (223/1043) for 0%-25% white.

d Omnibus P value for the overall category.

e The median center age was based on center-level data from the VA Hepatitis C Clinical Case Registry, and for each VA center, there is an age in years that is the median center age. The OR thus signifies the increase in the odds of waitlisting for every increase in 1 year of the median center age when comparing 2 centers.

Table 3. Hospital-Level Percentages of Veterans With Decompensated Cirrhosis Receiving Outpatient Care at a Veterans Affairs (VA) Center Who Were Waitlisted for Transplantation From 2003-2010

	Distance in Miles From VA Center to Closest VA Transplant Center[a]					
	0-100 (n = 3417)	101-200 (n = 5122)	201-300 (n = 7906)	301-500 (n = 9528)	>500 (n = 24 664)	*P* Value[b]
No. of VA centers within zone	8	14	26	28	61	
Veterans waitlisted, No. (%)						
For a transplant at any center	372 (10.9)	279 (5.5)	424 (5.4)	550 (5.8)	1270 (5.2)	<.001
For a transplant at a VATC	244 (7.1)	142 (2.8)	184 (2.3)	245 (2.6)	603 (2.4)	<.001
Per center % waitlisted, median (IQR)[c]						
At any transplant center	7.9 (5.0-12.5)	6.0 (4.4-6.8)	5.1 (3.3-6.6)	5.7 (2.8-7.2)	4.9 (3.5-6.1)	.18
At a VATC[d]	5.0 (3.5-7.4)	2.7 (1.9-4.0)	2.1 (1.3-2.9)	2.7 (1.6-4.1)	1.9 (1.1-3.4)	.007
Per center % waitlisted veterans waitlisted at a VATC, median (IQR)[e]	82.4 (37.5-93.1)	56.7 (42.8-68.8)	42.9 (23.1-66.7)	56.5 (35.0-71.4)	50.0 (32.6-64.6)	.09

Abbreviations: IQR, interquartile range; VATC, VA transplant center.

a Data presented per VA medical center and distance category. The 5 distance categories reflect the distribution of the data and cut points in the relationship between distance and waitlisting. Only veterans receiving care at a VA center within 100 miles of a VATC would be expected to have the opportunity to live at home after discharge from the transplant hospitalization.

b Derived from ?2 tests for the proportion of veterans waitlisted (yes or no) within each distance category or the Kruskall-Wallis test when comparing median and ranges between centers across distance categories.

c The median values for percentages listed at a VATC vs any transplant center do not add up because a different VA medical center may represent the median for different variables.

d From January 1, 2003, through December 31, 2007, the distance from a VA medical center to the closest VATC was measured from the Nashville VA for the 10 centers for which the Houston VATC is the closest because only 1 liver transplant was performed at the Houston VATC prior to January 1, 2008.

e For each VA center, this value represents the proportion of veterans eligible for inclusion in the study who were waitlisted at a VATC among eligible veterans waitlisted overall (ie, 20% if a specific center has 50 veterans waitlisted, of whom 10 are waitlisted at a VATC).

Categorical Analysis

The proportion of transplant-eligible veterans waitlisted for transplantation at any transplant center differed significantly by distance from a VATC (?100 miles, 372/3417 [10.9%; 95% CI, 9.9%-12.0%]; 101-200 miles, 279/5122 [5.5%; 95% CI, 4.8%-6.1%]; 201-300 miles, 424/7906 [5.4%; 95% CI, 4.9%-5.9%]; 301-500 miles, 550/9528 [5.8%; 95% CI, 5.3%-6.3%]; >500 miles, 1270/24 664 [5.2%; 95% CI, 4.9%-5.4%]; P < .001; Table 3). Of 47 219 veterans receiving care at a VA hospital located more than 100 miles from a VATC, 1174 (2.5%) were waitlisted at a VATC and 2523 (5.3%) at any transplant center (VATC and non-VATCs). The proportion specifically waitlisted at a VATC was also significantly varied by distance to a VATC (?100 miles, 244/3417 [7.1%; 95% CI, 6.3%-8.1%]; 101-200 miles, 142/5122 [2.8%; 95% CI, 2.3%-3.3%]; 201-300 miles, 184/7906 [2.3%; 95% CI, 2.0%-2.7%]; 301-500 miles, 245/9528 [2.6%; 95% CI, 2.3%-2.9%]; >500 miles, 603/24 664 [2.4%; 95% CI, 2.3%-2.6%]; P < .001; Table 3). Among all veterans who were waitlisted, the proportion specifically waitlisted at a VATC varied by distance. There was a broad range specifically waitlisted at a VATC across VA locations within each distance category (Table 3); however, when aggregated by distance, 66% of waitlisted veterans from the 8 VA hospitals within 100 miles of a VATC were waitlisted at a VATC compared with less than 51% across the other distance categories (Figure).

Access to Transplantation

Waitlisted veterans who received care more than 100 miles from a VATC were significantly less likely to receive a transplant once waitlisted at a VATC or at any transplant center (eTable 6 in Supplement). Among veterans waitlisted at a VATC, the proportion who received transplants at a VATC differed by distance from a VATC (?100 miles, 156/244 [63.9%]; 101-200 miles, 76/142 [53.5%]; 201-300 miles, 103/184 [56.0%]; 301-500 miles, 125/245 [51.0%]; and >500 miles, 326/604 [54.1%];P = .045). Among all waitlisted veterans, the proportion who received transplants at any transplant center varied significantly by distance from a VATC (?100 miles, 262/372 [70.4%]; 101-200 miles, 164/279 [58.8%]; 201-300 miles, 243/424 [57.3%];

301-500 miles, 294/550 [53.5%]; and >500 miles, 700/1270 [55.1%]; P < .001). In multivariable models of all waitlisted veterans, increasing distance from a local VA hospital to a VATC was associated with a 3% lower odds of transplantation at any transplant center between 2 populations of waitlisted veterans whose distance from a local VA hospital to a VATC differs by a multiplicative factor of 2 (subhazard ratio, 0.97 [95% CI, 0.95-0.98] for log 2 base distance variable; P < .001; Table 4).

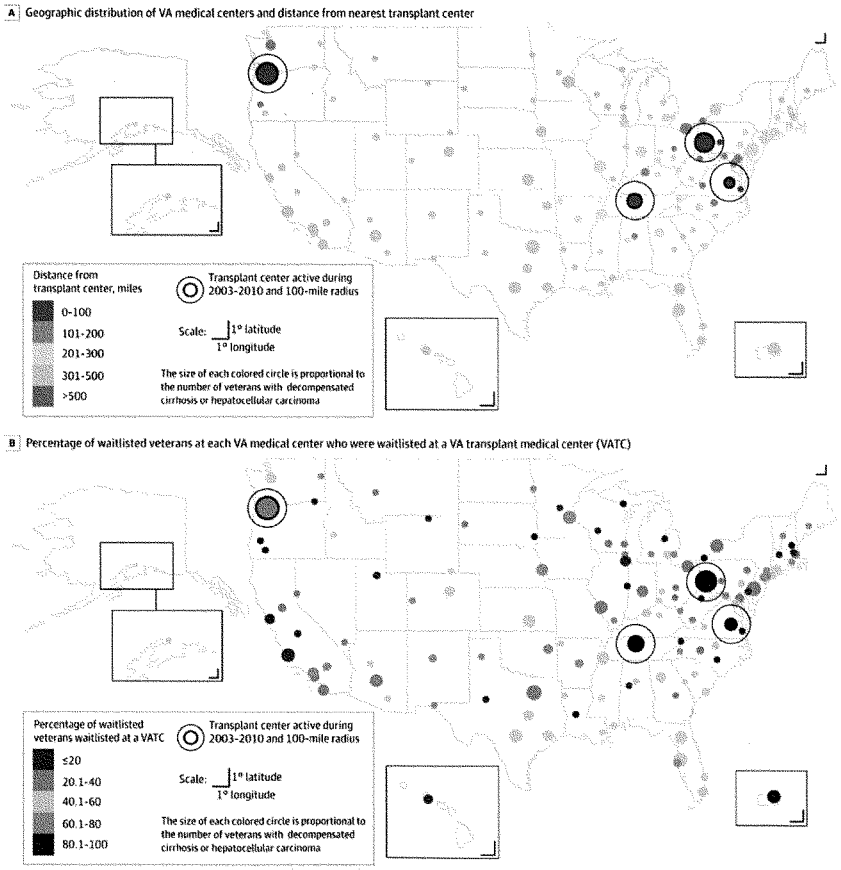
Survival

The overall survival rate of waitlisted veterans from the time of hepatic decompensation event differed by distance from a local VA hospital toa VATC (Table 5). Although the 1-year survival rates were similar, they dispersed over time. In multivariable survival models of all waitlisted veterans with high health care use, increasing distance from a local VA hospital to a VATC was associated with a significantly increased risk of mortality after hepatic decompensation event, with a 3% increased risk of mortality between 2 populations for every doubling of distance from a local VA hospital to a VATC (HR, 1.03 [95% CI, 1.01-1.04]; P = .001). For example, a waitlisted veteran living 25 miles froma VATC would havea 62.9% (95% CI, 59.1%-66.1%) 5-year adjusted probability of survival from first hepatic decompensation event compared with a 59.8% (95% CI, 56.3%-63.1%) 5-year adjusted probability of survival for a veteran living 100 miles froma VATC.

Discussion

Greater distance between a patient's local VA hospital and a transplant center was associated with a lower likelihood of being placed on a transplant list when liver transplant was indicated. Once waitlisted, longer distances were also associated with a lower likelihood of receiving a transplant and increased mortality. These findings may be explained by (1) living remotely from a transplant center reducing the likelihood of getting evaluated for transplantation because of long travel times; or (2) reduced ability to proceed with transplantation because of the need for a patient or his or her family members to relocate. When analyzed as a continuous variable, distance had a dose-response relationship with increasing distance resulting in decreased likelihood of being put on a waitlist, receiving a transplant, and having a higher mortality. When analyzed as a categorical variable, distance appeared to have a threshold effect, whereby veterans living more than 100 miles from a VATC had a decreased likelihood of transplantation compared with patients who had their base hospital located within 100 miles of a liver transplant center.

Our study has the advantage of a large sample of patients eligible for a lifesaving health care service. Our findings are consistent with other studies examining the relationship between distance and access to transplant services.4,5,7,10 One study did show the opposite effect; an examination of US dialysis patients found a greater likelihood of being waitlisted for renal transplant for patients living farther from a transplant center.13 The investigators hypothesized that rural residents treated with dialysis were a highly selected, motivated group to even initiate dialysis given the likely longer distances needed to travel for this service, that physicians in rural areas were aware of the challenges of having rural patients waitlisted due to difficulties in access distant transplant centers, thus expediting transplant referrals, or both reasons.13 Our cohort met inclusion criteria simply by having a disease warranting a transplant, thereby avoiding the selection bias that could have influenced that study, which required both the presence of a condition (end-stage renal disease) as well as receiving routine continuous therapy for that disease (dialysis).



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The median proportion of veterans waitlisted at a VA transplant center (VATC) was 2.3% (interquartile range [IQR], 1.4%-3.7%), and waitlisted at any transplant center was 5.5% (IQR, 3.5%-6.7%). The median center-specific percentage of veterans waitlisted at a VATC relative to overall waitlistings was 54.3% (IQR, 35.1%-66.7%).

Because we could access the medical records for all VA patients in the United States, we could directly estimate the denominator of patients eligible for waitlisting. Prior studies relied on estimates of hypothetical cohorts of patients who might be at risk for receiving a transplant based on census information.10,11 Most prior studies assessed care offered at many centers, with travel times of 15 minutes to 2 hours. Few prior studies evaluated services offered at only a very limited number of transplant centers. Patients in our study who were far away from a VATC did not necessarily reside in rural areas (ie, the Bronx VA Medical Center is >300 miles from the Pittsburgh VATC), resulting in our study being more of an examination of distance rather than urban vs rural. Our results were insensitive to adjusting for VA hospital academic affiliation, suggesting that our findings were related to distance rather than access to advanced liver care services.

Table 4. Competing Risk Model Evaluating Transplantation Among Veterans Waitlisted for Liver Transplantation (n= 2895)

	Total No.	Proportion Received Transplant Within Each Category, No. (%)	Multivariable Subhazard Ratio (95% CI)[a]	P Value[b]
Distance			0.97 (0.95-0.98)[c]	<.001
Age at listing			0.95 (0.88-1.03)[d]	.21
Male sex			1.15 (0.97-1.38)	.12
Race/ethnicity				
White	2194	1253 (57.1)	1 [Reference]	
Black	323	189 (58.5)	0.88 (0.65-1.19)	
Hispanic	318	182 (57.2)	0.88 (0.75-1.03)	<.001
Asian	19	13 (68.4)	1.86 (1.13-3.07)	
Other	41	26 (63.4)	1.40 (0.95-2.07)	
Primary etiology				
Hepatitis C	1788	1055 (59.0)	1 [Reference]	
Alcohol	431	214 (49.7)	0.93 (0.77-1.13)	
Hepatitis B	46	22 (47.8)	0.52 (0.26-1.04)	
NASH or cryptogenic	240	127 (52.9)	0.99 (0.82-1.20)	<.001
Cholestatic	74	45 (60.8)	1.07 (0.70-1.63)	
Autoimmune	52	35 (67.3)	1.51 (1.09-2.08)	
Other	264	165 (62.5)	1.03 (0.85-1.25)	
Blood type				
O	1309	718 (54.9)	1 [Reference]	
A	1123	630 (56.1)	1.06 (0.95-1.20)	<.001
B	337	214 (63.5)	1.25 (1.04-1.51)	
AB	126	101 (80.2)	2.64 (2.28-3.05)	
Hepatocellular carcinoma			4.04 (3.64-4.49)	<.001
Measured at time of waitlisting				
Laboratory MELD score[e]			1.06 (1.05-1.08)	<.001
Serum albumin level[f]			0.91 (0.82-1.01)	.07

Abbreviations: MELD, model for end-stage liver disease; NASH, nonalcoholic steatophepatitis.

a Competing risk model of all waitlisted veterans (Veterans Affairs [VA] transplant center [VATC] or non-VATC) with the outcome of transplant and the competing risk of death on the waitlist or within 90 days of waitlist removal. Outcomes reported as subhazard ratios because of the competing risk model. The distance x waitlisting at a VA interaction term was not included in the final multivariable model because it was not significant (P = .22), although waitlisting at a VATC was included in the model even though it was not significant (P = .60). Primary insurance type was also not significant (P = .72). Residential-level poverty was neither independently associated with mortality nor was it a confounder.

b The P value for the individual distance variables represents the pairwise comparison in the fully adjusted multivariable model, with 0 to 100 miles as the reference, whereas the P value for racial/ethnic composition, diagnosis, and blood type is the omnibus P value for the overall category.

c The subhazard ratio for distance corresponds to the difference in the hazard of transplantation between 2 populations whose distance from a local VA center to a VATC differs by a multiplicative factor of 2.

d The subhazard ratio for every 10-year increase in age at time of waitlisting.

e Unit of comparison is per increase in 1 unit of MELD score.

f Unit of comparison is per 1-mg/dL increase in albumin.

Our findings suggest a need to improve access to liver transplantation in the VA. Increasing the number of VATCs is one solution, and the VA National Transplant Program has approved the opening of 2 VATCs: one in Madison, Wisconsin, and the other in Miami, Florida. However, this will not eliminate problems related to distance from a VATC for many veterans. Other solutions might include (1) streamlining referral to VATCs; (2) using telehealth or allowing local clinician teams to perform initial waitlisting evaluations; (3) active monitoring of liver disease burden at all VA hospitals with assessment of hospitals with low transplant referral rates; and (4) lowering financial disincentives for access to local transplant services through VA-urchased care (ie, payment of medical services delivered outside of the VHA health system for VHA beneficiaries). Such measures would require significant investment to enact.

Table 5. Unadjusted 1-, 3-, and 5-Year Survival Rates Among Waitlisted Veterans From the Time of Initial Hepatic Decompensation Event (n=2895)

	Survival Rate From Date of First Hepatic Decompensation Event (95% CI)		
	1 y	3 y	5 y
Distance category of local VA center to VATC, miles			
≤100	90.5 (86.9-93.1)	72.4 (67.0-77.1)	57.5 (51.3-63.3)
101-200	92.5 (88.7-95.1)	64.0 (57.3-69.9)	50.2 (42.6-57.3)
201-300	89.4 (76.0-92.0)	67.1 (61.8-71.8)	51.6 (45.6-57.4)
301-500	90.7 (87.9-92.9)	66.1 (61.6-71.8)	41.9 (36.7-47.1)
>500	91.2 (89.4-92.6)	66.8 (63.9-69.6)	45.4 (42.0-48.9)

Broader Implications

This issue of distance and access to care is critical given the focus on accountable care organizations that create large networks of physicians and hospitals. As complex, expensive medical technology evolves, certain services may only be offered at a limited number of sites (eg, proton beam therapy). Although our findings are consistent with prior studies evaluating the association of distance to care, our study is the first, to our knowledge, to demonstrate the adverse consequences of centralization of specialized care at a limited number of sites.8

For example, since 2006, hospitals performing bariatric surgeries on Medicare beneficiaries are required to be a designated as centers of excellence.39 A subsequent single-center study demonstrated that this initiative was associated with reduced access to bariatric surgery based on distance (a subset of patients had to travel distances of >800 miles)1 despite similar bariatric surgical outcomes at non-centers of excellence vs centers of excellence.35 However, such an analysis in a national sample of bariatric surgery candidates is practically infeasible due to an inability to nationally define potential candidates based on body mass index data. Similarly, Blue Cross and Blue Shield restricts referrals for complex and rare cancers to centers receiving Blue Distinction.2 By demonstrating that increasing distance is associated with decreased access to care in a national sample of patients, our analysis may serve as a model of the national association of centralized care on services offered at selected centers. Future work must evaluate whether a causal relationship exists.

Limitations

As with any observational study, there may be unmeasured confounding, including that veterans living closer to a VATC have more severe liver disease. However, we specifically identified veterans with decompensated cirrhosis or hepatocellular carcinoma, thus warranting a transplant evaluation. Second, we identified our cohort using International Classification of Diseases, Ninth Revision, codes, not chart review. Even though a subset may be ineligible due to comorbid conditions or psychosocial contraindications (ie, alcohol use or homelessness), this proportion should not differ by hospital or distance. Also, the proportion of veterans waitlisted at a VATC track with those of a single VA hospital study,36 and a study of all patients hospitalized in Pennsylvania for liverrelated conditions.37 Third, our results may have been related to factors beyond distance (ie, VATC preference for waitlisting patients from their hospital), yet the potential dose-response relationship seen with the continuous distance variable may suggest otherwise. Fourth, distance was measured from the VA hospital. Nonetheless, hospital assignment is based on geographic proximity to a hospital, thus hospital-level distances are representative of the distance a veteran would need to travel. Fifth, categorical analyses were based on distance grouping that was determined after examination of the data; therefore, these analyses should be considered post hoc and the categorical findings exploratory. Sixth, we could not determine hepatocellular carcinoma stage to determine transplant eligibility criteria (Milan criteria38), but the results were unchanged with exclusion of all patients with hepatocellular carcinoma.

Conclusions

Among VA patients meeting eligibility criteria for liver transplantation, greater distance from a VATC or any transplant center was associated with lower likelihood of being put on a waitlist or receiving a transplant, and greater likelihood of death. The relationship between these findings and centralizing specialized care deserves further investigation.

ARTICLE INFORMATION

Author Affiliations: Division of Gastroenterology, Department of Medicine, University of Pennsylvania, Philadelphia (Goldberg, Forde, Kaplan); Center for Clinical Epidemiology and Biostatistics, Perelman School of Medicine at the University of Pennsylvania, Philadelphia (Goldberg, French, Forde, Halpern); Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia (Goldberg, French, Groeneveld, Halpern); Division of General Internal Medicine, University of Pennsylvania, Philadelphia (Groeneveld); Center for Health Equity Research and Promotion, Philadelphia VA Medical Center, Philadelphia, Pennsylvania (Groeneveld); Department of Medicine, University of Pennsylvania, Philadelphia (Bittermann); Department of Veterans Affairs/Office of Public Health, Philadelphia, Pennsylvania (Backus); Division of Pulmonary, Allergy, and Critical Care, Department of Medicine, University of Pennsylvania, Philadelphia (Halpern); Gastroenterology Section, Philadelphia VA Medical Center, Philadelphia, Pennsylvania (Kaplan).

Author Contributions: Drs Goldberg and Kaplan had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Goldberg, Backus, Halpern, Kaplan.

Acquisition, analysis, or interpretation of data: Goldberg, French, Forde, Groenveld, Bitterman, Backus, Halpern, Kaplan.

Drafting of the manuscript: Goldberg, Kaplan. Critical revision of the manuscript for important intellectual content: Goldberg, French, Forde, Groenveld, Bitterman, Backus, Halpern, Kaplan. Statistical analysis: Goldberg, French, Forde, Halpern, Kaplan.

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