

HEARING ON PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

JULY 11, 2017

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HEARING ON PENDING LEGISLATION

TUESDAY, JULY 11, 2017

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:32 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Committee Members Present: Senators Isakson, Boozman, Heller, Cassidy, Rounds, Tillis, Tester, Sanders, Brown, Blumenthal, Hirono, and Manchin.

HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this meeting of the Senate Veterans' Affairs Committee to order. Welcome to our Members and our guests today as well as all others that will testify.

As is always the tradition of the Committee, we will recognize visiting Senators who are here to testify first. They will be recognized for up to 5 minutes. There will be no Q&A, and you are welcome to leave afterwards, or if you want to stay, you can move to the back of the room—that is fine—or come up here and sit with me. It does not matter. [Laughter.]

You can do anything you want to. We are all United States Senators.

We are delighted to have you here at the Veterans' Affairs Committee, look forward to your input, and just—I will reserve—we will reserve opening statements until after these Senators speak.

We will, first of all, ask unanimous consent that the statement submitted for the record by Senator Crapo, who was going to testify and then could not come, be put in the record. Without objection.

[The prepared statement of Senator Crapo appears in the Appendix.]

Chairman ISAKSON. So, starting with Sen. Baldwin, we will recognize her up to 5 minutes. Welcome.

STATEMENT OF HON. TAMMY BALDWIN, U.S. SENATOR FROM WISCONSIN

Senator BALDWIN. Thank you so much. Thank you, Mr. Chairman. Thank you, Ranking Member Tester. I really want to thank you for the opportunity to testify today on bipartisan legislation that I have introduced, the Veterans ACCESS Act, and I was pleased to work across the aisle with Senator Moran on this bipartisan reform.

Together with the Disabled American Veterans, The American Legion, AMVETS, the Paralyzed Veterans of America, we are working to help ensure that no matter where they receive treatment, our veterans will find the quality health care that they need, deserve, and have earned.

The simple premise of this legislation is that a health care provider who is suspended or fired from the VA should not be able to then serve veterans seeking care through the Choice Program or other care-in-community programs.

This is a common-sense reform. If a doctor cannot treat our veterans at a VA facility, that doctor should not be able to treat our veterans under their own shingle in the community.

Currently, a loose patchwork of VA regulations intend to stop fired or suspended VA providers from participating in VA-administered community care programs; however, VA's lack of consistent implementation of national standards at the local level, including in Wisconsin, demonstrates that Congress must act and not leave veterans' health and safety to chance.

The Veterans ACCESS Act would require the VA Secretary to deny or revoke the eligibility of a health care provider to participate in community programs if that provider is fired from the VA, violates his or her medical license, has a Department certification revoked, or breaks the law.

In Wisconsin, a doctor was suspended from treating patients at the VA while under investigation for deadly prescribing practices for which he was later fired. However, in the intervening time between his suspension and firing at the VA, he opened a private practice and was alleged to have been trying to see former VA patients.

I wrote to the VA to ensure that he could not see patients through the Choice Program, and the VA responded that since his Wisconsin medical license was suspended, he could not see any patients. However, that temporary suspension was later overturned by a State administrative law judge, and from April 2016 until January 2017, this doctor had a valid Wisconsin medical license.

At last year's appropriations legislation—or in last year's appropriations legislation, at my request, Congress directed the VA to report back on existing VA policies to ensure that no health care providers removed for misconduct subsequently become providers through community care programs.

The VA sent back a laundry list of regulations without ever answering the very simple, central question of whether or not a health care provider removed from the VA could see a patient through the Choice Program.

Our legislation will ensure that the answer to this question is no, and it will provide Congress the needed oversight to ensure that the VA successfully implements congressional intent.

I look forward to working with the Committee to address any concerns that arise from today's hearing, and I want to thank the veterans service organizations testifying later for their support of this bipartisan legislation, including Disabled American Veterans, The American Legion, AMVETS, and the Paralyzed Veterans of America.

Thank you, Mr. Chair, Ranking Member, and all Members of the Committee.

[The prepared statement of Senator Baldwin follows:]

PREPARED STATEMENT OF HON. TAMMY BALDWIN, U.S. SENATOR FROM WISCONSIN

CHAIRMAN ISAKSON AND RANKING MEMBER TESTER, I want to thank you for the opportunity to testify before the Senate Veterans' Affairs Committee on bipartisan legislation that I have introduced, the Veterans ACCESS Act.

I am proud to be working across party lines with Senator Moran on this bipartisan reform.

Together, with the Disabled American Veterans, the American Legion, AMVETS and Paralyzed Veterans of America, we are working to help ensure that no matter where they receive treatment, our veterans will find the quality health care they need, deserve and have earned.

The simple premise of this legislation is that a health care provider who is suspended or fired from the VA should not be able to serve veterans seeking care through the Choice Program and other care in the community programs.

This is a commonsense reform. If a doctor can't treat our veterans in a VA facility, that doctor shouldn't be able to treat our veterans in their own communities as well.

Currently, a loose patchwork of VA regulations intend to stop fired or suspended VA providers from participating in VA-administered community care programs.

However, VA's lack of consistent implementation of national standards at the local level, including in Wisconsin, demonstrates that Congress must act and not leave veterans' health and safety to chance.

The Veterans ACCESS Act would require the VA Secretary to deny or revoke the eligibility of a healthcare provider to participate in community programs if that provider is fired from the VA, violates his or her medical license, has a Department certification revoked, or breaks the law.

In Wisconsin, a doctor was suspended from treating patients at the VA while under investigation for deadly prescribing practices for which he was later fired.

However, in the intervening time between his suspension and firing at the VA, he opened a private practice and was alleged to have been trying to see former VA patients.

I wrote to the VA to ensure that he could not see patients through the Choice Program and the VA responded that since his Wisconsin medical license was suspended, he could not see any patients. However, that temporary suspension was later overturned by a state administrative law judge and from April 2016 until January 2017, this doctor had a valid Wisconsin medical license.

In last year's appropriations legislation, at my request, Congress directed the VA to report back on existing VA policies that ensure no healthcare providers removed for misconduct subsequently become providers through community care programs.

The VA sent back a laundry list of regulations without ever answering the very simple question of whether or not a healthcare provider removed from the VA could see a patient through the Choice Program.

Our legislation will ensure that the answer to this question is unquestionably "no," and it will provide Congress the needed oversight to ensure that the VA successfully implements Congressional intent.

I look forward to working with the Committee to addressing any concerns that arise from today's hearing and I want to thank the Veteran Service Organizations testifying later today for their support of this bipartisan legislation—including Disabled American Veterans, the American Legion, AMVETS and Paralyzed Veterans of America.

Thank you.

Chairman ISAKSON. Thank you, Senator Baldwin. We appreciate your work with the Committee and your interest in our veterans and their affairs and the hard work you did on opioids in the last legislation that we passed through the Committee. Thank you very much.

Senator Flake.

**STATEMENT OF HON. JEFF FLAKE,
U.S. SENATOR FROM ARIZONA**

Senator FLAKE. Thank you, Mr. Chairman, Ranking Member Tester, and other Members of the Committee. I am pleased to speak today in support of the Veterans Treatment Court Improvement Act. I am pleased to have joined the Ranking Member to introduce this sensible piece of legislation.

Let me take the opportunity to introduce the bill now and to thank the veterans service organizations that support the bill, including The American Legion, AMVETS, Disabled American Veterans, Paralyzed Veterans of America, each of whom will testify here later.

Mr. Chairman, with your consent, I will submit for the record, letters from these four organizations—

Chairman ISAKSON. Without objection.

Senator FLAKE [continuing]. As well as several others that support the bill.

[These letters appear in the Appendix.]

Senator FLAKE. As you likely know, the State of Arizona has about a half a million veterans. These brave men and women have served in every conflict since World War II to present-day operations in the Middle East, and we are obviously proud to call them Arizonans.

Oftimes, when these soldiers return home from conflicts abroad, the transition back to civilian life proves to be its own battle, and with the support of family and friends and the tireless work of veterans service organizations, most are able to surmount these challenges.

For those that lack a support system, these issues could run into—or lead to run-ins with the law. While there is no justification, obviously, for criminal behavior, it is important to recognize that certain actions may be symptomatic of the harrowing experiences that these veterans have endured during their time of service.

By not providing treatment that actually addresses the underlying service-connected issues, our criminal justice system can create a vicious cycle.

Now, to address the absence of veteran-specific treatment in our criminal justice system, the Department of Veterans Affairs created the Veterans Justice Outreach Program in 2009. That program established specialty courts that remove veterans from the regular criminal justice process and provide tailored treatments for underlying issues like Post Traumatic Stress and substance abuse.

Veterans treatment courts have a proven track record of preventing initial incarceration and reducing recidivism, and the lifeblood of this program are the Veterans Justice Outreach specialists who link veterans to available court services. These outreach specialists identify veterans in jails and in local courts, assess their health status, and help to develop a rehabilitation program that is tailored to each of their needs.

In April, I had the opportunity to observe the veterans docket and to see some of the most dedicated specialists while visiting the Mesa Municipal Court in Arizona. Let me tell you, there is no experience—or no substitute for seeing this experience firsthand.

Even though it is a courtroom setting, there is a comradery and collaboration that you just do not see in a traditional courtroom setting, and that comes from having a judge and the hardworking staff there having served in the military themselves. They understand that coming home is not always easy, and though the program has experienced remarkable success, the demand for outreach specialists is outpacing the program's ability to serve all eligible veterans. This means that future veterans treatment courts cannot be established, existing courts go understaffed, and veterans go unserved.

To ensure that we have—that our veterans receive swift and appropriate access to justice, I have introduced the Veterans Treatment Court Improvement Act. It will provide 50 additional outreach specialists for veterans treatment courts nationwide. By increasing the number of dedicated specialists at these facilities, it will decrease the number of veterans who end up getting lost in the criminal justice system.

I am committed to work with the Committee on this common-sense legislative fix that will connect more veterans with the treatments that they have earned through their service.

Thank you again, Mr. Chairman, Mr. Ranking Member, and Members of the Committee.

[The prepared statement of Senator Flake follows:]

PREPARED STATEMENT OF HON. JEFF FLAKE, U.S. SENATOR FROM ARIZONA

Thank you Chairman Isakson and Ranking Member Tester for allowing me to speak today in support of the Veterans Treatment Court Improvement Act. I am pleased to have joined with the Ranking Member to introduce this sensible piece of legislation.

I would also like to take the opportunity now to thank the Veterans Service Organizations that support the bill, including The American Legion, AMVETS, Disabled American Veterans, and Paralyzed Veterans of America, each of which have a member testifying here today.

Mr. Chairman, with your consent I will submit for the record letters from these four organizations, as well as several others, in support of the bill.

As you likely know, the state of Arizona is home to more than half a million veterans. These brave men and women have served in every conflict from World War II to present day operations in the Middle East. I am proud to call them Arizonans.

But, oftentimes, when these soldiers return home from conflicts abroad, the transition back to civilian life proves to be its own battle. With the support of family and friends, and the tireless work of Veterans Service Organizations, most are able to surmount these challenges.

For those who lack a support system, these issues could lead to run-ins with the law. While there is no justification for criminal behavior, it is important to recognize when certain actions may be symptomatic of the harrowing experiences a veteran has endured during years of service.

By not providing treatment that actually addresses the underlying service-connected issues, our criminal justice system can create a vicious cycle. To address the absence of veteran-specific treatment in our criminal justice system, the Department of Veterans Affairs created the Veterans Justice Outreach program in 2009.

The program established specialty courts that remove veterans from the regular criminal justice process and provide tailored treatments for underlying issues like post-traumatic stress and substance abuse. Veterans treatment courts have a proven track record of preventing initial incarceration and reducing recidivism. The lifeblood of the program are the Veterans Justice Outreach specialists who link veterans to available court services. These outreach specialists identify veterans in jails and local courts, assess their health status, and help to develop a rehabilitation treatment program specific to each veteran's needs.

In April, I had the opportunity to observe the veterans docket and meet with some of these dedicated specialists while visiting the Mesa Municipal Court in Arizona. Let me tell you, there is just no substitute for seeing this process firsthand. Even

though it's a courtroom setting, there is a comradery and collaboration that you just don't see in traditional courtroom proceedings. That comes from having a judge and hardworking staff who have served in the military themselves. They understand that coming home isn't always easy.

Though the program has experienced remarkable success, the demand for outreach specialists is outpacing the program's ability to serve all eligible veterans. This means that future veterans treatment courts cannot be established, existing courts will go understaffed, and veterans will go unserved.

To ensure that our veterans receive swift and appropriate access to justice, I introduced the Veterans Treatment Court Improvement Act. This legislation will provide 50 additional outreach specialists for veterans treatment courts nationwide. By increasing the number of dedicated specialists at these facilities, we will decrease the number of veterans who will end up getting lost in the criminal justice system.

I am committed to working with the Committee on a commonsense legislative fix that would connect more veterans with the treatments they have already earned with their service.

Thank you.

Chairman ISAKSON. Well, thank you, Senator Flake.

I can tell you from my firsthand experience in Cobb County, GA, which is my home residence, where we have a drug court, the work that has been done in the drug treatment court is just amazing. The lives that have been changed is just amazing. It is a lot like the Court-Appointed Special Advocate Program for youthful offenders. It is a second chance, so to speak, to get a first impression for the veterans. I appreciate your emphasis and your work on that. I am glad you have introduced the legislation, and it will get a fair hearing.

Senator FLAKE. Thank you.

Chairman ISAKSON. Senator Inhofe.

**STATEMENT OF HON. JAMES M. INHOFE,
U.S. SENATOR FROM OKLAHOMA**

Senator INHOFE. Thank you, Mr. Chairman.

I would ask how you guys would feel if you experience what I experienced December 22, 2015. I picked up the *USA Today* paper, and on the front page above the fold was an article about how Oklahoma is doing such a lousy job with their veterans.

We have had a lot of complaints. We have two major areas in Oklahoma—Muskogee and Oklahoma City—and we had felt it was mostly because of leadership.

Anyway, the problems were very serious, and we investigated hundreds of inquiries, as you guys do, every time something like this might happen. Our veterans had been subjected to insufficient and possibly negligent care or denied access to rightfully-earned benefits.

Now, we have been helped by Ralph Gigliotti. Ralph Gigliotti is one of the VISN directors, I guess, VISN 19 director, and I could not have been happier with him. He came in, and he agreed with the problems that we had. He has been very supportive of us in the changes that we have to have on the ground to take care of the—and we solved the problems.

There were two problems that took a long time for us to get around. One has been taken care of already, and that was the bill that gives a VISN the authority to come in and fire someone, fire them on the spot. If they come in and then find out that they have to wait 6 months before they get rid of somebody, it takes away all of the problems that otherwise can be handled by quickly getting

with them. Of course, we took care of that in the legislation that we just passed recently giving them that authority.

Now we have two new directors in both Oklahoma City and in Muskogee, and because of Gigliotti's and the new directors' leadership, Oklahoma's facilities are now really improving. In fact, they have gone from one-star to three-star facilities already since that happened in December 2015.

Now, we were holding—in order to bring in a third party, which the VA did not want to do, I actually, Mr. Chairman, had to go down to the cloakroom and put a hold on our own President's nominee for IG. It took about 2 weeks after that before they would agree to finally let some third party come in with him. They did that. A great job was done by the third party. That happened to be—what was the name of that group?

The Joint what? You have got to talk louder.

ATTENDEE. Joint Commission.

Senator INHOFE. Very good. Joint Commission.

They came in to investigate and really did a great job. Now the standards are going up and all that, but the problem is having that authority to go and seek this.

So, the problem that I have in Oklahoma is not just in Oklahoma. I think it is probably in each State that is represented on the panel here. So, this is something that I cannot imagine anyone would be opposed to.

Now, we address this along with my junior Senator, James Lankford, by introducing S. 1266, the Enhancing Veteran Care Act. It provides permanent authority for VISN directors, like Ralph Gigliotti, and medical center directors to contract with outside entities to do these kinds of investigations. There is no better way of getting through than to have another party looking over the shoulder of those who are doing investigations.

It is something that is—I cannot imagine anyone would be opposed to and certainly is one that we will make sure that we give the right treatment to our veterans. I was hoping that you will be able to bring this up and pass it for our veterans' sake.

[The prepared statement of Senator Inhofe follows:]

PREPARED STATEMENT OF HON. JAMES INHOFE, U.S. SENATOR FROM OKLAHOMA

I would like to address the Committee on some of the VA health clinic challenges we have had in my state of Oklahoma.

We have had serious problems at both VA centers in Oklahoma—Muskogee and Oklahoma City. My office has investigated hundreds of inquiries from Oklahoma veterans who have been subjected to insufficient, and possibly negligent care, or denied access to rightfully earned benefits.

We have been helped by Ralph Gigliotti, our VISN 19 director, who is outstanding. He has been very supportive of ensuring the changes that need to happen on the ground in Oklahoma actually take place.

Both OK VA centers now have new directors, Wade Vlosich and Mark Morgan. Because of Gigliotti and the new directors' leadership, the Oklahoma facilities are implementing new processes and procedures that will improve care. The OKC center has gone from a one-star to a three-star facility in the last year alone.

It was only after I held the VA IG nomination on the Senate floor last year that the VA ensured us that they would send a third-party to investigate these facilities. The VA contracted with the Joint Commission to do an investigation of Oklahoma's facilities in conjunction with the VA Inspector General.

It's important we hold care providers accountable to the highest standards of excellence for our veterans. Having this outside entity come in and compare the VA facilities to private sector health care facilities is helping identify clear problems for

the local and regional directors to go after and fix. A fresh set of eyes, from outside the VA, will enhance everyone's efforts to ensure our VA facilities are world class.

This is not just a problem in Oklahoma. Across the Nation, veterans have become all too familiar with the unsatisfactory care being provided through the VA health care system. Too often, internal VA reports and investigations do not match the facts on the ground, and the regional directors know this. As a result, many veterans and VA employees have lost faith in the agency and are not receiving the proper care they deserve.

To address this I, along with the junior Senator from Oklahoma, James Lankford, introduced S. 1266, the Enhancing Veteran Care Act, which provides permanent authority for VISN directors, like Ralph Gigliotti, and medical center directors to contract with outside entities to do these kinds of investigations.

There is no better group to give this contracting authority to than the regional VA directors who know firsthand the issues their medical facilities face and are directly responsible for bringing about change in the midst of excessive bureaucracy. I believe this to be an important authority that needs to be explicitly provided to them, so that more of the VA health center problems, which we hear about far too often, can be fully addressed.

Thank you for having me today and I encourage swift passage of this important legislation.

Chairman ISAKSON. We appreciate your introduction and you being here today. We will give it every due consideration. We are trying to make sure that we get everything out of the Committee before July recess or August recess or whenever the recess is—

Senator INHOFE. You tell us. [Laughter.]

Chairman ISAKSON [continuing]. And then get finished by the end of the year. We appreciate your effort very much, Senator Inhofe.

Senator INHOFE. Yes, sir.

Chairman ISAKSON. Senator Strange, welcome.

**STATEMENT OF HON. LUTHER STRANGE,
U.S. SENATOR FROM ALABAMA**

Senator STRANGE. Thank you, Mr. Chairman and Ranking Member Tester.

I would first like to thank the Committee for the ongoing work it is doing to champion the interests of our Nation's veterans. All the proposals here that have been presented are very noble bills that I think would make a difference. I know, as a former Attorney General, the veterans courts are particularly satisfying and effective in this area.

There are lots of issues, of course, that divide us, but I am glad that we all come together when it comes to the care of the veterans who have served this country so long and hard.

For so many who have served, the VA is what they rely upon. It is the face of the promise the Nation made to them to take care of them. It is critical that the VA facilities stand ready to meet the needs of that population.

I am here today to introduce a bill that will improve the quality of service and care available to veterans by implementing needed reforms to the VA hiring and employee management systems.

As the Members of this Committee know well, we are up against significant challenges in this effort. You know that a 2016 Best Places to Work survey ranked the VA second to last among large agencies, second to last in executive leadership, and dead last in pay.

It is vital that our veterans can count on high-quality services and care, and the first step in restoring that accountability is ensuring that the VA is equipped with talented professionals ready to meet their needs.

The VA Quality Employment Act of 2017 would build on progress made already by the VA Accountability and Whistleblower Protection Act, which President Trump signed into law just last month. It would take a number of important additional steps to enable the agency to attract and retain top talent, hold poor performers accountable, and deliver services worthy of our Nation's heroes.

First, it would establish health care and benefits fellowship programs connected to the private sector to train and retain a top-notch, service-oriented workforce. In today's evolving workforce providing opportunities for professional advancement and development is critical in motivating talented caregivers and administrators to commit to the VA.

Second, the bill would provide for training human resource professionals on recruiting and retaining Veterans Health Administration employees and would create a database of VA job openings. Too often, the right candidates are unaware of the opportunities that desperately need filling.

Third, it would direct the VA to conduct annual performance plans for political employees to ensure that the agency is in the hands of a high-quality leadership. Veterans should never be subjected to subpar care because politics got in the way of public service.

In March, a companion bill, H.R. 1367, passed the House of Representatives unanimously by a vote of 412 to zero, a rare occurrence in Congress these days. The millions of veterans who rely on the VA deserve swift and decisive action in the Senate as well.

So, I would like to urge my colleagues here today to recognize the need to improve the care we promise to those who protect our freedoms and join me in support of this legislation that will fill the urgent need and help the VA keep its covenant with our Nation's heroes.

Mr. Chairman and Senator Tester, thank you again for the courtesy you have extended for allowing me to speak today, and I look forward to working with each one of you to advance this bill through the process. Thank you very much.

[The prepared statement of Senator Strange follows:]

PREPARED STATEMENT OF HON. LUTHER STRANGE, U.S. SENATOR FROM ALABAMA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, I would first like to thank the Committee for its ongoing work to champion the interests of our Nation's veterans.

There are a lot of issues that divide us these days, but taking care of those who have served must continue to be a unifying cause.

For so many Americans who have served, Veterans Affairs' employees are relied upon as the face of a promise the Nation made to take care of them, and it is critical that VA facilities stand ready to meet the needs of our veteran population.

I'm here today to introduce a bill that will improve the quality of services and care available to veterans by implementing needed reforms to the VA hiring and employee management systems.

As Members of this Committee, you are each well aware of what we're up against in this effort. You know that a 2016 Best Places to Work survey ranked the VA second to last among large agencies, second to last in executive leadership, and dead last in pay.

It is vital that our veterans can count on high-quality services and care, and the first step in restoring that accountability is ensuring that the VA is equipped with talented professionals ready to meet their needs.

The VA Quality Employment Act of 2017 would build on the progress made by the VA Accountability and Whistleblower Protection Act, which President Trump signed into law just last month. It would take a number of important additional steps to enable the agency to attract and retain top talent, hold poor performance accountable, and deliver services worthy of our Nation's heroes:

First, it would establish healthcare and benefits fellowship programs connected to the private sector to train and retain a top-notch, service-oriented workforce. In today's evolving workforce, providing opportunities for professional development is a critical component in motivating talented caregivers and administrators to commit to the VA.

Second, the bill would provide for training human resource professionals on recruiting and retaining Veterans Health Administration employees and create a database of VA job openings. Too often, the right candidates are unaware of the opportunities that desperately need filling.

Third, it would direct the VA to conduct annual performance plans for political employees to ensure that the agency is in the hands of high-quality leadership. Veterans should never be subject to sub-par care because politics got in the way of public service.

In March, a companion bill, H.R. 1367, passed the House of Representatives unanimously by a vote of 412-0. The millions of veterans who rely on the VA deserve swift and decisive action in the Senate, as well.

I would like to urge my colleagues here today to recognize the need to improve the care we promise to those who protect our freedoms. Join me in support of legislation that will fill urgent needs and help the VA keep its covenant with our Nation's heroes.

Mr. Chairman, Mr. Ranking Member, thank you again for the courtesy you've extended in allowing me to speak today. I look forward to working with each of you to deliver this important bill for our Nation's veterans.

Chairman ISAKSON. Thank you very much, Senator Strange, Senator Inhofe, and to all the members who came and gave their time. Thanks for your interest in our veterans. We will be getting back to you shortly in trying to work together to see this all can become law. So, thank you.

Senator STRANGE. Thank you very much.

**OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN,
U.S. SENATOR FROM GEORGIA**

Chairman ISAKSON. We have two panels today to talk about the legislation that is before us, but before we do, I want to make a brief opening statement, as does the Ranking Member.

Let me thank the Members of the Committee that are here today and make note that more often than not, attendance at the Veterans' Affairs Committee is better by percentage than almost any committee in the Senate, and I want to thank the Members of the Committee for their active engagement so far this year and allowing us to accomplish any number of things.

To that end, there is an article that appeared in *The New York Times* about this Committee and the amazing amount we have accomplished in the last year together as Republicans and Democrats, to the credit of the Ranking Member who has worked so hard with me to make sure that we did not forget about each other while we kept our veterans first. Further, in the few challenges we have before this year is over, we are going to demonstrate once again we can find common ground to meet those challenges to confront both the VA and what is required of it as well as our veterans themselves.

I want to let all the Members know, and, for the record, say publicly that it has been a complete team effort, with everybody on the Committee making an effort to contribute, Republican and Democrat alike. I am proud of what we have been able to do, and I think the rest of it is within our reach as long as we keep the same attitude, the same spirit, and same commitment of work that we have in the last few months.

I want to thank the Ranking Member for his support. He called me from his tractor Saturday returning my call on something we are going to be talking about today, just to make sure we had every I dotted and T crossed. We try to communicate that well, so we do not ever catch each other by surprise. I want every Member to know how much we appreciate your effort and what you do.

Ahead of us, before this year is out, is to make sure we deal with the Choice shortfall, dealing with modernization of the Choice Program for standards and requirements, dot the I's and cross the T's to make sure the appeals process gets put to bed, which is about done, and work with the House Members on the shortfall in terms of Choice to make sure it gets funded before the year is out in an appropriate way.

That is a big lift that in many years would have seemed impossible and not in our reach, but this year, because of the work of the Committee, the spirit of the Committee, and the commitment to getting the job done for our veterans, I just believe we are going to do it. I am very proud to be a part of it.

I want to thank everybody on the Committee for their effort and introduce the Ranking Member for his opening statement.

**OPENING STATEMENT OF HON. JON TESTER, RANKING
MEMBER, U.S. SENATOR FROM MONTANA**

Senator TESTER. Well, thank you, Mr. Chairman. I want to thank you for calling maybe the most important hearing that we are going to have this year.

Before I get into my prepared remarks, I just want to say thank you for your leadership. Your commitment to solid communication and making it so there are no surprises, has been critically important on this Committee to move the ball ahead.

I think it is important that we recognize what we have accomplished, but I think it is also important to recognize what we have yet to accomplish. That is why this hearing today is so very, very important, because there are fewer things more important to an individual than their health.

We are seeing the access to health care issues play out day in and day out here in the Senate, in the media, and back home. Today that discussion comes to the Veterans' Affairs Committee. The issue of where a veteran receives care and how that process is constructed has been looming over this Committee for years, and today we will hopefully get constructive feedback and guidance that moves us forward to a final product.

I have had listening sessions back in Montana. Those veterans told me that the Choice Program has not improved access to care in Montana. In fact, if anything, it has made it worse. In the process, it has caused a lot of veterans and community providers to lose faith in the VA, and we have got a lot of work to do to win those

folks back. We need a dramatic revamp of VA's community care program, and we need to be thoughtful in our approach.

I said many times that I think we should be taking our cues from the veterans, and I believe that my community care bill does exactly that. Rather than just giving the veteran a card to seek care in the private sector, I believe the VA must continue to serve as a coordinator and primary provider of care while the private sector fills in the gaps in care after the VA takes into account the specific needs of an individual veteran.

That is exactly what my discussion draft, the Improving Veterans Access to Community Care Act of 2017, would do. It would put the decision of where a veteran received care in the hands of a patient and provider, which is exactly where it should be. In my view, a doc and a veteran should talk about that veteran's specific needs and any challenges that veteran faces in receiving care. This approach understands that one size does not fit all when it comes to health care and outlines factors that could be considered when the docs and patients have that discussion. Those factors are not meant to be binding or cumbersome; they are meant to be a jumping-off point for the doc and the veteran to have a conversation about what that veteran needs.

This common-sense approach takes the needs of the veterans in places like Montana under consideration, where local providers are often unable to absorb those veterans or to provide the specialized care that is required. Do not get me wrong. There is an important role for community care in the delivery of veterans' health, but when a veteran goes into the community for care, it should be based on what is best for the veteran. And sending veterans into the private sector does not absolve the VA of its responsibility for the care and benefits that veteran received. The VA can transfer that care, but it can never transfer the ultimate responsibility for that veteran's well-being. That is why my bill would treat disabilities incurred as a result of care received in the private sector just like disabilities that result from care received at the VA.

I believe the VA is just as responsible when a veteran has had a bad experience with their local civilian facility as they are if that veteran was at a VA hospital. We cannot let VA lose oversight of the quality of care the veterans receive, regardless where it is. While we are focusing on where veterans get their care, we also need to address how we work to bolster VA's internal capacity to provide better care.

That is where my Better Workforce for Veterans Act comes in. This workforce bill supported by my sometimes friend and foe—

Is he here? Damn it. I hate to waste good comments. [Laughter.]

Senator TESTER [continuing]. Focuses on recruiting, hiring, and retaining a talented workforce for the VA. The VA has some well-known human capital challenges, and my bill begins to address them, legislation that I think makes a lot of sense, given the Office of Inspector General's findings that physician assistants are one of the top six critical-need occupations at VA is also on today's agenda.

The Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017 allows the Government to continue reaping returns on our investment in training medics and corps-

men by keeping these individuals in Government service. I introduced this legislation earlier this year with the support of Senators Brown and Moran, among others. It provides training and education opportunities for veterans who served as medics and corpsmen who agree to serve the VA in underserved areas. Once these veterans are certified as physician assistants, they would be required to work at the VA for at least 3 years.

My bill also includes physician assistants in the Nurse Locality Pay System. Once we have these folks on board, we need to keep them there by paying them on par with what a PA in a local community is making.

VA needs more PAs, and my legislation will help bring them on board and keep them there serving veterans. While we are examining these big-picture issues on where veterans get their care and how to improve VA workforce-related issues, we need to also make sure that we are improving the services VA provides to veterans in making sure programs that tend to help veterans evolve with the times. That is why, I along with Senator Murkowski and on this Committee, Senators Blumenthal, Brown, and Murray, introduced the Servicemembers and Veterans Empowerment and Support Act of 2017. The fact that anyone in uniform has to deal with sexual assault or harassment during the course of their service to our country is unacceptable.

Following reports that nude photos of female servicemembers were posted on Facebook and other websites without the servicemembers' knowledge or consent, we introduced legislation to make it clear that servicemembers and veterans who have experienced online sexual harassments are able to access VA counseling and benefits.

Mr. Chairman, earlier this year I was pleased that we would come together in a bipartisan manner to make some much needed changes to Choice. I really think we have an opportunity to do that again by coming to agreement on a path forward for community care. As we continue to work toward a compromise on community care legislation, I am hopeful that this hearing will help inform that effort in a big way.

Thank you, Mr. Chairman. I also want to thank the Members of this Committee.

Chairman ISAKSON. Thank you, Senator Tester. I am confident we can come to that agreement to make Choice work, make it work even better, and solve those problems that confront us today.

Before we go to our panels, I see Senator Cassidy is here and has two bills that are on the agenda today. Senator Hirono is here and has one that carries her name, and Senator Heller was here, but he disappeared when I looked the other way a minute ago. So, I do not know if he is coming back or not.

Did you want to say anything about yours, Senator Cassidy or Senator Hirono?

Senator CASSIDY. I yield, Mr. Chairman.

**STATEMENT OF HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Well, let me add my thanks to you and the Ranking Member for the bipartisan work that we do in this Committee; this is well-deserved recognition.

Regarding my bill, I am glad that the VA is supportive as well as the veterans organizations across the country, because we have a lot of veterans who need long-term care, and we want to keep those facilities supported.

Thank you.

Chairman ISAKSON. Senator Cassidy?

**STATEMENT OF HON. BILL CASSIDY,
U.S. SENATOR FROM LOUISIANA**

Senator CASSIDY. I only have one bill. You threw me for a little bit of a loop. I was thinking, "Wait a second; do I have two?"

So, ours is the Veterans Emergency Room Relief Act of 2017, where if a veteran has an urgent care need and he does not live near a VA hospital or if the VA hospital emergency room line is long, this would allow him or her to go to that urgent care center which the VA was contracted for a reasonable rate and for the veteran to receive their care there.

The idea is that emergency rooms are roughly twice the cost of urgent care centers at least, and this would allow the veteran to receive the care at a lower-cost setting than in an emergency room. We think that it would save the VA money. It would also allow someone who might be dissuaded from receiving care because of long lines in an ER to perhaps receive that care that would be vital to health; because the line was shorter, it was more efficient to go through. It gives the veteran greater access to health care in their community.

We also have a basic cost-sharing mechanism for urgent care visits and allowing the VA to establish some sort of cost sharing but excluding conditions such as service-related, those which require an admission, or other hardship for the veteran, et cetera, and then for the Secretary of Veterans Affairs to submit a report every 2 years regarding both urgent care utilization and the impact upon ER facilities. We think it is a good bill, and it has support of many of the veterans service organizations.

Chairman ISAKSON. Thank you, Senator.
Senator Sanders?

**STATEMENT OF HON. BERNIE SANDERS,
U.S. SENATOR FROM VERMONT**

Senator SANDERS. Thanks, Mr. Chairman.

I just wanted to say a few things. I think most importantly, what this Committee has got to do—and I think we do a pretty good job at it—is listen to the veteran service organizations and listen to the veterans of this country. What they tell us over and over again: "The VA is not perfect. The VA has problems." But, what they are telling us is that the VA provides very high-quality care to veterans who are in the system. The veterans organizations want to see the VA strengthened. They want to see, among other things, the tens of thousands of vacancies which currently exist within the VA—

doctors, nurses, other medical personnel—they want to see those vacancies filled.

I think when we talk about filling vacancies and attracting doctors, which is a difficult problem all across this country, especially in primary care, I want to reiterate my belief that we have got to expand the debt forgiveness program to attract more doctors and nurses and other personnel into the VA.

I think there has been a lot of discussion—I know Senator Boozman has been involved in this—on the feeling that we do not want to see our veterans overmedicated. There are too many drugs. Opioids are used. We want to find other ways to ease pain, and I think the VA in general has done a pretty good job. I want to see that expanded, so those are some of the concerns that I am going to be focusing on, Mr. Chairman.

Chairman ISAKSON. Well, I appreciate those comments.

Senator Baldwin, who was here a little bit earlier, and Senator Johnson did a great job in terms of the Tomah problem, which was the lead problem on opioid overuse and over-prescription at the VA. This Committee took strong action to give the VA the power it needed to see to it that operation was shut down and that practice was stopped. We find ourselves continuing to focus on opioids, as we will, because it is a major problem throughout the country.

Your comment about the VSOs, I am very proud that at every hearing we have had in the 3 years that I have been on the Committee as Chairman, we have always had a panel of the VSOs represented. They will be here today on our second panel. I could not do the job I am called upon to do without their effort and their work. I acknowledge and appreciate their input every single day that we get it.

As far as the empowerment of the Veterans Administration and the Veterans Health Administration, I think we have made some of the greatest steps forward, one in David Shulkin who was approved unanimously by the Senate, the only Presidential Cabinet appointee approved unanimously and who has demonstrated what he has done. He shows a love and respect for the veteran, a knowledge of health care, and a commitment to see to it the VA is everything it needs to be to serve our veterans and their health care needs in the years to come. I support that 150 percent, and I appreciate your acknowledgment of those challenges. We are going to continue to work on those every single day.

Does any other Member of the Committee have a comment to make before we go to the first panel? [No response.]

Chairman ISAKSON. If not, Doctor, are you ready?

Dr. YEHIA. I am ready.

Chairman ISAKSON. I always want to call him “Dr. Yehia,” and I think that is right, isn’t it?

Dr. YEHIA. It is right.

Chairman ISAKSON. I finally got it right this time.

Dr. Yehia from the Veterans Administration, accompanied by Dr. Tom Lynch, Brad Flohr, and Carin Otero. We are glad to have you all here today. You have got plenty of support, Dr. Yehia. You are recognized for your testimony.

STATEMENT OF BALIGH R. YEHIA, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TOM LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VHA; BRAD FLOHR, SENIOR ADVISOR FOR COMPENSATION SERVICES, VETERANS BENEFITS ADMINISTRATION; AND CARIN OTERO, ASSOCIATE DEPUTY ASSISTANT SECRETARY FOR HUMAN RESOURCES POLICY AND PLANNING, HUMAN RESOURCES AND ADMINISTRATION

Dr. YEHIA. Good afternoon. Thank you, Mr. Chairman, Ranking Member Tester, and Members of the Committee. Thank you for inviting us here today to present our views on veterans' access to VA's programs and services.

My written statement provides VA's detailed views on 11 of the bills on the agenda today, and in the interest of time, I would like to briefly touch on several of these bills before us.

I did want to note that there are two bills that the Department was unable to provide views at this time, and we will get back to the Committee after the hearing.

So, first, we support Senate Bill 115, which would allow VA to better care for veterans receiving live organ transplants.

We also support increasing access to care through hiring more physician assistants, as broadly outlined in Senate Bill 426, and extending VA's authority to provide nursing home care to certain severely disabled veterans, as Senate Bill 683 would do.

We also appreciate Senate Bill 833, which is intended to improve access to care and benefits for a veteran and servicemembers who experience military sexual trauma.

Ensuring that we hire and retain the highest-quality providers is critical to providing care to veterans, which is why we support many of the provisions in Senate Bill 1325, the Better Workforce for Veterans Act of 2017.

We also support the intent of Senate Bill 1261, the Veterans Emergency Room Relief Act of 2017, which attempts to simplify and consolidate access to emergency and urgent care.

However, there are several other bills on the agenda today that address important topics but, as written, would limit our ability to effectively manage VA programs and resources. For example, VA is already taking steps to hire more justice outreach specialists as would be required in Senate Bill 946, the Veterans Treatment Court Improvement Act of 2017.

We are very committed to ensuring that veterans have access to care, both inside and outside the Department, which is why we support the principles in Senate Bill 1153, the Veterans ACCESS Act, although we are concerned that this bill could actually create some administrative burdens that would limit high-quality providers joining our community care network.

We also do not support some of the provisions in Senate Bill 1266, the Enhancing Veteran Care Act. VA already has demonstrated an ability to provide comprehensive reports on quality care over several decades, and we think this legislation might be a little bit duplicative.

Last, I want to focus on The Veterans Choice Act of 2017 and the Improving Veterans Access to Community Care Act of 2017. Let me say that we understand that the future of VA's community care program is one of the most important and possibly one of the most difficult items on the legislative agenda. We want to work with everyone to ensure that this legislation is as strong as possible. We believe that the law that is ultimately enacted should embrace a few broad principles. These principles are based on lessons learned through VA's existing community care programs, including the Choice Program, and discussions with their key stakeholders.

First and foremost, the future community care program must empower the veteran and their care team so that the veteran gets the right care at the right time from the right provider.

Second, the Department must be able to establish a high-performing network of VA and community providers who can furnish the very best care. To do this, we must have flexibility, flexibility in payment rates and the type of agreements we form with providers. In addition, we must have flexibility in our ability to simplify our interactions with community providers so we can pay timely and accurately and that we can share information more easily between the two.

Third, it is important that VA retain flexibility to adjust and adapt to an evolving health care landscape. Legislation that is too prescriptive in terms of rules, responsibilities, or processes can only limit our options in the future, which would lead to frustration from our veterans, our community providers, and VA employees. With the Choice Program, we have had five separate law changes in just under 3 years. That is not really a sustainable model. We believe that the best legislation would provide broad, general authority that VA could define and implement through regulation, policies, and contracts.

Last, it is critical that the legislation provide VA with sufficient time to develop and lead to implementation. We know from our efforts in the Choice Program that a short period of implementation will not help veterans. Ideally, we would like to have a full year to establish provider networks, draft regulations, and build the necessary relationships and systems that will empower our veterans, community providers, and VA staff to deliver the best health care to our Nation's veterans.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee would have.

[The prepared statement of Dr. Yehia follows:]

PREPARED STATEMENT OF BALIGH R. YEHIA, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD MORNING, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs' (VA or Department) programs and services. Joining me today is Dr. Tom Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration (VHA); Brad Flohr, Senior Advisor for Compensation Services, Veterans Benefits Administration; and Carin Otero, Assistant Deputy Assistant Secretary for Human Resources Policy and Planning, Human Resources and Administration.

This written statement includes VA's views on eleven significant bills on important topics. Because of the timing of receipt of two of the bills, we are not able to provide formal views in this statement on S. 1279, the Veterans Health Administration Reform Act of 2017 or the draft bill, "The Department of Veterans Affairs Quality Employment Act of 2017." We also will follow up with the Committee on one section (section 10) of the Veterans Choice Act of 2017. We look forward to providing views at a later time and discussing these bills with you today.

S. 115, VETERANS TRANSPLANT COVERAGE ACT

S. 115 would add section 1788 to Title 38, authorizing the Secretary of Veterans Affairs (Secretary) 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 healthcare. 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.

VA supports S. 115, 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 two years after the procedure is performed by a VA facility. 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 (FY) 2018, \$9.7 million over 5 years, and \$21.5 million over 10 years.

S. 426, GROW OUR OWN DIRECTIVE: PHYSICIAN ASSISTANT EMPLOYMENT AND EDUCATION ACT OF 2017

S. 426 would provide new authorities for VA to provide educational assistance and other benefits to support physician assistants (PA).

Section 2 would require VA to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as PAs.

Having a pilot program will help alleviate the healthcare workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA healthcare facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill. These service agreement obligations secure the graduates' services for up to three years, which reduces turnover and costs typically associated with the first two years of employment.

While VA supports section 2, contingent on the provision of additional resources to support implementation, we believe that the Congress should provide more flexibility in implementation. The bill is very specific, including in areas such as directing the management structure of the pilot program and the specific criteria for participant eligibility. VA should be afforded the flexibility to implement such a program in a manner that can minimize any unintended consequences and promote consistency across Title 38 programs.

We recommend removing language in paragraph (j) that would require the positions of Deputy Director for Education and Career Development for Physician Assistants and Deputy Director of Recruitment and Retention to be filled by a Veteran and a current employee. The limitation of filling the proposed Deputy Director positions with Veterans only (as opposed to employing Veteran preference) would significantly limit the pool of applicants with the necessary experience and skill sets necessary to successfully carry out the responsibilities of the positions, as well as potentially run afoul of Merit Systems Principles.

The total cost of administering the pilot program under section 2 would be \$546,000 in FY 2018 and \$2.9 million over 5 years.

Section 3 would add a new section 7618A that would ensure that not fewer than 25 new scholarships in the Health Professional Scholarship Program are awarded each year to individuals for education and training to become physician assistants.

It would also add a new section 7676 that would similarly require that 25 new scholarships in the Employee Incentive Scholarship Program be awarded for education and training to become physician assistants.

While VA supports section 3 in principle, and contingent on the provision of additional resources to support implementation, VA already has the authority to dedicate scholarships toward these professions. Similar to section 2, providing these scholarships will help VA address workforce shortages through the required service obligation.

The total cost of section 3 of the Health Professional Scholarship Program (HPSP) with HPSP Stipend cost for 175 awards (35 per year) over five years would be \$10.2 million.

Section 4 would require the Secretary of Veterans Affairs to establish standards for the Department for using educational assistance programs to educate and hire PAs. This provision would require that the standards ensure that VA's Educational Debt Reduction Program (EDRP) is available to participants in the PA pilot program. To the maximum extent practicable, VA would be required for each year over a five year period to increase the scholarships amounts under subchapters II and VI of chapter 76, Title 38, and any other relevant educational assistance programs offered by VA for courses of education or training to become physician assistants.

VA does not support this section because EDRP assistance is targeted for specific positions that are designated as difficult to recruit and retain. In order to meet local Veteran population needs, local medical centers have the flexibility to determine the positions that have the most critical need for EDRP awards and advertise accordingly. Loan repayment awards are an attractive tool; however, EDRP is a limited resource and offering EDRP to an entire occupational series would be contrary to the statutory mission of the program and would set a precedent for other occupations to seek similar authority.

The PA occupation is recognized as a top 5 mission-critical occupation within VA, ranking fourth and tied with physical therapy, according to the January 2015 VA Office of Inspector General report after medical officer (physician), nurse, and psychologist.

Over the last several fiscal years, the number of new PA hires has fluctuated between 250–350 annually. The number of EDRP awards made for newly hired PAs has gradually increased from 26 to 45 (62 percent increase) from FY 2014 to FY 2015, and currently comprises 13 percent of all new PA hires. In the FY 2015 EDRP award cycle, the average EDRP award for PAs was \$63,000. Current projections estimate similar awards for the PA occupation based on qualifying student loan debt. Overall, the OIG's top 5 occupations represented 82 percent of all EDRP awards made in FY 2015.

EDRP awards are typically five year awards. If EDRP was offered to every new PA hire, nearly \$4.6M would be needed each year for new awards, and additional funding would be required to sustain current participants.

Including EDRP in all announcements, as would be required by the mandated standards, would also give interested candidates for hire the impression that EDRP would be available. EDRP awards are not made until after qualifying student loan debt can be confirmed with education institutions and lenders, which can take several months and occurs after employees are onboard. Without significantly increasing EDRP funding, including EDRP in all PA vacancy announcements will prevent facilities from offering the award to other positions that are more difficult for recruitment and retention locally. Advertising EDRP in all PA announcements, without significantly increasing funding, is misleading and likely to disenfranchise new employees early in their VA career.

Advertising EDRP for an entire occupation sets a precedent that will likely encourage other occupations to seek the same. Such costs are not only unsustainable, but in conflict with the statutory mission. PAs are nationally ranked as a mission-critical occupation; however, certain facilities report no issues recruiting PAs (i.e., Michael E DeBakey VA Medical Center in Houston, TX, has a strong PA program with academic affiliates and reports no issues hiring PAs). Requiring all facilities to advertise EDRP for positions would deny the facility the ability to make awards for other positions that are the most critical.

Alternative approaches may be better suited for strengthening the PA occupation within VA, such as making compensation of PAs the primary driver in recruitment and retention.

VA supports section 5 of the bill, contingent on the provision of additional resources to support implementation, which seeks to eliminate the pay disparity between VA and the private sector.

The cost for 5,250 new EDRP awards over 5 years would be \$68.2 million. Salary and development costs are estimated at an additional \$792,451, bringing the total cost of this proposal (including cost of living adjustments) to \$69 million.

S. 683, KEEPING OUR COMMITMENT TO DISABLED VETERANS ACT OF 2017

S. 683 would amend 38 U.S.C. § 1710A to extend until December 31, 2018, the period in which the Secretary shall provide nursing home care to certain Veterans.

VA supports this provision, which would ensure that Veterans in need of nursing home care for a service-connected disability and any Veteran who has a service-connected disability rated at 70 percent or more are eligible to receive nursing home care.

If the authority in section 1710A continues to be extended, VA estimates the cost would be \$4.73 million in FY 2018, \$25.13 million over 5 years, and \$53 million over 10 years.

S. 833, SERVICEMEMBERS AND VETERANS EMPOWERMENT AND SUPPORT ACT OF 2017

Section 2(a) of S. 833 would amend 38 U.S.C. § 1720D(a)(1) to authorize VA to provide a Veteran with counseling and care and services determined (by a VA mental health professional) to be needed to overcome psychological trauma resulting from cyber harassment of a sexual nature.

VA supports this subsection in principle, but we do not believe it is necessary because of VA's current authority. Under section 1720D, VA is authorized to provide counseling and treatment for trauma resulting from sexual harassment (defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character"), and this can include sexual harassment that is conducted through verbal or cyber contact, including the use of Internet social media services. We also note that the phrase "cyber harassment of a sexual nature" is ambiguous, and it is unclear exactly what the drafter intends to cover. It would also be helpful to clarify whether the bill is intended to extend eligibility to those who were the victim of cyber harassment in only one instance or if, as is the case with the definition of sexual harassment in 38 U.S.C. § 1720D(f), the harassment must be "repeated." As drafted, we presume the intent is to allow VA to define this term through rulemaking, but if there are specific parameters the drafter wishes to ensure are specified, including them in the bill text would be advisable.

Additionally, it is unclear if the language as drafted would cover all of the types of cyber harassment incidents that are intended. As amended, section 1720D would still require that the cyber harassment occur while the Veteran or Servicemember was on active duty, active duty for training, or inactive duty training. However, it may not be clear exactly when the harassment occurs. For example, the harassment could occur when the content is created (e.g., a photograph or video is made), when the content is posted online, when the individual discovers the content is online, or when content that was posted with permission is shared with others without permission (e.g., if a photo or video that was only intended for a limited number of parties is made available to others). Depending upon which standard controls, different Veterans and Servicemembers would be eligible. Due to the intricacies of the subject, it would be beneficial if the legislation addressed "cyber-harassment" in a separate subsection of section 1720D. We believe it would be prudent to phrase this authority in a way to ensure it does not become outdated by changes in technology. We would be happy to assist the Committee in exploring these issues further and in developing technical assistance to ensure the legislation reflects the drafter's intent.

Section 2(b) would amend section 1720D(a)(2) to permit VA to provide without a referral needed counseling, care, and services for sexual trauma that was suffered by Servicemembers, including members of the National Guard and Reserves, during periods of active duty, active duty for training, or inactive duty training. Current law authorizes VA to provide services under this authority only to Servicemembers, including members of the National Guard and Reserve, who are serving on active duty.

VA supports section 2(b), but notes this support is contingent upon additional resources to support implementation. While this provision is discretionary and could only be implemented in consultation with the Secretary of Defense, this subsection has potentially significant cost and workload implications that, without additional resources, could jeopardize VA's ability to provide timely services to Veterans.

It is difficult to estimate the new demand for care that would be produced by section 2, as VA has no data currently available on how many members of the National Guard and Reserve (as well as other members of the Armed Forces) experienced military sexual trauma while on active duty, active duty for training, or inactive

duty training. Similarly, it is impossible to know how many of these persons would seek care from VA, and how many would continue to seek care on an ongoing basis. While VA currently furnishes care to Servicemembers through sharing agreements and other arrangements, the Department of Defense (DOD) reimburses VA for such care. It is unclear if DOD would do so when the Servicemember is no longer in active duty, active duty for training, or inactive duty training.

Section 3(a) would amend 38 U.S.C. § 1154 by adding a new subsection (c). The current subsection (b) of section 1154 provides a liberal approach to evaluating claimed disabilities based on a Veteran's engagement in combat with the enemy. This provision acknowledges the disruptive "circumstances, conditions, or hardships" of combat, and the resulting incomplete record keeping, as the basis for a liberal approach to evaluating claims. The newly proposed subsection (c)(1) would establish a liberal standard of proof to "any Veteran who claims that a covered mental health condition was incurred in or aggravated by military sexual trauma during active military, naval, or air service."

VA appreciates the purpose of section 3 but does not support it as written. Under subsection (c)(1) of 38 U.S.C. § 1154, as proposed to be added, the military sexual trauma stressor/event would be required to be "consistent with the circumstances, conditions, or hardships of . . . service" in order to be associated with a current covered mental health condition. Although this language, as used in current section 1154(b) in relation to conditions allegedly incurred or aggravated in combat makes sense for the specific disruptive circumstances of combat as a potential Post Traumatic Stress Disorder (PTSD) stressor, there are no specific circumstances, conditions, or hardships of service that are associated with military sexual trauma, which can occur at any time and any location during the period of service.

Section 3(b) would add a new section 1164 to title 38 that would codify VA's current liberal approach for evaluating PTSD/military sexual trauma claims under its regulation at 38 CFR 3.304(f)(5). While VA supports this provision in principle, it would be preferable to allow VA the flexibility to revise its regulations based on experience without the need to seek statutory amendments, as would be required if the current regulation is codified in statute.

VA does not have a cost estimate for this section at this time.

Section 4 would require the Secretary of Defense to inform members of the Armed Forces of the eligibility of such members for services at VA's Vet Centers. The Secretary of Defense would be required to ensure that DOD's Sexual Assault Response Coordinators advise members of the Armed Forces who report instances of sexual trauma about their eligibility for services from VA's Vet Centers.

While VA defers to the Secretary of Defense on the specific obligations this bill would impose, we support this section in principle. VA currently provides counseling for military sexual trauma to active duty Servicemembers and is pleased to do so. Informing Servicemembers of the benefits for which they are eligible is important to ensuring they receive the care and services they need. We note there may be technical issues with some of the bill language, but we would be happy to discuss this with the Committee with DOD's input as well. In addition, additional resources to support implementation may be required.

S. 946, VETERANS TREATMENT COURT IMPROVEMENT ACT OF 2017

S. 946 would require VA to hire additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved Veterans. Specifically, S. 946 would require that VA hire not less than 50 VJO Specialists and place each such VJO Specialist at an eligible VA medical center (VAMC). The bill would require that the total number of VJO Specialists employed by the Department not be less than the sum of (a) the VJO Specialists employed on the day before the enactment of this provision; and (b) the number of VJO Specialists hired under this bill. The bill would require that the Secretary prioritize placement of the VJO Specialists at facilities that will create an affiliation with a Veterans treatment court that is established on or after the date of enactment of the bill, or one that was established prior to enactment but is not fully staffed with VJO Specialists. The bill would require the Secretary to submit a report to Congress on the progress and effects of implementing these provisions within one year, with new reports submitted annually after that. The bill would also require the Comptroller General to submit to Congress a report on the implementation of this authority and the effectiveness of the VJO Program. The bill would authorize to be appropriated \$5.5 million for each of fiscal years 2017 through 2027, and would require the Secretary to submit to Congress a report that identifies such legislative or administrative actions that would result in reduction in expenditures by the Department that are equal to or greater than the amounts authorized to be appropriated.

VA supports the intent of this bill and is already working to hire more than the 50 additional VJO Specialists in FY 2017. However, the bill could ultimately result in a reduction of \$5.5 million in funding to other programs (including possibly programs for homeless Veterans). Because of this potential reduction in funding, VA does not support the legislation as drafted. Demand for VJO Specialists has grown considerably over the past several years, partly as a result of the adoption of the Veterans Treatment Court model in new jurisdictions. Limited VJO staff resources have affected VA's ability to partner effectively with Veterans Treatment Courts, especially those newly established.

As a technical matter, we note that provisions of section 2(e) of the bill concerning the authorization of appropriations may not accomplish the intended objective. We understand this provision is intended to ensure that the Secretary identifies offsets to fund the program required by this bill. However, the bill only requires the Secretary to report to Congress on legislative or administrative actions that would result in a reduction of expenditures equal to or greater than \$5.5 million. To the extent that the Secretary identifies legislative actions that would result in a reduction of expenditures, there is no guarantee that Congress would take such actions. We further note that the offsets would likely affect adversely VA's ability to implement and run other programs, which could result in delays in the provision of benefits, healthcare, and other critical services to Veterans and other beneficiaries. Ultimately, we do not believe this is an appropriate mechanism for funding the program required by this section.

We also note that the definition of "local criminal justice system" in section 2(f)(3) of the bill would exclude Federal law enforcement issues. We understand there are some Federal district courts that have Veterans treatment courts, and these would not be supported under this bill.

While we estimate the hiring of 50 additional VJO Specialists would cost \$5.5 million in FY 2018, because the bill would require VA to identify offsets, we believe the ultimate cost would be \$0 in FY 2018 and over both 5 and 10 years. We again caution that the costs for implementation would involve reductions to other VA programs.

S. 1153, VETERANS ACQUIRING COMMUNITY CARE EXPECT SAFE SERVICES (ACCESS)
ACT OF 2017

S. 1153 would require the Secretary of Veterans Affairs to deny or revoke eligibility of certain healthcare providers to provide non-VA healthcare services to Veterans. The bill would, in general, require that the Secretary deny or revoke the eligibility of a healthcare provider to provide non-Department healthcare services if the Secretary determines that: (1) the provider was removed from employment at VA due to conduct that violated a policy relating to the safe and appropriate delivery of healthcare; (2) the provider violated the requirements of a medical license; (3) the provider had a Department credential revoked that would impact that provider's ability to provide safe and appropriate healthcare; or, (4) the provider violated a law for which a term of imprisonment of more than one year may be imposed. The bill would permit, but not require, the denial, revocation, or suspension of the eligibility of a healthcare provider to furnish non-Department healthcare when the Secretary has a reasonable belief that such action is necessary to immediately protect the health, safety, or welfare of Veterans and: (1) the provider is under investigation by the medical licensing board of a State in which the provider is licensed or practices; (2) the provider has entered into a settlement agreement for a disciplinary charge related to the practice of medicine; or, (3) the Secretary otherwise determines that such action is appropriate under the circumstances. The bill would require that the Secretary suspend the eligibility of a healthcare provider to provide non-Department care if that provider is suspended from serving as a healthcare provider of the Department. The bill also would require that the Secretary review, within one year of enactment, each non-Department healthcare provider to identify whether he or she was an employee of the Department to determine if the provider meets any of the criteria for denial, revocation, or suspension of eligibility. Finally, the bill would require the Comptroller General to submit a report to Congress within 2 years of enactment on the implementation of these authorities and its effects.

VA supports the proposed legislation in principle and would appreciate the opportunity to work with Congress to develop a proposal that builds upon similar requirements already in place without creating the unnecessary administrative burdens we believe the bill would produce, as these burdens could negatively impact Veterans' access to quality care. Currently, VA procures most community care using Third Party Administrators (TPA), under Patient Centered Community Care (PC3)/Choice

contracts, which include the development and maintenance of an adequate provider network of high quality, credentialed/certified healthcare providers. VA monitors adherence by performing quality checks through the use of a Quality Assurance Plan (QASP). As part of the QASP, VA utilizes a “three lines of defense” model to oversee the credentialing and certification process of network healthcare providers. These lines of defense involve both VA and the TPA performing ongoing reviews to ensure the quality of the providers in the network. Additionally, VA requires the contractor to report to VA, not more than 15 days after being notified, of the loss of or other adverse impact to a network provider’s certification, credentialing, privileging, or licensing. Future acquisitions will carry similar criteria as they pertain to review of provider licensure and credentialing, as VA remains committed to developing contracts for high performing networks.

Because of the measures already in place to ensure that VA only utilizes the highest quality providers in the community, VA is concerned that the administrative requirements of this legislation as written would have the potential to adversely impact Veteran access to community care as well as limit current and future contractors’ ability to timely recruit and retain qualified providers within their networks.

VA also has concerns relating to due process protections under the bill. To the extent VA relies on any fact that had not been established through a complete and fair process satisfying the requirements of due process (e.g., a criminal conviction, or a full investigation and determination by a State licensing board), the Agency’s decision should be appealable. VA does not have an existing process that could accommodate such appeals. Affected providers must be given notice and an opportunity to be heard to contest such determinations or beliefs in order to satisfy due process requirements, but it is unclear how VA would provide for this.

VA is unable to provide a cost estimate for this proposal as currently written because it is unclear what additional administrative requirements would be needed to ensure appropriate review and protections are in place.

S. 1261, VETERANS EMERGENCY ROOM RELIEF ACT OF 2017

Section 2(a) of S. 1261 would add a new section 1725A to Title 38. This new section would require the Secretary to enter into contracts with urgent care providers under which the Secretary would pay the reasonable cost of urgent care provided to eligible Veterans. Eligible Veterans would be defined as Veterans who are enrolled in VA healthcare and who have received healthcare under chapter 17 during the preceding two year period. The bill would also require the Secretary to establish a cost-sharing amount that eligible Veterans would pay to the Secretary when receiving urgent care under this section. This cost-sharing measure would not apply to Veterans who are admitted to a hospital after the provision of urgent care or to Veterans receiving urgent care for a service-connected disability. VA would be the primary payer for care provided under this section. Section 2(b) would require the Secretary to establish a cost-sharing amount that Veterans would pay for the receipt of care at a VA emergency room, unless the Veteran is receiving care for a service-connected disability, is admitted to a hospital for treatment or observation after receiving emergency care, or meets a hardship exception established by the Secretary for purposes of this section. Under section 2(c), the Secretary could not require a Veteran to pay multiple cost-sharing amounts if the Veteran sought urgent care under section 1725A and at a VA emergency room for the same condition within a period of time determined by the Secretary. Finally, section 2(d) of the bill would require VA to submit a report to Congress within two years of enactment, and not less frequently than once every two years thereafter, on the use of urgent and emergency room care by Veterans.

VA supports the intent of this bill, contingent on the provision of additional resources to support implementation. We would like the opportunity to work with the Committee on this proposal to ensure Veterans have access to timely and urgent care.

We estimate the bill as written, with certain limiting assumptions, would cost \$287.3 million in FY 2018, \$1.525 billion over 5 years, and \$3.298 billion over 10 years.

S. 1266, ENHANCING VETERAN CARE ACT

S. 1266 would authorize the Secretary to contract with a nonprofit organization that accredits healthcare organizations and programs to investigate a VAMC to assess and report deficiencies of the facility. The Secretary would be required to delegate this contracting authority to the Director of the Veterans Integrated Service Network (VISN) in which the medical center is located or to the VAMC Director. Before entering into a contract, the VISN Director or VAMC Director would be re-

quired to notify the Secretary, the VA OIG, and the Comptroller General of the United States to ensure that the investigation conducted by the contracted entity is coordinated with any investigation conducted by one of these entities. Nothing in this bill would be construed to prevent the OIG from conducting any review, audit, evaluation, or inspection, or to modify the requirement that employees assist with any review, audit, evaluation, or inspection of the OIG.

VA does not support S. 1266. VA believes that this legislation is unnecessary and runs counter to long-standing procedures governing quality of care investigations. Within the VHA, the Office of the Medical Inspector (OMI) and other offices, including the Office of Compliance and Business Integrity, the National Center for Ethics in Healthcare, and the Office of Internal Audit and Risk Assessment, are integral elements of VHA's oversight and compliance program, with responsibility for assessing the quality of VA healthcare through site-specific investigations and system-wide assessments. Through coordination of all of these resources, VA is able to carry out a wide range of investigations of whistleblower allegations, patient complaints, compliance violations, and ethics questions, among other issues. VA is also equipped to produce comprehensive reports with actionable recommendations and to follow-up with line managers to ensure fulfillment of corrective actions. VA has successfully managed the volume of cases. Furthermore, the OIG has the statutory responsibility for conducting assessments, reporting deficiencies, and ensuring corrective actions at VA facilities. Given these existing functions within VHA and OIG, the bill would mandate an unnecessary additional function.

VA has demonstrated an ability to manage a large caseload and provide comprehensive reports. VA has the infrastructure in place to conduct timely quality-of-care investigations in VA health facilities and a professional staff with decades of experience in conducting such reviews. Many of our investigators have worked in VA medical centers and are intimately familiar with their operations, policies, procedures, and unique culture. We are concerned that requiring the organizations that perform accreditations to investigate the same medical facilities they accredit could result in a potential conflict of interest. Accrediting organizations do not routinely conduct investigations of the type envisioned by the bill. VA believes that by relying on its internal systems and specific experience in these types of investigations, the intended objective of the bill can be achieved in the most efficient and Veteran friendly way possible.

We are unable to provide a cost estimate for this bill, as it is unclear how often and when such investigations would occur, or how much they would cost.

S. 1325, BETTER WORKFORCE FOR VETERANS ACT OF 2017

The draft bill, "Better Workforce for Veterans Act of 2017," contains a number of provisions intended to improve the authorities of the Secretary to hire, recruit, and train employees of the Department.

Section 101(a) would create a new section 718 that would authorize the Secretary to recruit and appoint qualified recent graduates and post-secondary students to competitive service positions within the Department, notwithstanding certain provisions of Title 5. The Secretary would only be authorized to appoint no more than a number equal to 15 percent of the number of hires made into professional and administrative occupations at the GS-11 level or below (or equivalent) during the previous fiscal year. The Secretary would be required to develop regulations governing this authority. To the extent practicable, the Secretary would be required to publicly advertise positions available under this section within certain constraints.

VA supports the concept of this provision, but also would like to note that the Administration authored a similar proposal that would be applicable to all agencies, and transmitted it for consideration in the FY 2018 National Defense Authorization Act (FY 2018 NDAA). This would provide greater flexibility to hire students and recent college graduates, providing an immediate opportunity for new employees to begin their careers with VA. The Administration would prefer a Government-wide solution that would provide a significant recruitment benefit if all agencies were able to utilize it.

Section 101(b) would create a new section 719 that would require the Secretary to prescribe regulations to allow for excepted service appointments of certain students and recent graduates leading to conversion to career or career conditional employment.

VA defers to OPM on implementation of this provision as an important element to implementing the program authorized by section 101(a) for certain students and interns. OPM would be best suited to provide any necessary technical drafting assistance to align these authorities with OPM's current Government-wide Pathways Program.

Section 102 would amend section 3304(a)(3)(B) of Title 5 to permit the Secretary to appoint directly for positions for which there is a severe shortage of highly qualified candidates. OPM would have the authority to determine what positions would qualify, as well as having the ability to delegate the authority to make those determinations.

VA supports this provision as this would provide greater flexibility to directly reach applicants when we have a severe shortage of highly qualified candidates. This would help the Department address some of its most critical vacancies.

Section 103 would create a new section 712 to authorize the Secretary to appoint a former Federal employee to a high-demand position within the Department for which the former Federal employee is highly qualified without regard to provisions concerning competitive appointments. The former Federal employee could be appointed to a position at a higher grade or with more promotion potential than the position the employee previously held. Within 18 months of enactment, the Inspector General of the Department would be required to conduct an audit of the use of this authority by the Secretary and report to Congress on the results of that audit.

VA defers to OPM on this provision. Currently, we could hire someone non-competitively to a position at the same level they previously held, while this provision would allow VA to hire someone to a higher level than they previously held. Therefore, implementation would need to be measured, with appropriate controls in place to prevent misuse.

Section 104 would create a new section 720 to require the Secretary to develop and implement a resume-based application method for applications for appointment to senior executive positions within VA. The application would have to be, to the extent practicable, comparable to the resume-based application method for the Senior Executive Service (SES) developed by the Office of Personnel Management (OPM), and would have to be used for initial applications for a position as a senior executive to the extent such use will be more efficient and effective and less burdensome for all participants. The Secretary would be authorized to make an initial career appointment of an individual to a position as a senior executive if a review board convened by VA certifies the executive and managerial qualifications of the individual.

At this time, VA does not support this provision because we do not believe it is necessary. Resume-based application is allowed under current rules, and VA would like to maintain flexibility in hiring and assessment. VA currently uses a resume-based system for executive recruitment for its medical center Director positions, and with the recently enacted Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41), signed June 23, 2017, VA now has direct hiring authority for these and VISN Director positions. We continuously evaluate our hiring methods, timeframes, and outcomes to identify opportunities for improvement, and we would be happy to share our findings with the Committee.

Section 105 would establish a new section 721 that would require the Secretary to establish and periodically review a single database that lists each vacant position in VA that the Secretary determines is critical to VA's mission, difficult to fill, or both. If the Secretary determines that an applicant for a position listed in the database is qualified for such position, but the Secretary does not select such applicant, the Secretary, at the election of the applicant, would be required to consider the applicant for other, similar vacant positions listed in the database. If the Secretary did not fill a vacant position listed in the database after an appropriate time (as determined by the Secretary), the Secretary would be required to ensure that applicants who were not selected for other positions but who meet the qualification requirements are considered. The Secretary would also be required to use the database to assist in filling such positions. Within one year of enactment, the Secretary would be required to submit a report to Congress on the use and efficacy of the database established under this section.

We support the concept of identifying and maintaining a database of vacancies, but do not support this particular provision. VA completed the implementation of a commercial software product as the core foundation to our new enterprise automated human resources system. We will implement an enhancement in FY 2018 to manage positions, which will provide real-time vacancy information. With the systems we currently have in place and in development, we believe we can meet the intent of this provision without legislation, and in a way that is less administratively burdensome.

Section 106 would create a new section 722 that would require the Secretary to measure and collect information on indicators of hiring effectiveness concerning certain identified factors related to recruiting and hiring candidates, as well as the satisfaction of employees, newly hired employees, and applicants. To the extent practicable, and in a manner protecting personally identifiable information, the Sec-

retary would be required to collect and report data disaggregated by facility and VISN to ensure the data is collected from human resources offices throughout VA. The Secretary would be required to submit an annual report to Congress on the information collected, and to make such information publicly available.

As written, we do not support this provision. We are concerned the vagueness of the language could result in application to virtually every aspect of the recruitment process. The terminology in this provision includes subjective terms, and we believe some provisions may be inconsistent internally. In addition, these provisions could be inconsistent with other agencies' recruitment and hiring information. We have a number of technical comments and recommendations and would be glad to share those with the Committee. We also would request that the Committee solicit OPM for technical drafting assistance on this provision.

Section 107 would create a new section 723 requiring the Secretary to develop and carry out a standardized, anonymous, voluntary exit survey for career and non-career employees who voluntarily separate from VA. The survey would have to ask questions regarding the reasons for leaving, any efforts made to retain the individual, the extent of job satisfaction and engagement, the intent of the employee to remain in or leave Federal employment, and other matters considered appropriate by the Secretary. The Secretary would be required to share the results of the survey with the directors and managers VA facilities and VISNs, and the Secretary would be required to report annually on the aggregate results of the exit survey.

We do not support this provision because we believe it is unnecessary, given that we already use exit surveys that capture almost all of the content this legislation would require.

Section 108 would amend section 2108(1) of Title 5 concerning Veteran preference so that any Veteran who served a total of more than 180 days would qualify, rather than only those who served more than 180 consecutive days.

We note that this provision would amend title 5 and apply to the entire Federal Government. As a result, we defer to OPM on this provision.

Section 109 would amend section 705(a) of the Veterans Access, Choice, and Accountability Act of 2014 to clarify that recruitment, relocation, or retention incentives are not subject to the limitations on awards and bonuses available in the Department.

VA supports this provision. Currently, the limitations on awards and bonuses include recruitment, retention, and relocation incentives, which have severely limited the Department's ability to offer incentives to hire and retain critical positions. Under these limitations, the Department has attempted to reserve the bulk of the funds that are available to provide incentives to positions, particularly medical professionals with specialized skills and expertise that would be difficult or impossible to replace. This has resulted in an inequitable treatment among employees, as there are fewer resources available for those otherwise deserving and equally dedicated employees.

If this authority were enacted, VA would reallocate funds already appropriated for recruitment and retention of highly qualified employees.

Section 110 would amend section 7309 of Title 38 to remove the requirements that the Chief Officer of VA's Readjustment Counseling Service (RCS) must have at least 3 years of experience providing direct counseling services or outreach services through RCS, as well as 3 years of experience administering direct counseling services or outreach services through RCS.

VA supports this provision. This would provide greater flexibility to appoint the Chief Officer of RCS, which oversees VA's Vet Centers, a critical component to providing Veterans and Servicemembers readjustment counseling and other services.

There would be no costs associated with this provision.

Section 111 would require, within 120 days of the date of the enactment of this Act, the Secretary to submit a report to Congress on vacancies within the Veterans Health Administration. This report would have to include vacancies of personnel appointed under section 7401 of title 38, vacancies of human resource specialists in VHA, a description of any impediments to filling certain vacancies, and an update on the implementation of several plans and reports.

We do not believe section 111 is necessary, but we do not oppose this requirement. Until the system enhancement previously mentioned is implemented in FY 2018, collecting this information is a manual and intensive effort. As a result, we are concerned that the 120 day deadline would be difficult to meet. We believe that we would be in a better position to gather this information within the next year.

Section 201 would create a new section 724 providing that for any reduction in force by VA, competing employees would be released with due effect to the following in order of priority: tenure of employment, military preference, efficiency or performance ratings, and length of service.

We do not oppose section 201 because this would only change the order of consideration for how reductions in force would occur. However, we would defer to OPM, to ensure that reduction in force procedures remain consistent across the Government. We note that for hybrid title 38 positions, we think it would be appropriate to also consider the level and type of licensure, as well as the scope of practice, in making such determinations.

Section 202 would create a new section 725 authorizing the Secretary to arrange, with the agreement of a private-sector organization, for the temporary assignment of VA employees to such organization to occupy a position in that organization and for the private sector employee who held that position to temporarily occupy the position of the VA employee. In essence, these employees would be trading positions for a temporary period. The VA employee would return to work for the Department, and if either employee failed to carry out the agreement, the employee would be liable to the United States for payment of all expenses of the assignment, with certain exceptions; such liability would be a debt that could be waived if the Secretary determined collecting it would be against equity and good conscience and not in the best interests of the United States. The VA employee would be prohibited from using pre-decisional, draft deliberative, or other information for the benefit or advantage of the private sector organization. Assignments would be for periods between 3 months and 4 years. VA employees assigned to the private sector organization would be considered, during the period of assignment to be on detail to a regular work assignment in the Department for all purposes. The private sector employee assigned to VA employment would generally not be considered a Federal employee with certain exceptions and would have other constraints imposed upon the scope of that employee's work with the Department. The private sector organization would be prohibited from charging VA, as direct or indirect costs under a Federal contract, for the pay or benefits paid by the organization to the employee assigned to VA. The Secretary would be required to take into account certain considerations in operating this program.

In theory, VA supports the concept of rotational assignments for professional development, and notes that the Administration submitted, in the context of the FY 2018 NDAA, a similar proposal to provide governmentwide authority for industry exchange programs. We note, however, that the potential for conflicts of interest in this provision are significant, notwithstanding the language in the bill attempting to limit this. There are several areas where this provision is ambiguous, and we would appreciate the opportunity to discuss this further with the Committee prior to taking a position on this section. We would recommend that the Committee work with the Office of Government Ethics on the appropriate language to address issues related to conflicts of interest.

Section 203 would amend section 7306 to allow for the appointment of VISN Directors in addition to medical center Directors to suit the needs of the Department. It would also remove the requirement for these Directors to be qualified doctors of medicine, or doctors or dental surgery or dental medicine. It would further amend that section to allow the Secretary to establish qualifications for these Directors and appoint them under this authority. The Secretary and the Director would be required to enter into an agreement that permits employees appointed under this authority to transfer to SES positions in other Federal agencies and to be deemed career appointees who are not subject to competition or certification by a qualifications review board.

Section 207 of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41), signed June 23, 2017, significantly amended VA's authority to hire directly VISN and medical center Directors. In this context, we would like the opportunity to discuss this proposal further with OPM and the Committee to consider the effects of these proposed changes before taking a position on this section.

Section 204 would create a new subchapter VII in chapter 74 concerning pay for medical center Directors and VISN Directors. The new section 7481 would provide that pay for these Directors would consist of basic pay and market pay, which would be determined by the Secretary on a case-by-case basis and consist of pay intended to reflect the needs of the Department with respect to recruitment and retention of such Directors. The bill would impose other requirements in terms of determining market pay under this section. The Secretary would be required, not less frequently than once every 2 years, to set forth within defined parameters Department-wide minimum and maximum amounts for total pay for Directors, and to publish such limits in the *Federal Register*. Pay under this section would be considered pay for all purposes, including retirement benefits. A decrease in the pay of a Director resulting from an adjustment in market pay could not be considered an adverse action, while a decrease resulting from an involuntary reassignment in connection

with a disciplinary action would not be subject to appeal or judicial review. The OPM Director would be required to undertake periodic reviews of the Secretary's determinations and certify to Congress each year whether or not the market pay is in accordance with the requirements of this section. If the Director determined the amounts were not in accordance with the requirements of this section, the Director would report to Congress on such determination as soon as practicable after making such determination.

We appreciate the Committee's interest in this regard. Similar to section 203, we note that given the recent change (Public Law 115-41) in our appointment authority for VISN and medical center Directors, we would like to discuss this proposal further with OPM and the Committee prior to taking a position on the specific provisions in this section. We anticipate there would be additional costs to implement this section.

Section 205 would create a new section 7413 that would require the Secretary to provide to VHA human resources professionals training on how best to recruit and retain VHA employees. The Secretary would provide such training in a manner considered appropriate considering budget, travel, and other constraints. The Secretary would be required to ensure that each VHA human resources professional received such training as soon as practicable after being hired and annually thereafter. The Secretary would be required to ensure that a medical center Director, VISN Director, or senior officer at Central Office certified that the professional completed such training. The Secretary would be required to report annually on the training provided under this authority, including the cost of such training, and the number of professionals who receive such training.

We do not support section 205 because VA already has the authority to conduct such training. VA provides training to human resources professionals currently, and we are concerned that the specific requirements in this provision could constrain our ability to adapt training to emerging needs. We also have some technical concerns with this provision that we will share with the Committee.

Section 206 would require the Secretary to include education and training of marriage and family therapists and licensed professional mental health counselors in carrying out the education and training programs conducted under section 7302(a)(1). The Secretary would be required, to the degree practicable, to ensure that the licensing and credentialing standards for therapists and counselors participating in this program are the same as the licensing and credentialing standards for eligibility of other participants in the program. Finally, the Secretary would be required to apportion funding for education and training equally among the professions included in the program.

In general, we currently have the authority to carry out this section. VA has already established training programs for licensed professional mental health counselors and marriage and family therapists. We are concerned with the potential effect this could have on the quality of the education and training standards, and we would appreciate the opportunity to discuss this further with the Committee. We are also concerned that the language, particularly in subsection (c) of this provision, is too prescriptive and could limit VA's flexibility to adjust training needs and resources to meet operational needs.

Section 207 would require, within 180 days of the date of enactment of this Act, the Secretary and the Surgeon General to enter into a memorandum of understanding (MOU) for the assignment of not fewer than 500 commissioned officers of the Regular Corps of the Public Health Service to VA. The Secretary would reimburse the Surgeon General for expenses incurred in assigning commissioned officers to VA. Within 1 year of enactment, the Secretary and Surgeon General would each be required to submit to Congress a report on the MOU and the commissioned officers assigned under this authority.

We do not support this provision because it is unnecessary. VA and the Department of Health and Human Services (HHS) signed an MOU earlier this year to allow for commissioned officers of the Public Health Service to serve in VA. We would like the opportunity to discuss this further with the Committee and HHS to determine what, if any, legislative authority we need in this area.

Section 208(a) and (b) would require, within 1 year of the date of enactment of this Act, the Under Secretary for Health to develop a comprehensive competency assessment tool for VHA human resources employees to assess the knowledge of such employees on how employees appointed under section 7401(1) are treated differently than employees appointed under other authorities. Within 2 years of the date of enactment of this Act, and once every 2 years thereafter, the Secretary would have to submit a certification to Congress as to whether an assessment of all VHA human resources employees was conducted and whether such employees used the results of such assessment to identify and address competency gaps. Within 18 months of

the date of enactment of this Act, the Under Secretary for Health would be required to evaluate the extent to which these training strategies are effective at improving the skills and competencies of VHA human resources employees.

Section 208(c) would require, within 1 year of enactment, the Under Secretary for Health to establish clear lines of authority that provide the Assistant Deputy Under Secretary for Health for Workforce Services the ability to oversee and hold the heads of the human resources offices of VA medical centers accountable for implementing initiatives to improve human resources processes and for ensuring employees undertake the assessment required under subsection (a). Within 1 year of enactment of this Act, the Secretary would be required to clarify the lines of authority and processes for the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration with respect to overseeing holding the VISN and VA medical center Directors accountable for the consistent application of Federal classification policies.

Section 208(d) would require the Secretary to ensure the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration are responsible for monitoring the status of corrective actions taken at human resources offices of VA medical centers and that such actions are implemented.

Section 208(e) would require the Secretary to ensure that meaningful distinctions are made in performance ratings for VHA employees.

Section 208(f) would require, within 1 year of enactment of this Act, the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration to develop a plan to implement a modern information technology (IT) system to support employee performance management processes.

Section 208(g) would require, within 1 year of enactment of this Act, the Under Secretary for Health to establish clear lines of authority and accountability for developing, implementing, and monitoring strategies for improving employee engagement across VHA. The Under Secretary for Health would be required to report to Congress on whether VHA should establish an employee engagement office at the headquarters level with appropriate oversight of VISN and VA medical center employee engagement initiatives.

We do not believe this section is necessary. We are currently implementing the requirements of these provisions based on the recommendation of a Government Accountability Office (GAO) report (GAO 17-30). We also have some technical concerns we believe need to be addressed, and we will be glad to provide those to the Committee.

Section 208(h) would require, within 1 year of enactment, the Comptroller General to examine the overlapping functions of human resource structures within VHA and the Office of the Assistant Secretary of Human Resources, whether there are opportunities to centralize offices and tasks that are duplicative, and whether the use of multiple hiring structures has had an effect on the speed with which VA hires new employees. The Comptroller General would report to Congress on the Comptroller General's findings.

VA defers to the Comptroller General on this provision.

Section 209 would require, within 120 days of enactment of this Act, the Secretary to report to Congress on the effect the freeze on the hiring of Federal civilian employees ordered by the President on January 23, 2017, has had on the ability of VA to provide care and services to Veterans.

We do not believe this is necessary, and do not support it, as the hiring freeze was only in effect, at most, for a limited number of positions not related to patient care or access. We also do not believe it would be possible to identify to any meaningful degree any effects that may have occurred as a result of the hiring freeze.

Section 210 would require, within 180 days of enactment of this Act, the Secretary to report to Congress on how the Secretary plans to implement the portions of the plan of the OPM Director to reduce the size of the Federal workforce through attrition as it pertains to VA.

We believe this provision is unnecessary. VA is working to implement an agency reform plan, consistent with the OMB Director's requirements. We are looking at how we will be filling administrative positions that become vacant, along with other potential actions, and will be updating these plans and assessments in the future. We would be happy to share with the Committee the plan the Department submits to OMB when it is available.

Section 211 would require, within 180 days of enactment of this Act, the Secretary to publish online information on staffing levels for nurses at each VA medical facility. The head of each medical facility would be required to update the information as changes to the staffing level of nurses at the facility occur. The Secretary would be required to consult with Centers for Medicare & Medicaid Services in developing the information required by this section. The Secretary would be required to submit

a report to Congress discussing and assessing the use by medical center Directors of authorities to provide nurses pay that reflects market conditions, the adequacy of training resources for nurse recruiters, the key recruitment and retention incentives of VHA for nurses, and other factors.

We do not support this provision for two major reasons. First, the staffing levels referenced in the bill are not defined. Second, the actual number of nurses varies on an almost daily basis given the volatility in terms of staffing. It would be incredibly cumbersome to maintain this information and update it in real time. We already report to Congress each year on efforts to provide nurses greater pay, and this report would be duplicative of that effort.

Section 212 would require, within 1 year of enactment of this Act, the Secretary, in consultation with the OPM Director, to ensure that the job description, position classification, and grade for each position as a police officer or firefighter in VA are in accordance with standards for the classification of such positions prepared by OPM. The Secretary would be required to develop a staffing model for the positions of police officers and firefighters within the Department. The VA Inspector General would be required to conduct an audit of VA's efforts to recruit and retain police officers and firefighters and report to the Secretary and Congress on the audit's findings. Finally, the Secretary would be required to report to Congress on the use by medical center Directors of special pay incentives to recruit and retain trained and qualified police officers and the steps the Secretary plans to take to address the critical shortage of police officers throughout the Department.

We have some concerns with this provision. We believe the reviews required by this section could require a considerable amount of resources. We would like the opportunity to discuss this proposal further with the Committee and OPM to determine what we may be able to do currently to address the Committee's concerns and interests in this matter.

Section 213 would require, within 1 year of enactment of this Act, the VA Inspector General to complete a study on how VHA communicates its directives, policies, and handbooks to the field, including the compliance with such documents, and the effectiveness of each VISN in disseminating information to employees within the Network and Veterans served by the Network.

The Department defers to the Inspector General on this provision.

As noted above, VA will be providing follow-up views for the record on S. 1279, the Veterans Health Administration Reform Act, the draft Department of Veterans Affairs Quality Employment Act of 2017, and section 10 of the Veterans Choice Act of 2017.

S. XXXX, VETERANS CHOICE ACT OF 2017

The draft Veterans Choice Act of 2017 contains a number of provisions intended to improve VA's community care program. Community care has helped significantly expand access to care for Veterans nationally and plays an important role in VA's effort to build a modern, integrated healthcare network.

Section 3(a) of the bill would amend section 1703 of title 38 to authorize the Veterans Choice Program. Under this Program, all enrolled Veterans would be eligible to elect to receive hospital care, medical services, mental health services, and certain diagnostic services, outpatient dental services, and diagnostic services from specified eligible providers. These services could be provided through telemedicine, at the election of the Veteran. The Secretary would be required to enter into consolidated, competitively bid regional contracts with healthcare organizations or third party administrators to establish networks of eligible providers for the purpose of providing sufficient access to care and services. The bill would define various responsibilities for these organizations or administrators, including enrolling covered Veterans, conducting referrals and authorizations, customer service, and maintaining an interoperable electronic health record. These parties would be required to leverage advanced technology to allow Veterans to make their own appointments, including online and through smart phone applications. Veterans who need assistance making their appointments could receive assistance from the organization or administrator or the Secretary. The organizations or administrators would be required to meet capability, capacity, and access standards established by the Secretary, including those established pursuant to sections 9 and 10 of this bill. Providers who currently furnish care or services under another authority would be offered the opportunity to furnish care and services through this Program.

Under the Veterans Choice Program, the rates paid for care or services could not exceed the Medicare rate, except in highly rural areas, in the State of Alaska, in a State with an All-Payer Model Agreement that became effective on January 1, 2014, or at other rates established by the Secretary if no Medicare rate exists. The

Secretary would be authorized to recover from a third party for any care furnished for a non-service-connected disability, and the Secretary would be responsible for paying the copayment, deductible, or coinsurance charged to the Veteran for care or services. Veterans could not be required to pay a greater amount for receiving care or services than they would if they had received comparable care or services at a VA medical facility or from a VA medical provider.

The proposed amendments to section 1703 would impose other requirements. For example, VA would have to ensure the Veterans Health Identification Card issued to every enrolled Veteran includes the words “Choice eligible” and additional information needed to serve as an identification card for the Program. Additionally, the Secretary would be required to monitor a number of quality and access standards related to the care furnished under this Program. These changes would become effective upon the termination of the current Veterans Choice Program operated pursuant to section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

We support many of the principles in the proposed section 1703. We appreciate that the section’s eligibility criteria would be simple to administer by making every enrolled Veteran eligible to participate. We also appreciate the flexibility in terms of eligible providers, and the regional network model generally matches our current plans with the Community Care Network solicitation. We also appreciate the section’s recognition of the importance of ensuring quality care is furnished to Veterans through this Program.

However, we have some significant concerns with certain provisions of proposed section 1703. In many areas, there are provisions that are overly prescriptive and that would narrow the Secretary’s authority to adjust to evolving situations. For example, the Secretary would be prohibited from directing Veterans to certain health care providers. While we support Veterans’ choosing their own providers, we understand that many Veterans do not express a specific preference for an individual provider, and this language could restrict our ability to direct Veterans to high-performing providers who are available. Also, the responsibilities of the regional networks are too specific—we would prefer the language be silent on these matters so that we can adjust responsibilities between VA and our regional networks to ensure the best services are available for Veterans. Furthermore, the language concerning payment rates is too limiting. There will be situations where VA will need to pay more than the Medicare rate other than in highly rural areas, the State of Alaska, and States with All-Payer Model Agreements. We have serious concerns with the language in proposed 1703(h), which would require the Secretary to pay the amount of a Veteran’s copayment, deductible, or coinsurance. This would be inconsistent with private sector and VA’s current practice. Section 1729 currently provides that Veterans are not required to pay a copayment, deductible, or coinsurance required under the terms of their health insurance for care and services furnished by the Department. Moreover, requiring the Department to pay a Veteran’s copayment, deductible, or coinsurance could significantly increase the Department’s expenses, including its administrative costs, in ways that we cannot currently project given the variability in insurance plans and payment responsibilities for the millions of Veterans with such insurance. While we support the principle of ensuring quality care, we are concerned that some of the language in proposed 1703(l) would be too prescriptive, and we would prefer more general language.

Requiring that the words “Choice eligible” appear on a Veterans Health Identification Card (VHIC), as provided for in proposed section 1703(k), would create redundancy and be extremely costly. The bill would make any enrolled Veteran eligible for Choice, and all enrolled Veterans are issued VHICs, so any person with a VHIC would already establish his or her eligibility by virtue of having the VHIC. Requiring Veterans to have a VHIC with the words “Choice eligible” would also produce greater demands on Veterans who would have to come to a VA facility to receive an updated version of their VHIC.

Finally, we are concerned that there is no transition period contemplated by section 3(a)(3). The new 1703 would take effect immediately upon the expiration of the current Veterans Choice Program, based on the exhaustion of the Veterans Choice Fund. We believe that either a clear timeline (such as one year from enactment) or an event within the Department’s control (such as the publication of regulations) would be preferable for the transition between the current Choice Program and the future Choice Program. We also may encounter problems where individual authorizations made under the current 1703 would no longer have any legal authority for payment upon this transition, as this provision would completely rewrite section 1703. While the Department would try to reduce the potential for this issue, we would not be able to eliminate this problem.

Section 3(b) would prohibit VA from entering into or renewing any contract or agreement under a non-Department provider program, which would include the cur-

rent Veterans Choice Program; the Patient-Centered Community Care (PC3) program; the Project Access Received Closer to Home (ARCH) program; VA's retail pharmacy network; agreements entered into with DOD, IHS, or other Federal agencies; agreements entered into with academic affiliates of VA; agreements to furnish care, including on a fee basis; or agreements with non-governmental entities. If the Secretary continued to administer any of these programs after the date on which the new Veterans Choice Program begins, they could only be administered under that Program. The Secretary would be required to ensure continuity of care by making services available through regional contracts or other agreements entered into under the new Veterans Choice Program.

We are very concerned with this provision and do not support it. It would require VA to renegotiate, reissue, or terminate every agreement and contract, regardless of the terms or conditions of such an agreement permitting extensions or other flexible authorities. We believe this could affect such agreements as those with DOD, IHS, and tribal health programs, as well as with our academic affiliates and contractors. This would include thousands of agreements, would be very difficult and costly to do, and would not produce any clear, tangible benefit. If these agreements would also now be subject to the limitations in proposed section 1703, this provision could put conditions on these agreements that would be unacceptable to certain providers or in certain areas. This could also potentially impact our relationships with certain providers, such as IHS and tribal health programs, which require consultation prior to changes. We also note, given the breadth of section 3(b)(4)(E), that extended care services procured from the community would be included, but note that the language for the Veterans Choice Program in section 1703 does not address such services; as a result, it is unclear what terms and conditions would apply to these services.

Section 4 would establish a new section 1703A authorizing VA to enter into Veterans Care Agreements (VCA). VCAs could be entered into when the Secretary is not feasibly able to furnish hospital care, medical services, or extended care services at VA facilities or when such care or services are not available under the Veterans Choice Program. Providers could opt to enter into a VCA, at the discretion of the eligible provider. The eligibility of Veterans for care would be the same as if they received care in a VA facility. The Secretary would be prohibited from directing Veterans seeking care or services to healthcare providers who have entered into contracts or sharing agreements under different authorities, except for Veterans Choice Agreements authorized under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 or under the regional contracts or other arrangements made under section 1703, as revised by section 3 of this bill.

The Secretary would be required to establish a process for the certification of eligible providers. VCAs would have to include certain terms, including accepting payment at Medicare rates (except in highly rural or underserved areas), accepting payment as payment in full, and other terms and conditions. Each VCA would permit the provider to submit to the Secretary clinical justification for any services furnished without authorization when seeking payment, and the Secretary would review these submissions on a case-by-case basis in determining whether or to pay the provider for such services. The Secretary would be required to review periodically VCAs of a material size to determine whether it is feasible and advisable to furnish the care and services at a VA facility or through contracts or sharing agreements. VCAs would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. Parties entering into a VCA would not be treated as a Federal contractor by the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor, and they 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 parties entering into a VCA. The Secretary would be required to establish a system or systems, consistent with those used by the Centers for Medicare and Medicaid Services, to monitor the quality of care provided and would be required to establish administrative procedures for dispute resolution. The Secretary would be required to prescribe an interim final rule within 1 year of enactment to carry out this section.

We generally support this provision, but have some concerns we would like to address. In particular, proposed section 1703A(a)(2)(A)(ii) would prohibit the Secretary from entering into a VCA if care or services are available under the new Veterans Choice Program. Although we appreciate the intent of this provision, we believe there may be situations where the clinical need of the Veteran will require the use of a VCA notwithstanding the availability of such services under the Choice Pro-

gram. For example, a Veteran may require a certain type of orthopedic procedure, and while orthopedics in general are “available” under a contract, the specific procedure or a specialist may not be included within the contract, or would only be available at a lesser quality. In other situations, a Veteran may elect to receive care from a certain provider that would be ideally suited to furnishing the care required, but who is not a member of the network. We want to ensure we have flexibility in situations like these to deliver the care the Veteran requires in a timely and appropriate way. We also note these provisions apply for when the Secretary may “enter into” agreements, rather than “use” agreements. We have found, through our experience with the current Veterans Choice Program that it is more efficient to enter into these agreements before they are needed to ensure that there is no delay in the receipt of care by eligible Veterans. We believe the language could be modified slightly to impose restrictions on the utilization of VCAs to ensure the integrity and use of the network of providers under the new Veterans Choice Program.

Proposed section 1703A(e)(2) is unclear, and depending upon what the intent is, we may or may not support it. If the provision is intended to simply allow providers to submit claims for care that was unconnected or unrelated to the services VA originally authorized, we are concerned this could create situations where VA pays for services that were neither authorized nor clinically needed. This would create a significant administrative burden on both the providers and VA. If, on the other hand, this is intended to apply only in limited circumstances for care that VA would have authorized, then we have no objection to it.

Regarding proposed section 1703A(g), VA agrees with the idea of monitoring how VCAs are utilized by VA. However, we are concerned that the threshold for when an agreement for the purchase of extended care services is considered to be of “material size,” i.e., exceeding “\$1,000,000 annually,” is too low. Costs for long term extended care and nursing home care costs can easily exceed this level. The threshold also does not account for providers who may have a national presence.

Section 5(a) would establish a new section 1703B concerning payment of non-Department healthcare providers. Specifically, VA would be required to comply with the provisions in this section and in chapter 39 of title 31 (the Prompt Payment Act). Non-Department providers would be required to submit a claim for reimbursement within 180 days, and the Secretary would have to pay claims according to specified time standards or else interest would accrue on the amount owed. If a provider submits a clean claim, VA would have to pay the claim within 30 days if it was submitted electronically or 45 days if it was submitted other than electronically. If a claim were not clean, the Secretary would have to inform the provider within 10 days on the steps that would be needed to make it clean. By January 1, 2020, the Secretary would only be authorized to accept claims electronically except in certain circumstances.

We generally support section 5(a), but have some concerns with a few of the provisions. For example, we think there should be more flexibility to accept paper claims from smaller providers, such as Homemaker/Home Health Aides. We are also concerned that, as written, this language could require that late payments of providers who have entered into contracts with the Regional Networks could subject VA to interest payments, even though VA has no privity of contract with these providers and is paying the Network on time. Finally, we do not believe the Committee had transactions between VA and other Federal entities in mind when it included a prompt payment standard in the draft bill. An exception could be added in this section to address this issue.

Section 5(b) would require the Secretary, not later than 2 years after the date of the enactment of this Act, to enter into an agreement with a third-party entity to process claims for reimbursement through an electronic interface.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the term “process” is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead.

Section 6 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 6, although, we have similar concerns to those we expressed regarding section 4 with respect to the applicability of certain laws.

Section 7 would amend section 1705 to require the Secretary, upon the enrollment of a Veteran in the VA healthcare system, to assign the Veteran to a dedicated primary care provider of the Department, unless the Veteran elects to choose a primary care provider from among the healthcare providers furnishing care in the network established under the new Veterans Choice Program.

We do not support section 7 because this would require all enrolled Veterans to be enrolled in provider panels, even if we do not furnish care to those Veterans. We typically only assign Veterans to a panel once they have expressed interest in receiving care from the Department. We are concerned that assigning other Veterans to panels will complicate our projection models for demand and our estimates for resources for our facilities. We are also concerned that the ability of a Veteran to elect to choose a primary care provider from among VA's network of community providers could allow for the control and coordination of care, including the authorization of care (and the obligation of Federal funds), to move to a non-Federal agent, which presents issues concerning the proper use of appropriated funds.

Section 8 would require the Secretary to enter into national contracts with private healthcare providers to make dialysis treatments available in the community. Veterans would be able to choose the provider from which they would receive dialysis services. Under subsection (c), the Secretary could not pay more than the Medicare rate for the same dialysis services or treatment.

While we support the intent of this proposal, we are concerned that this could potentially limit the Department's ability to furnish dialysis care. This provision would limit VA to paying the Medicare rate; we currently pay more than the Medicare rate in certain circumstances, and it is unclear if we could enter into contracts for the same care at a reduced rate. If we were unable to enter into these contracts, VA would not be able to provide this essential clinical service.

Section 9 would require VA to establish a demand profile with respect to each health service furnished under the laws administered by the Secretary. The demand profile would have to include various factors, such as the number of requests for services, the number of appointments (both in VA and the community), the capacity of the Department to provide such services, and an assessment of the need for community care for the service. The Secretary would use these profiles to inform the capability and capacity of the provider networks established in the new Veterans Choice Program. Within 120 days of the date of enactment of this Act, the Secretary would be required to submit to Congress a strategic plan with a 5 year forecast on the demand for care and the Department's capacity and capability to satisfy that demand within its facilities. The Secretary would have to update the strategic plan annually.

VA agrees in concept with the provisions in section 9; however, we believe this provision is not necessary as VA has currently embarked upon a national market-by-market assessment effort that will produce the same level of information called for in the bill. VA's market-by-market assessment is in response to a requirement in section 240 of Division A of Public Law 114-223, the "Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017." That law requires VA to develop a national realignment strategy. As a result, the assessment of VA's 98 marketplaces across the United States is currently underway.

Section 10 would require the Secretary to establish uniform access standards for furnishing healthcare services, including through community providers, for urgent care, routine care, referral or specialty care, and wellness or preventive care. These access standards would have to include the average time a Veteran is expected to wait to receive an appointment, the average time a Veteran is expected to drive to arrive at an appointment, the average time a Veteran is expected to wait at a facility to receive healthcare services, and such other factors as the Secretary considers appropriate. The Secretary would be required to coordinate with DOD, the Department of Health and Human Services (HHS), private entities, and other non-governmental entities in establishing these standards. The Secretary would be required to submit a report to Congress within 120 days of the date of the enactment of this Act detailing the standards established under this section.

We do not have views on section 10 at this time.

Section 11 would require the Secretary, within 1 year of enactment, to procure a commercial, off-the-shelf electronic health record platform that conforms to the standards of interoperability required under section 713 of the National Defense Authorization Act for Fiscal Year 2014. The bill would define a number of require-

ments for this system, including its interoperability with DOD's systems and private sector systems and compliance with national standards identified by the VA and the DOD Interagency Program Office in collaboration with HHS' Office of the National Coordinator for Health Information Technology.

VA does not believe section 11 is necessary because the Secretary has already announced his intention to procure a commercial system for VA's Electronic Health Record capability. Similar to our concern with other provisions, we note that the specificity in this provision could limit the Secretary's ability to ensure this new system is responsive to Veterans' needs.

Finally, section 12 would make various conforming amendments to reflect the changes made by section 3 of this bill by updating references in other statutes to VA's community care authorities.

We support section 12 as a measure to consolidate VA's community care programs.

We are unable to provide cost estimates on the bill at this time but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

S. XXXX, IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT OF 2017

The draft Improving Veterans Access to Community Care Act of 2017 also contains a number of provisions intended to improve VA's community care program.

Section 101(a)(1) would create a new section 1703A, establishing the Veterans Community Care Program. Many of the terms and conditions governing this Program would be similar to those applicable to the existing Veterans Choice Program. Under this new Program, hospital care and medical services would be furnished to eligible Veterans at the election of the Veteran through contracts or agreements with eligible providers. The Secretary would be responsible for coordinating care and services, including ensuring that an eligible Veteran receives an appointment for care and services within the wait-time goals of the Veterans Health Administration (VHA). To be eligible under the Program, Veterans would have to be enrolled in VA healthcare and meet one of the following criteria: reside in a location, other than Guam, American Samoa, or the Republic of the Philippines that requires the Veteran to travel by air, boat or ferry to reach a VA medical facility; be enrolled in Project ARCH; the Veteran and the Veteran's VA provider determine the Veteran should be eligible based upon the eligibility criteria in the current Veterans Choice Program, namely being unable to schedule an appointment within the clinically indicated timeframe, residing more than 40 miles driving distance from the nearest VA medical facility with a full-time primary care physician, residing within a State without a full-service VA medical center, or facing an unusual or excessive burden in accessing services from a VA medical facility. The Veteran and provider could also determine whether the Veteran should be eligible under the Program based upon a compelling reason that the Veteran needs to receive care and services from a non-Department facility. The Secretary would be required to establish a process to review any disagreement between Veterans and their providers, and the Secretary would make the final determination as to the eligibility of the Veteran.

While we appreciate the intent of the eligibility criteria for Veterans, we are concerned with how this program is structured. We fully agree that the provider-patient relationship should be the basis for eligibility to receive community care. However, the draft bill would combine this approach with the current administrative eligibility criteria in the Choice Program. We believe this would result in an ultimately confusing "hybrid" standard that would be difficult for providers to apply. In addition, we believe continuing to use administrative criteria would be inappropriate, as they are arbitrary in nature and not informed by the patient-provider relationship. The proposed approach would also be unduly limiting in terms of the types of clinical factors that a provider could consider; for example, a Veteran who lived across the street from a full-service VA medical center with no wait times and who was fully ambulatory would not appear to qualify under any of these provisions, and yet the Veteran may require a certain type of service that would be best delivered by a community provider. We would like to work with the Committee to better understand the underlying issue that proposed subsection (b)(2), concerning the review of provider determinations, is intended to address.

Under section 1703A, providers would have to meet the same eligibility criteria in the current Veterans Choice Program to participate in the new Program, including maintaining the same or similar credentials and licenses as VA providers. The Secretary would be authorized to create a tiered provider network, but would not be able to prioritize providers in a tier over providers in any other tier in a manner

that limits the choice of an eligible Veteran to select that provider. The Secretary would be required to enter into contracts with eligible providers for furnishing care and services, but before entering into such a contract, the Secretary would be required, to the maximum extent practicable and consistent with the requirements of this section, to furnish care and services with eligible providers pursuant to sharing agreements, existing contracts, or other processes available for procuring care. In this section, the term “contract” would have the definition given that term in subpart 2.101 of the Federal Acquisition Regulations. Providers would be paid under a negotiated rate that, to the extent practicable, would not exceed the Medicare rate, with limited exceptions for highly rural areas, Alaska, and States with an All-Payer Model Agreement. Eligible providers would be prohibited from collecting any amount greater than the negotiated rate. The Secretary would be authorized in negotiating rates to incorporate the use of value-based reimbursement models to promote the provision of high-quality care. The Secretary would be authorized to collect from third-parties the costs of furnishing care for non-service-connected disabilities under this section, and such collections would be deposited into the Medical Community Care account and remain available until expended.

We do not support the provision requiring providers to maintain the same or similar credentials and licenses as VA providers; while this is a requirement in the current Veterans Choice Program, we have found it to be administratively difficult (and at times impossible) to implement in certain situations. We believe strongly in the importance of ensuring our providers furnish quality care, but recommend a different approach than this obligation. We are also concerned that some of the language regarding the terms of the agreements with providers contemplates a direct relationship between VA and the providers, rather than a relationship between VA and a network administrator, and a separate relationship between the administrator and the provider. Similarly, we do not support the provision that would require the deposit of collected funds into the Medical Community Care account. Funds collected by VA under sections 1725 and 1729 of title 38, and section 2651 of title 42 are currently deposited in the Medical Care Collections Fund, where they may be used to support both VA and community care. We believe creating a separate collection account would be duplicative and would limit our funding flexibility. Finally, we note that referencing the definition of “third party” in section 1729 produces a narrower effect than if the definition in section 1725 were referenced.

The Secretary would be required to provide Veterans information about this Program upon their enrollment and when they become eligible based on a determination between the Veteran and his or her provider. The Secretary would be required to ensure that follow up care, including specialty and ancillary services deemed necessary, are furnished through the Program at the election of the Veteran. Veterans would be required to pay a copayment for care under this Program, but the copayment could be no more than what the Veteran would owe if such care or services were furnished directly by the Department. The Secretary would also be required to establish a claims processing system to ensure prompt and accurate payment of bills and claims for authorized care. Under subsection (j), a Veteran’s election to receive care under this Program would serve as written consent for purposes of section 7332(b)(1), which governs the disclosure of certain protected health information. Providers would be required under subsection (k)(1) to submit copies of the Veteran’s medical records upon the completion of the provision of such care and services, but these records could not be required prior to reimbursement. Under subsection (m), the Secretary would be required to track missed appointments to ensure the Department does not pay for care or services that were not rendered.

We note that subsection (j) is no longer needed given the amendments to section 7332 made by Public Law 115–26. In terms of subsection (k)(1), we believe it would be better for the records to be required as determined by the Secretary to ensure that the records are provided in a timely fashion and that care provided by VA and others is informed. We also recommend against including subsection (m), regarding the tracking of missed appointments, as our experience with the current Veterans Choice Program has proven this difficult to implement. We have taken other precautions to ensure the Department is not paying for care and services that were not provided, and we believe this approach is more suitable for the legislation’s intent.

Section 101(a)(3) would terminate the current Veterans Choice Program authority and make other conforming amendments.

We do not support this provision, as the Department will need a transition period during which it can prepare for the future of community care while still ensuring Veterans receive care through the current Choice Program.

Section 101(a)(4) would require a report within 1 year of the date of enactment of this Act providing information about services rendered under the new Program.

We note that subparagraph (D) of this provision would require a report on the results of a survey of Veterans who have received care or services under this program. Given the time it may take us to develop a survey, VA may not be able to gather meaningful information in the time between OMB approval of the information collection and the reporting deadline. Regarding subparagraph (E), which would require an assessment of the effect of furnishing care and services under new section 1703A on wait times, we have not found reliable data that would support a firm assessment through the current Choice Program, and we believe we would encounter the same issues under this proposal.

Section 101(b) would provide that services under various programs and authorities be considered services under the Veterans Community Care Program established under the new section 1703A, including PC3, contracts through VA's retail pharmacy network, VCAs, and healthcare agreements with other Federal and non-Federal agencies.

We are not sure exactly what it means for services under another program to be "considered" services under the Veterans Community Care Program. If this would require that all of the agreements and programs identified in this subsection meet the terms and conditions of the Veterans Community Care Program, we would not support that requirement.

Section 101(c) would state that all amounts required to carry out the new program would be derived from the Medical Community Care account, and that all amounts in the Veterans Choice Fund would be transferred to the Medical Community Care account. Section 802 of the Veterans Access, Choice, and Accountability Act of 2014 would be repealed, and conforming amendments would be made to section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

We agree with the importance of consolidating funding for community care, but we recommend that the transfer of funds from and the repeal of the Veterans Choice Fund only apply to unobligated funds and provide a delayed effective date to support the transition from the current program to the future program.

Section 101(d) would require, within 90 days of the enactment of this Act, the Secretary to establish consistent criteria and standards for furnishing non-Department care, including the eligibility requirements of providers and reimbursement rates (which, to the extent practicable, would be the Medicare rate). These standards would not apply to the Veterans Community Care Program established under section 101(a)(1).

We support the intent of subsection (d). We have minor technical recommendations that we would be pleased to discuss with the Committee.

Section 101(e) would require the Secretary to establish a working group to assess the feasibility and advisability of considering under subsection (b) services under healthcare agreements with healthcare providers of the Indian Health Service (IHS) and tribal health programs to be provided under the Veterans Community Care Program. The working group would include representatives of IHS, tribal health programs, and Veterans who receive services from either IHS or tribal health programs. Within 180 days of enactment of this Act, the working group would be required to submit a report to the Secretary on the feasibility and advisability of considering such services to be services under the Veterans Community Care Program, and within 90 days of receiving this report, the Secretary would be required to submit a report to Congress on the feasibility and advisability of implementing the working group's recommendations.

We do not oppose greater coordination and discussion with IHS or tribal health programs, but we do not believe the timelines in the legislation are realistic. We also do not believe it is necessary to require this coordination in law, as we are already working with these groups to improve cultural understanding and resource sharing. We also note that the Federal Advisory Committee Act (FACA) would likely apply to the working group, given the inclusion of non-government personnel.

Section 102(a) would create a new section 1703B regarding prompt payment of providers. It would require substantially the same things required by section 5(a) of the draft Veterans Choice Act of 2017, with a few exceptions. For example, this bill would authorize the Secretary to accept claims and medical records submitted other than electronically if the Secretary determines the provider is unable to submit claims or medical records electronically. It would also authorize the Secretary to accept non-electronic claims if the Secretary determines doing so is necessary for the timely processing of claims due to a failure or serious malfunction of the electronic interface of the Department (required in section 102(b)) for submitting claims.

As discussed with respect to section 5(a) of the draft Veterans Choice Act of 2017, we generally support these provisions and appreciate the flexibility contained in this version.

Section 102(b) would require, not later than January 1, 2019, the Chief Information Officer of the Department to establish an electronic interface for healthcare providers to submit claims for reimbursement under section 1703B. The bill would define various requirements in terms of functions of the interface and protection of information. By January 1, 2018, or before entering into a contract to procure or design and build such an interface, the Secretary would be required to conduct an analysis to determine whether it would be better to build or buy such an interface and submit a report on such analysis to Congress. The bill would define various requirements of this analysis and report, and the Secretary would not be authorized to spend any amounts to procure or design and build the electronic interface until 60 days after the required report is submitted to Congress.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the provision is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead. We also caution that the deadline in subsection (b)(2) of January 1, 2018, for making a decision to internally design and build or enter into a contract to procure an electronic interface is likely too soon, given the uncertainty regarding community care funding, continuing developments of the design of the new EHR, and the potential implications to other information technology projects.

Section 103 would amend 38 U.S.C. § 1151(a) by adding a paragraph that would require VA to pay compensation if a Veteran's disability or death was caused by hospital care or medical services furnished under proposed section 1703A of title 38, United States Code, and the proximate cause of the disability or death was carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault by the provider or an event not reasonably foreseeable.

VA fully supports ensuring that Veterans have access to high quality care, and that they are made whole in the event of a medical error. However, VA does not support this provision as written based on several concerns. First, section 103 would expand section 1151(a) to require VA benefit payments where the "proximate cause" of a Veteran's disability or death was the negligence of a non-Department healthcare provider or an unforeseeable event occurring during treatment by such a provider. The "term 'proximate cause' is used to label generically the judicial tools used to limit a person's responsibility for the consequences of that person's own acts. At bottom, the notion of proximate cause reflects 'ideas of what justice demands, or of what is administratively possible and convenient.'" *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268 (1992) (quoting *W. Keeton, D. Dobbs, R. Keeton, & D. Owen, PROSSER AND KEETON ON LAW OF TORTS* § 41, p. 264 (5th ed. 1984)). Section 103 would make the Federal Government liable for disability or death that is the proximate result of a non-Department medical provider's negligence or an unforeseeable event. This is contrary to the basic principle of American law, which holds an individual legally responsible for injuries caused by his or her negligent conduct.

Second, VA adjudicators would be required to develop evidence regarding care that is not provided by VA employees or in VA facilities, including DOD and other Federal healthcare providers and academic affiliates, and to determine whether a Veteran's disability was proximately caused by negligence on the part of the community provider or an unforeseeable event occurring during non-Department medical care. See 38 U.S.C. § 5103A. This would entail gathering medical and other records from community providers as well as expert medical opinions about whether the event that occurred during the non-Department treatment was not foreseeable. This development burden of obtaining and evaluating evidence from non-Department providers and facilities can be expected to slow the adjudication of other Veterans' claims for benefits and potentially add to the disability compensation backlog.

Third, under 38 U.S.C. § 1151(b), a recovery under the Federal Tort Claims Act as a result of a judgment or settlement for a disability or death for which compensation is awarded under 38 U.S.C. § 1151(a) results in a suspension of the section 1151 benefits until the amount of the judgment or settlement is recouped. In contrast, section 103 does not provide for a suspension of compensation for any recovery by a Veteran or Veteran's survivors from the non-Department provider as a result of a private lawsuit based upon the same disability or death. As a result, a Veteran or a Veteran's survivor could receive a recovery of both section 1151 benefits and tort damages based upon a judgment or settlement. This would create an inequity by allowing duplicative recovery for the same disability or death for persons whose entitlement is based on care furnished by community providers.

We have not yet had time to estimate the costs for section 103. However, we do know that, in FY 2016, 2.2 million Veterans received care from community providers under existing VA statutory authorities. During the first three quarters of FY 2017, 1.2 million Veterans have received such care. VA purchases care from more than 500,000 community providers, and the number continues to grow. VA's FY 2018 budget requests a 13 percent increase in funding for community care. As a result, VA could potentially be liable for section 1151 benefits for any of these 2 million Veterans who suffer additional disability or death due to negligence or an unforeseeable event caused by community care provided by community providers despite the absence of a causal connection between the additional disability or death and VA medical treatment.

Section 104 would add a sunset provision to section 1703 of title 38 terminating that program on December 31, 2018. It would make other conforming amendments similar to those proposed in section 12 of the draft Veterans Choice Act of 2017.

We support section 104.

Section 201 would add a new section 1703C to authorize the Secretary to enter into VCAs, similar to the authority that would be provided under section 4 of the draft Veterans Choice Act of 2017. However, there are a few differences in the proposed section 1703C that section 201 would create. First, the draft Veterans Choice Act of 2017 would require that care be unavailable under the Veterans Choice Program established in that draft bill prior to entering into a VCA, while the Improving Veterans Access to Community Care Act of 2017 has no such limitation. The draft Veterans Choice Act of 2017 would authorize providers to opt out of a VCA, but the Improving Veterans Access to Community Care Act of 2017 does not include this provision. The draft Veterans Choice Act of 2017 would limit the ability of the Secretary to direct patients to providers that have entered into contracts or agreements under other authorities, while the Improving Veterans Access to Community Care Act of 2017 does not include such a restriction. The draft Improving Veterans Access to Community Care Act of 2017 would include greater flexibility in terms of the Medicare rate through inclusion of the phrase "to the extent practicable" in prescribing the rates the Secretary would pay under VCAs. While we believe the draft Veterans Choice Act of 2017 would allow the Secretary, on a case-by-case basis, to determine whether or not to pay for care not authorized, the Improving Veterans Access to Community Care Act of 2017 would allow the Secretary to pay a provider who provides services in the course of treatment pursuant to an agreement with the Secretary but is not a party to the agreement. Finally, the draft Veterans Choice Act of 2017 would state uniformly that the OFCCP would not have authority over parties to a VCA, while, through section 205, the Improving Veterans Access to Community Care Act of 2017 would apply the limits established for the TRICARE Program in Directive 2014-01 of OFCCP to any healthcare provider entering into an agreement or contract with VA under section 1703A, 1703C, or 1745.

We support section 201 and prefer those provisions that differ from the draft Veterans Choice Act of 2017.

Section 205 would apply the OFCCP moratorium to VA, and VA supports that provision. We recommend against including a specific deadline, as that would allow flexibility in the event that the OFCCP Directive is further revised. Many of the technical concerns we identified with the draft Veterans Choice Act of 2017 regarding VCAs apply here as well, and we look forward to working with the Committee and the Department of Labor to address concerns.

Section 202 would modify VA's authority under section 1745 and is identical to section 6 of the draft Veterans Choice Act of 2017.

VA's views on that provision apply here as well.

Section 203 would amend section 106 of the Veterans Access, Choice, and Accountability Act of 2014 to require that, at the beginning of each fiscal year, the Secretary to transfer to VHA an amount equal to the estimated amount required to furnish hospital care, medical services, and other healthcare through non-Department providers during the fiscal year. The Secretary would be authorized to make adjustments to the amount transferred to accommodate variances in demand for such care and services from non-Department providers.

We support section 203 because this would provide greater flexibility to adjust resource allocations based upon actual demand.

Section 204 would create a new section 1730B, which would allow the Secretary, notwithstanding sections 1341(a)(1) and 1501 of title 31, to record an obligation of the United States for non-Department care on the date on which a claim for payment is approved, rather than the date on which the care or services are authorized.

VA understands this provision is intended to bring the Department closer to industry practices in terms of allocating resources for care and developing better estimates concerning our community care liabilities. VA appreciates the Committee's

willingness to engage on this issue given our prior discussions on this, and we look forward to working with you further on this proposal.

Section 205 of the bill is discussed above in the analysis of section 201, and the Department's views on this provision are provided in that discussion.

We are unable to provide cost estimates on the bill at this time but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee may have.

Chairman ISAKSON. Thank you for your testimony. I want to start out with where you ended up talking about Choice, because that is the critical thing we have facing us.

I want to start off by saying in every meeting you and I have had or every meeting you have been in where I have been and vice versa, it is patently clear that this Committee's commitment is for a robust VA health system for our veterans. Is that not correct?

Dr. YEHIA. That is correct.

Chairman ISAKSON. I have not yet seen a proposal from the VA that did anything to undermine that being the case. In fact, that is what you want too.

Dr. YEHIA. That is right.

Chairman ISAKSON. That being the end, there have been some who feared the Choice Program might be a route away from VA health care to a privatized health service. Is that not true?

Dr. YEHIA. Some have that concern.

Chairman ISAKSON. Nothing we have done would either ratify that concern or in any way indicate that is the way we are moving. In fact—and you do not have to agree with anything I say if you do not want to, by the way. [Laughter.]

But, in fact, it acts as a force multiplier to give us professionals to handle the needs of veterans in a timely fashion and a route for our veterans to get timely health. Is that not correct?

Dr. YEHIA. Mm-hmm.

Chairman ISAKSON. You said you needed four or five things, but most importantly, it was flexibility and time; flexibility to deal with the differences that the various regions of the country would offer, which probably is the number 1 place you need flexibility, as well as the time to put it in place. It is true that a lot of the problems in the initial Choice bill, simply we did not have enough time, and we over-bureaucratized the decisions to the point that it made it more cumbersome than smooth. Is that not correct?

Dr. YEHIA. That is correct.

Chairman ISAKSON. So, you all have been working at the VA hard and long to come up with the type of systems that will give you the satisfaction that we have the discipline that we need without the over-bureaucratization of the process. Is that not true?

Dr. YEHIA. Yeah.

Chairman ISAKSON. Most important in that is your number 1 item, which is to enhance the experience of the veteran and the decisions to be made by the veteran and their doctor within the VA. Is that not correct?

Dr. YEHIA. That is correct.

Chairman ISAKSON. I think that is an important point for all of us to understand. A lot of these cases are not a one-time doctor's

visit for a sore throat. Many of them are a condition that is going to take treatment over time, and with the VA doctor being a quarterback and the veteran in consultation with the doctor making the decisions on their health care, you have the perfect pairing. Is that not correct?

Dr. YEHA. Yes. It is that dyad of the doctor and the patient together to determine what makes the best sense for that veteran in front of them.

Chairman ISAKSON. I intend, as one Member of the Committee in anticipation on what we do to lead up to the completion of the improvement in Choice, to see to it that you do have the flexibility and the time, and that we never diminish the role of the Veterans Administration's health services and the lives of our veterans today or the lives of our veterans in the future.

I want to personally thank you for the countless hours you have spent on some of the challenges we have been trying to meet over the last few months to lead us to a point in time to make the right decisions as far as that is concerned.

Dr. YEHA. Thank you, Chairman.

Chairman ISAKSON. I have one other question. That was more of a statement than a question, but I have one other thing I would like to ask you about. How many different community care programs do we fund out of the VA right now for choice?

Dr. YEHA. We gave about seven to eight different programs.

Chairman ISAKSON. Is there any reason those could not be consolidated into one?

Dr. YEHA. We would prefer that they be consolidated into one.

Chairman ISAKSON. This is not a setup by the way. I know this is going to sound like a setup, but Dr. Yehia is so smart, he just led me right into this. So, I am playing straight man. Is it not true that if they were all one, we would not have these periodic crisis problems where we have run out of money when we really have not run out of money?

Dr. YEHA. That is exactly right. We need one program with a set of rules that is flexible enough, puts the veteran in the middle, and we want to move toward one pot of money to administer that program.

Chairman ISAKSON. The important thing I am trying to make in this statement is that we have got a situation right now where we are running out of money, but we are running out of money in one fund. So, we have got to take it out of another fund, where if it was all in the same fund, you would better manage your money. You would better have accountability on your money, and you would not have the type of crisis problems that we have had.

Dr. YEHA. That is right.

Chairman ISAKSON. That is one thing we want to try to be sure we fix in terms of Choice as we work toward that at the end of this year.

All right. Let us see. I guess the Ranking Member is gone. Senator Sanders?

Senator SANDERS. Thanks, Mr. Chairman, and thank you, Dr. Yehia.

Well, I am one of those people, as you know, Mr. Chairman, who believes that in the Congress, there are those who believe that we

should privatize Social Security, privatize Medicare, privatize Medicaid, privatize the Postal Service, and want to go after the Veterans Administration. I do not think that is hyperbole; I think that is a fact. I think there are folks who spend hundreds of millions of dollars in the political process who want to do just that, so I have that concern.

But, here is my concern now. I think we can deal with this problem, and I think Dr. Cassidy made a good point a few minutes ago. It is not a complicated issue, which I think there is a lot of agreement.

Number 1, there is some veteran in South Dakota or Vermont who lives a zillion miles away from a VA hospital. Should that person be able to get the health care across the street in their community? Who would argue against that?

If Dr. Cassidy mentioned the VA has a long waiting line, people cannot even get in, so their choice is going to an emergency room, which is double the price of other types of health care. What is the problem with that? I do not see any.

But, here is the problem I see, Mr. Chairman, and that is while we want to give veterans choice, we do not want to do it in a way which dismantles the VA. What I worry about is that at a time when the VA has 45,000 vacancies, when many parts of this country are understaffed, there may well be funding coming out of the VA to fund the Choice Program, and that does concern me very, very much.

I think the answer is that we want to, first of all, given the fact that there is overwhelming—Dr. Yehia, I do not know if you have this information or not, but every internal poll—and maybe the service organizations have more on hand, but every internal poll that they do seems to indicate tremendous support for the VA, the desire to maintain the VA, desire not to see the VA privatize. Does that sound familiar to you?

Dr. YEHIA. Yes.

Senator SANDERS. All right. So, we want to maintain the strength of the VA, and what we do not want to do is, piece by piece, dismantle the VA and put that money into the Choice Program.

I have no problem with when people want to have the opportunity, need the opportunity to get care outside of the VA when it is reasonable. Count me in. That is common sense. I will not allow the VA to be dismembered.

Last point. It is very easy to criticize the VA. They are the largest integrated health care system in this country. You have got 131 medical centers, hundreds and hundreds of CBOCs, et cetera, et cetera? Every day there is going to be a problem. We forget that the private health care system is somewhat dysfunctional in America today.

We forget that today in the private-sector system, hundreds of people will die because of medical malpractice in hospitals, care they are not getting or mistakes that are being made, and that very often—we heard from Dr. Shulkin, you will recall at the last hearing, that recent studies from—I think it was JAMA or the AMA indicated that on studies that are on many of these issues, the VA ends up doing better than the private sector.

So, our job is to strengthen the VA, to make it the best that it can, and where appropriate, to make sure that people do have the opportunity to go outside of the VA.

Thank you very much, Mr. Chairman.

Chairman ISAKSON. Well, thank you for your statement, Senator Sanders.

And, let me just say for the record, the first challenge I was handed when I became Chairman was the Denver hospital, which was being closed and unfinished, finished at about 40 percent. We are finishing that hospital, spending \$1.4 billion on an opening, and it is a VA hospital. If there was ever an intent of anybody to go from VA to a privatized situation, that would have been it, but we made it work. We found the funds. We got it done.

You look through everything that we have done. There is a total commitment on the part of this Committee and its Members to make sure veterans' health services is the best health service they can be and our veterans get the best services they can get, or else we would not be here right now. I agree with you 100 percent.

If there is an enemy out there somewhere, we will watch out for them together. OK?

That said, Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you much, Mr. Chairman. I appreciate you and the Ranking Member for going forward with this hearing so that we can discuss these bills.

I understand the Senator's concern, Senator Sanders, regarding, again, any effort to dismantle the VA. I do think that the changes that we have done so far are being very positive, especially in rural States like mine, like Arkansas, where the reality is that people have to travel extended distances.

I think we can be very, very proud of that. I think we need to build on it, again, making sure that we do protect the VA infrastructure that we have and make sure that it works as well as it can for the benefit of our veterans.

A couple weeks ago, there were news articles about the significant shortage of critical nursing staff at our VA medical facility in Little Rock, and I say that because it is not just in my State, but it is throughout the country. Can you speak to the broader state of nursing staffing nationwide, what we are doing in that regard?

Senator Sanders said we have got that problem in the VA. We have got that nationwide, as far as he mentioned, incentives to try and get nurses to practice in the VA versus private care. Probably the pay is not as good in the VA, so—

Dr. YEHA. Yeah. I am going to turn it over to my colleague, Dr. Lynch.

Dr. LYNCH. I could not agree with you more, Senator. I think nursing has been a problem for all of health care.

We have been working aggressively in Little Rock. We have had our chief nursing officer working with the facility to identify staff and nursing to get to the facility, but we have also been looking at our system as an enterprise and identifying where we have the opportunity to look for pay supplements that can make us competitive with the private sector. But, it is a problem, and it is one that

we share with the health care sector, and we have to be on top of it.

Senator BOOZMAN. I agree totally, and again, it is something that because it is a problem nationwide in the private sector also, you all can have a tremendous influence and be a leader in the direction forward.

I would like to talk a little bit, Dr. Yehia, about the Veterans Treatment Court Improvement Act, sponsored by Senators Flake, Manchin, Tester, and Tillis. I have seen a number of the veterans courts, and they do a tremendous job.

In fact, today I was visiting with the Association of Drug Court Professionals, and they tell me that 92.5 percent do not reoffend within 3 years. That statistic is amazing compared to other alternatives.

But, in doing that, having success, long-term success and also short term, where you have got the veterans who do not have to go off someplace to serve time—they are there in the community that they are from—when they go off—invariably these folks many times are helping to support the family—you leave the family destitute.

I know you have said that you have some concerns about perhaps that affecting the homeless programs and things like that. Can you talk a little bit about that and tell us why it is not a great idea to support the drug courts all that we can?

Dr. LYNCH. Let me take that one, if you would, Senator.

Number 1, we already have plans to hire 50 or more new Veterans Justice Outreach representatives for VA. Our concern with the bill is the requirement for an offset for that salary of \$5.5 million. We have already committed to hire. We would prefer not to have to offset against other parts of our program, such as homeless, to find funds for that \$5.5 million when, in fact, we have already committed to hire those individuals. That is our concern, not the hiring of the individuals, not the good work that the program is doing, but we are trying not to harm other programs within VA by the required offset.

Senator BOOZMAN. Yeah. Hopefully, we can work on that. Many of the homeless are having problems with drugs, alcohol, and other things, but I would argue that the human cost, the cost to the VA, again, in not rehabilitating these individuals, them going off and coming back with the same problem, because they are not going to have the 97 percent success rate that we see, is going to cost you a heck of a lot more money down the line.

So, let us work with you. I hope we can get that worked out because it really is a very, very important program. It is doing a tremendous job.

Dr. LYNCH. Absolutely.

Senator BOOZMAN. Thank you.

Chairman ISAKSON. Thank you, Senator Boozman.

Senator HIRONO.

Senator HIRONO. Thank you, Mr. Chairman.

I would like to thank Senators Collins, King, and Markey for their close sponsorship of S. 683, my Keeping Our Commitment to Disabled Veterans Act, which would ensure coverage for around 350 veterans in Hawaii, some 20,000 veterans across the country,

and in Hawaii at non-public and private nursing home care facilities across the State who depend on VA reimbursement for their health care needs.

On February 17, I visited Hale Makua Health Services on Maui, which operates the only two freestanding nursing homes on that island. They would be impacted by a lapse in the program that I just mentioned. Wes Lo, who is the CEO of Hale Makua, said that passing this bill is needed so that more veterans on Maui will be able to receive around-the-clock nursing care and supervision in his facilities.

We must keep our commitment to these veterans, which is why I am grateful to the VA and the veterans service organizations here today for their testimony in support of the bill.

I wanted to ask you, Mr. Yehia, could you share with the Committee how a lapse in the support for this program, funding for this program, would impact the veterans at Hale Makua and the over 20,000 veterans in facilities across the country with VA reimbursement, and what would VA do if such a lapse occurred?

Dr. YEHIA. Well, we are definitely very supportive of the bill, and Dr. Lynch can provide a little bit more context on what would happen.

Dr. LYNCH. We run in or have run into problems with lapses in the past. These are not good things to have.

Senator HIRONO. Mm-hmm.

Dr. LYNCH. We have to look for workarounds to keep the veteran in the nursing home and to give them the care that they need. So, anything we can do to continue legislation that keeps the veteran in the nursing home and provides the care they need is strongly supported by the VA. We do not want to be in a position where a bill would lapse.

Senator HIRONO. Do you feel pretty confident that we will not let this program lapse? Because otherwise you have to have a Plan B.

Dr. LYNCH. I am hoping with the support from your colleagues—

Senator HIRONO. Yes.

Dr. LYNCH [continuing]. That we can pass the legislation and we do not face that problem.

Senator HIRONO. Yes.

Dr. LYNCH. If we face the problem, VA will work to solve it.

Senator HIRONO. The 350—

Dr. LYNCH. But, I am hoping we do not get there.

Senator HIRONO [continuing]. Veterans in Hawaii, that is really a large number of veterans who would be impacted.

Dr. Yehia, in your testimony, you state that if the disabled veteran nursing home care authority continues to be extended, VA estimates the cost would be \$4.73 million in fiscal year 2018, \$25.13 million over 5 years, and \$53 million over 10 years. What would you attribute to the bulk of this increasing cost? Is it that we have more veterans who will need this kind of care? Is it that the cost of the care is rising or a combination?

Dr. LYNCH. Cost of health care is going up across the country, and so we have to allow for that increase.

But, generally, it is a rising population. We know if we look at our geriatric population, we are seeing an increase over the next

20 years. It is the Silver Tsunami, and we have to be prepared to address those veterans.

Senator HIRONO. When you say Silver Tsunami, that is an age group of what?

Dr. LYNCH. That could be an age group, depending upon who you are and what your age is, anywhere from 50 to 75.

Senator HIRONO. So, that is a growing group of veterans that will need—

Dr. LYNCH. The geriatric population is one of our most rapidly growing sets of populations within the VA. Yes.

Senator HIRONO. There is a certain percentage of them who will need this kind of intensive—

Dr. LYNCH. Our goal, quite honestly, as you bring up the point—our goal is to try to keep people out of institutions and to try to keep them in their home or home environment. But, there are some veterans, regardless of the support that we can provide, that are going to need nursing homes. Yes.

Senator HIRONO. Let me turn to the Veterans Choice Act, and at some point, maybe I will submit a question to you as to what would be the top three changes that you would make to the Choice Program to make it better.

I know that you are very concerned with the provisions of the draft Veterans Choice Act of 2017 that would require VA to renegotiate, reissue, or terminate every agreement and contract, regardless of the terms or conditions of such an agreement permitting extensions or other flexible authorities. Your testimony states that this provision would affect such agreements as those with the Department of Defense, Indian Health Services, and Tribal Health Programs, as well as with your academic affiliates and contractors.

Could you confirm whether this provision would also impact the existing agreement that VA has under the Choice Program with the Native Hawaiian Health Centers, and if so, what would VA do to renegotiate the contract you have with the Native Hawaiian Health Centers?

Dr. YEHIA. Our partnerships with our Indian Health Service and the Tribal Health Partners is outside of the Choice Act, so we have different arrangements with them. As we consider consolidating community care, that is—those are some of the relationships we want to ensure that we maintain. So, I think this will be important as we come up with a draft legislation that does not harm some of those key partners that we have and ensuring that we have the flexibility to partner wherever we need to with some governing rules overarching them.

Senator HIRONO. I think it is important, since the need is great, that the kind of contracts you have will enable the Indian Health Services and the Native Hawaiian Health Services to continue to be a part of the providing of services. So, thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you.

Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

We are fortunate in South Dakota that we have three VA facilities: one in Sioux Falls, one in Hot Springs, one in Sturgis. Last year all three received five-star ratings. This year two of the three have five-star. One is a four. But, there is about a 300-mile spread between the facilities, and for that reason, we had a real interest in seeing Choice not only be successful, but be improved. That is one of the reasons we had authored a proposal that made the VA a primary payer rather than a secondary, and that cleaned up a lot of the challenges that we had in some of the rural parts of the United States.

Dr. Yehia, the discussion draft for the Veterans Access to Community Care Act—Senator Tester is the primary—affords substantially less choice to veterans than the discussion draft for the Chairman's proposal. I am open-minded on the issue of finding some common ground, but so far, I just do not see a downside to giving the veteran the final say on where he or she gets their health care.

I think of a veteran that lives in Miller, SD, or in Winner, SD, more than 150 miles away from another facility. To suggest to them that they need to go to a facility in order to get permission to see their family physician in a local area seems to be a little bit challenging. I would just like your thoughts on it, please.

Dr. YEHIA. Sure. The Secretary articulated this as little bit, maybe about a month or so ago, in front of the Committee.

What we are talking about really is that relationship between a patient and their doctor. I am a practicing provider in the VA system, and my patients want to know who is the best cardiologist in the community, where they should get their health care. We believe it is important for that dialog to occur because it actually empowers a veteran to make an informed decision about where they should best get their health care. We want to provide them with some guidance based on if we offer the service, is it accessible, and is it feasible for you to drive to receive that care.

In the construct, though, as described, I think we are more about how do we empower the veteran with information to make the best decision that is right for them.

Senator ROUNDS. I think the idea of providing the veteran with an opportunity is very appropriate, but I think requiring permission from the VA to make that is probably where I would have a concern. Would you see a difference between or would you see a different approach, perhaps, than what you would find within the bill today?

Dr. YEHIA. So, two items there. I think the intent is not to have them drive to have that discussion, and I think there are many different avenues, whether it is through a phone call or virtual or email or an in-person visit. I think that is important, that you can get in contact with your care team, more than just driving over there.

In my experience as a clinician, for the most part, there is high degree of concordance between the patient and the doctor.

Senator ROUNDS. One of the reasons—excuse me.

Dr. YEHIA. Yeah.

Senator ROUNDS. One of the reasons why the Choice Program was actually put in place in the first place is because not only do

people live more than 40 miles away, but also because they were waiting for more than 30 days to actually make contact with the physician. It seems to me that what we are going back to is something similar to that, once again, where we are saying in order to get your local care, you need to have that contact. How do we assure them that they have that contact when they need it?

Dr. YEHIA. Yeah.

Senator ROUNDS. Would it not seem more appropriate to offer it, make it available, encourage it, but still allow that individual to be able to access local care when they feel it necessary, and would not that be even more empowerment for that veteran to make that decision?

Dr. YEHIA. I think some of the challenges that we have been facing with the current Choice Program are these 30 and 40 rules, which are very administrative. When I went to medical school, there was nothing about 30 days or 40 miles.

Senator ROUNDS. Yeah.

Dr. YEHIA. There are certain patients that I need to be seeing in 2 days, not in 30 days, and the law does not allow for that. Or there might be folks that live 15 miles away from the VA, but if they are getting chemotherapy every day, it might make sense for them to get it closer to their home.

We are actually looking for more flexibility and empowering that veteran, that veteran patient, and their care team to make those decisions, because I actually think there are situations that arise today where the Choice Act is not able to allow access to the community as much as it should.

Senator ROUNDS. Well, I most certainly want to make sure that that veteran has the ability to access local care in a timely fashion, and I like the idea of having access to a VA physician where there is an opportunity to do so. But, as you recall, the reason for the Choice Program in the first place was the failure of the VA to be able to provide those services in a timely fashion.

Dr. YEHIA. Yeah.

Senator ROUNDS. I hate to lose the protections that our rural VA members have received through Choice. I would not want to go back on that arrangement right now and lose those protections and those capabilities that they have got right now.

Dr. YEHIA. Well, I look forward to working with you and others because I think there are opportunities there to figure out how to craft and ensure that those veterans, especially the highly-rural veterans, continue to receive the care that they need.

Senator ROUNDS. Thank you.

Dr. YEHIA. Yeah.

Senator ROUNDS. Thank you, Mr. Chairman.

Chairman ISAKSON. Excellent point, Senator Rounds. I appreciate your pointing that out. That is one thing we are going to be dealing with as we get to the final decisions on this Choice Program, making it work, but not forgetting what got us to Choice in the first place, which was people not getting appointments within 30 days and sometimes 90 days. People who lived 40 miles away could not get an appointment at any time. So, we have got to remember why we got to where we are and not allow ourselves to slip back and get there again.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair. Thank you all for being here.

Just a real quick one. I want to go back to some questions related to Senator Boozman's comments around the Veterans Treatment Court Improvement Act. I am a cosponsor of that bill. I appreciate Senator Flake's work on it. The VSOs, I think, support—all the VSOs support it. You all support it with provisions.

Could you drill down a little bit more on things that we need to work on that cause you concern?

Dr. LYNCH. Senator, I think, number 1, we support it, and in fact, we are already in the process of hiring 50 or more specialists to work in the Veterans Justice Outreach Program.

Our main concern is the requirement for an offset to the salary. We already have committed to the hire. We are concerned that if we have to offset that salary, we may have to take it from other wraparound programs that we provide to veterans, perhaps the homeless, perhaps in social work or caregiver.

Senator TILLIS. So, it is purely the pay-for?

Dr. LYNCH. Right now the main concern is having to pull money when we do not think we need to do that, sir.

Senator TILLIS. I want to go back also the discussion we are having about maybe different directions on what some people refer to as Choice 2.0. You are familiar with some of the proposals out there.

How do we bridge the gap? I think there are some legitimate concerns that have been expressed on both sides, but how do we bridge the gap, and how do we provide you all with flexibility? I want you to answer that question, but I have to go back to something that I do in every one of these committees.

Some believe that there is an effort to privatize the VA. I have to continue to say that the hospitals that I have in North Carolina, the health care centers that I have in North Carolina, the brick-and-mortar presences of the VA are critically important elements to anything that we do in the future. This is about figuring out how to redouble our efforts with non-VA care, which it still continues to be a significant amount of how we have provided care for quite some time, and then getting choice right.

Can you give us some thoughts on how we bridge the gap and get to a bill that has bipartisan support and gets to the President's desk?

Dr. YEHA. Absolutely. One of the things that I noticed for every bill, on the Choice bills today on the docket, what I have noticed when I was looking through them is that they are touching on the key important aspects that need to be addressed. They are addressing eligibility. They are addressing how we design the network. They are addressing provider payments. They are addressing provider agreements. So, I think that is a very good step forward. For the most part, the key elements that need to be there are there.

We just need to figure out how—every one of them has different strengths and weaknesses.

Senator TILLIS. If you were to—if you were to back off of maybe the universe of ideas to the specific things that you think that you need the authority to move forward with, what would that look like?

Dr. YEHA. I think that, just very broadly, there are a couple of key things that would help us continue to improve the program. One is we have learned through our experience of Choice today that being overly prescriptive ends up hampering us, and that is one of the reasons why in partnership, the Congress has passed more than five legislative changes to the program.

Ensuring that there is enough flexibility to allow us to adjust to different geographies, different veteran populations, and different types of providers will be key. Some of the bills that are on discussion today are very prescriptive of you can only pay the Medicare rate and nothing above that. Well, there might be certain areas of the country that that is not the going rate, and we might lose on high-quality providers. So, there are a number of those sort of examples that I think with a couple tweaks here and there, we can get to a more robust place that allows this new modernized single program to adapt to the different veteran populations across the U.S.

Senator TILLIS. Yeah. I think that is one thing that is important, is for you all to provide feedback. I would be happy to meet with you, but the folks who are moving the bill, to a certain extent, sometimes I think we have gone too far. Then, the reworks that you have talked about have cost us time and possibly money and resources that could be spent on other areas that you are working on. So, it would be very helpful to get ahead of that and say it is a great thought but a potential distraction based on what we need to accomplish on a more immediate basis.

Dr. YEHA. That is right.

Senator TILLIS. I appreciate the opportunity to speak with you all about that. Thank you very much.

Dr. YEHA. We would be happy to do that.

Senator TILLIS. Thank you, Mr. Chair.

Chairman ISAKSON. Thank you very much, Senator Tillis, and thanks to the members of the VA for your being here for this panel. We appreciate your testimony.

Senator TESTER. I got to go yet.

Chairman ISAKSON. Oh, I am sorry.

Senator TESTER. That is all right.

Chairman ISAKSON. I thank you for—

Senator TESTER. I tell you, there goes the relationship right down the tubes. [Laughter.]

Chairman ISAKSON. Senator Tester.

Senator TESTER. It is perfectly all right.

Chairman ISAKSON. Take as much time as you want.

Senator TESTER. No, no, no. It is perfectly all right.

First of all, thank you for being here. I do have a few questions.

I think what gives some people (at least on this side) heartburn, but I think it gives you guys heartburn too on the other side, is the President came out and said guys ought to have a card, let them go wherever they want. The ultimate end result of that would be a VA that no longer exists, maybe not in the short term, but

certainly in the long term. So, I think that is where part of the heartburn comes from.

I think, Senator Rounds, when you look at the VA, you look at it from a South Dakota rural perspective, which is the way you should, so I do not think we are this far off. I mean, I think we are—you are looking at it as a challenge like somebody who has to drive 300 miles, and other people are looking at the VAs sitting there and there is another facility right beside it and should the VA be involved in those decisions. So, hopefully, we can get to a point on that.

Look, a couple things I want to talk to you, Dr. Yehia, about, and one of them is responsibility. I said it before on this Committee that you can outsource the service, but I do not know that you can outsource responsibility. I just want to know your perspective on that in that whether you think the VA should be held responsible in the end for somebody that you guys are going to—I cannot remember the word—you are going to certify them as being somewhere that the veteran can go and ends up getting bad service. What should be the role of the VA in that under Choice 2.0?

Dr. YEHIA. Let me provide some broad comments, and I will turn it over to Mr. Flohr to provide a little bit more detail.

Senator TESTER. Sure.

Dr. YEHIA. So, in general, we absolutely agree that the network that VA builds, whether it is inside or outside, needs to deliver high-quality care, which we are responsible for building that network, ensuring top quality providers, and helping the veteran navigate and coordinate that care. So, I think, in general, from a principle perspective, that is the case.

I know that in one of the provisions of the bill, there is specific language about if there is a veteran that gets injured or harmed from a malpractice or not getting the right service in the community, what sort of—how are they made whole again?

Senator TESTER. Right.

Dr. YEHIA. Now, I will ask Mr. Flohr to just comment a little bit on that from VBA.

Senator TESTER. Yeah. Go ahead.

Mr. FLOHR. Thank you.

Yes. It is VBA that makes decisions—

Senator TESTER. Yeah.

Mr. FLOHR [continuing]. On whether or not a veteran has been harmed through—

Senator TESTER. Right.

Mr. FLOHR [continuing]. Medical care in VHA.

Senator TESTER. Yep.

Mr. FLOHR. I just saw this bill in the last couple of days.

Senator TESTER. Yeah.

Mr. FLOHR. I have not really had a chance to study it. I am not sure how that would—I do know that I did a little research, and I found that approximately 47 percent of clinicians have been sued at one point or another in their lives and their career.

Senator TESTER. Yeah.

Mr. FLOHR. How that would impact a private provider in terms of the insurance that they have, their malpractice insurance,

whether that would go up if they were seeing more patients or veterans—

Senator TESTER. Veterans.

Mr. FLOHR [continuing]. So, I just do not know at this time.

Senator TESTER. Yeah.

Mr. FLOHR. I do not know what the impact would be on our workload.

Senator TESTER. Yep. Well, look, I mean, I guess I see your hesitancy for it because you do not know how that is going to impact your budget going forward.

Mr. FLOHR. Correct.

Senator TESTER. But, on the other side, when the rubber hits the road, it is your responsibility. They signed up. You said you are going to give VA care. It is your responsibility.

Mr. FLOHR. Bottom line is we are here to assist veterans—

Senator TESTER. That is right.

Mr. FLOHR [continuing]. And make sure they get all the care—

Senator TESTER. So—

Mr. FLOHR [continuing]. And benefits they need.

Senator TESTER. Let me ask you how this—would this be part of the accreditation process with the hospitals? You have got electronic medical records or medical records, period, even if they are not electronic. Is there something we need to be doing in this bill to ensure that that information, what work has been done on that veteran outside the VA is wholly transferable to inside the VA?

Dr. YEHIA. Luckily, both bills have some of those provisions in there, which is what are the criteria for a provider to enter into the network, and I call that really the first line of defense—

Senator TESTER. Good.

Dr. YEHIA [continuing]. Because having a medical license and credentialing is really the first one.

Then, we want to go above that and look at what are the outcomes, what is the service, and make that as transparent as possible to a veteran so they can choose between providers, which one is best for them.

Senator TESTER. The only thing I would caution you on is some of the same concerns that Senator Rounds had. In some of the more frontier areas, these are very small hospitals that oftentimes do not have access to enough money, especially depending on what we do with health care here at this level. So, be aware of that.

The last thing I would ask you, before I turn it back to the Chairman, is cost. We are paying the bill whether it is done inside the VA or outside the VA. Have you guys or any of your sharp-penciled people—I will call them that—done any assessments on cost compared to VA-delivered health care, whether it would be up, down, static?

Dr. YEHIA. You mean a delivery of VA services—

Senator TESTER. Yep.

Dr. YEHIA [continuing]. Versus the community?

Senator TESTER. VA versus community care and what those costs might be because—and the Chairman remembers we got into a pretty vibrant discussion with one of our Members as to what the cost for community care is from the Congressional Budget Office, I believe. So, have you guys done any of that kind of work?

Dr. YEHIA. From an apples-to-apples way of looking, if a colonoscopy is done in the VA versus the community, I do not have that off the top of my head, but there have been a lot of cost estimates that have been done on what would happen if there was full access, full choice between the VA and the community.

Senator TESTER. Yeah.

Dr. YEHIA. The Secretary mentioned this about a month or so ago. It could add up to about \$20 billion more a year. The Commission on Care had a range from about \$5 billion to \$35 billion additional per year.

Senator TESTER. Is that per year or over 10 years?

Dr. YEHIA. Per year.

Senator TESTER. OK.

Dr. YEHIA. There have been some other studies that have looked at that, so that is an important consideration.

Senator TESTER. OK. Have you guys picked a favorite of the three bills that are up there between Isakson, myself, and Crapo? [Laughter.]

Dr. YEHIA. We have not picked a favorite. I think each of them has, like I said before, really—they are addressing the key issues, which is important, and there is strength and weakness for all.

So, I think across the three, there is real goodness there to move us to that consolidated program that we need.

Senator TESTER. All right. Thank you, Mr. Chairman.

Chairman ISAKSON. Spoken like an excellent politician. We appreciate that. [Laughter.]

Senator Manchin.

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman. Thank you all.

There is a fundamental debate around the third-party administrators, and one argument in the VA is—one argument is that the VA cannot handle the task of scheduling and administering a non-VA care program, so the private sector has got to step in.

The second argument is that third-party administrators do not take care of our veterans, plus we cannot do oversight over them. This may be the biggest fight in a non-VA care debate that we are going to be encountering. I will tell you that when I visit veterans in Beckley or in my Clarksburg VA hospitals, they really do not like the third-party administrators because veterans do not think those docs know them, do not know their concerns, their needs, and how to take care of them.

So, my question is, are you all capable and ready to administer a robust non-VA care program and on their own if that is the path that we are going to go down? How are you going to get them up to speed of the care that the VA and the veteran needs?

Dr. YEHIA. So, I think there is a need and a role for third parties as we move into the future.

I think one of the lessons learned from our various town halls, interacting with veterans and community providers is we outsourced the relationship, and that has been critical. Veterans want a relationship with their VA provider or between doctors; sometimes that was hampered during our existing relationships today with a contractor.

So, moving forward, I think what would be important is for those veteran-facing and community-facing functions, it is important that those relationships interact between a doctor and a doctor or between a patient and a doctor and do not have someone else in there. A case in point has really been in our pilots in Alaska and in Fargo that have really shown that—and soon to be in Montana—that having that relationship is critical.

Now, I do want to say that—

Senator MANCHIN. How are you preparing—how are you preparing a non-VA caregiver to understand this veteran and understand their care? I speak specifically to opiates.

Dr. YEHIA. Sure.

Senator MANCHIN. We got a lot of pill mills. We got a lot of doctors pushing pills.

Dr. YEHIA. So—

Senator MANCHIN. What guarantees that you are not going to be sending one to one of these pill mills?

Dr. YEHIA. Exactly. That is part of the discussion that we were just having about ensuring that there are high-quality providers in the network.

Senator MANCHIN. Who does that?

Dr. YEHIA. It is really a two-step process. One is we want to ensure we set the standards. Some of them are actually in the current bills we are discussing today of who can enter the network, and then we need oversight from our contracting partners to—

Senator MANCHIN. Doctor, what I am asking is who in—are you capable in the VA of qualifying and overseeing these people? Do you have continuing education? What are you doing to ensure that if we send a veteran from Beckley and Clarksburg—

Dr. YEHIA. Sure.

Senator MANCHIN [continuing]. Outside of their arena, they are going to not be getting somebody taking advantage of them and has basically the skill sets to take care of them?

Dr. YEHIA. So, we rely on our contracting partners to ensure that we have quality providers, and then what we do offer is CME, continuing medical education, free of charge that the VA has put on to not only address things such a opioids—

Senator MANCHIN. Is it mandatory, or is it—

Dr. YEHIA. It is voluntary right now for the community providers.

Senator MANCHIN. Why would it be voluntary?

Dr. YEHIA. There are a lot of various State rules that look at—some are more mandatory, depending on the State that you are in.

Senator MANCHIN. Yeah, but you got the paycheck. You got the pay—I mean the checkbook. If you tell me I got to do something in order to qualify, I am going to do it.

Dr. YEHIA. Well, in some areas, we definitely have that market power where they are seeing a lot of veterans, but in some—in other areas, especially in highly-rural, if you put a lot of burdens on the community providers and they are seeing a few, handful of veterans, they just will not sign up.

Our goal is to be more of having a carrot rather than a stick. We would like to really identify those providers that have completed that training, that are providing high quality, and say, you know, “These are our preferred providers. We would like you to consider

them.” So we have to be cognizant of really the amount of market share that we have in each area and not putting overly prescriptions on the docs, because then they might not want to take care of our veterans.

Senator MANCHIN. Can we bring that to a higher profile so we can identify those people that do and do not?

Dr. YEHIA. Absolutely.

Senator MANCHIN. I mean, the community is going to have to get involved.

Dr. YEHIA. Yeah.

Senator MANCHIN. We all talk a good game. We are all out here showing all of our support for the VA during election time. During the non-election time, these people still need the same care.

Dr. YEHIA. Yeah. I think there is a lot—

Senator MANCHIN. That is community involvement.

Dr. YEHIA. I agree with you. I think there is a lot of opportunity to get the hospital associations, the medical groups, all kind of involved in helping educate not only about military culture competency, but specifically opioids and prescribing. Happy to work with you on that.

Chairman ISAKSON. Thank you, Senator Manchin.

Thanks to all the panelists for being here today. Thanks for your time, Dr. Yehia. We appreciate it very much.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO BALIGH R. YEHIA, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

The Choice Program is not working for health care providers or veterans. A primary challenge with Choice is that patients are unable to effectively connect with their providers, and authorizations for care are delayed. Veterans can end up waiting for health care services, and providers wait for payment in a way that defeats the entire intended purpose of cutting wait times for treatments.

Dr. Yehia, I'd like to share the story from one provider at the Hospital for Special Care in New Britain, Connecticut with you:

The Hospital for Special Care Pulmonary Rehabilitation program provides therapy that can reduce hospitalizations and exacerbations for patients with lung disease. This New Britain hospital offers a multidisciplinary, “gold standard” pulmonary rehab program that addresses quality of life, anxiety and depression, nutrition, and other concerns for patients with chronic lung disease.

Prior to the VA Choice program, there was a functioning system in place to facilitate referrals. At the Newington VA, the Non-VA Care Department ensured that private providers had all documentation necessary, including referral, agreement as a payor, and medical records. They were very efficient and cooperative, and understood the medical necessity of Pulmonary Rehab.

But, after VA Choice, providers at the Hospital for Special Care have expressed concerns. In the case of one patient treated for chronic lung disease, the physician's note stated that he wanted this patient to attend the Hospital for Special Care Pulmonary Rehabilitation Program. VA Choice delayed the sending of authorization paperwork and during that time, the patient was hospitalized twice. The referral was discontinued on two occasions, even though the physician's notes stated that he wanted the patient to attend our program. At this point, my Connecticut office intervened to get this veteran the health care that he required.

Question 1. Dr. Yehia, such barriers to care are exactly the opposite of what Congress intended with the Veterans Choice Program. Which legislation on the hearing agenda today do you believe will best address the shortcomings of the current Choice Program?

Response. We appreciate the opportunity to work with the Committee to review proposed legislation to improve VA community care for Veterans. A principle we all agree on is making sure that VA is organized around and focused on the needs of Veterans. This means making community care simple to understand and easy to ad-

minister, which is our vision for this program. With that in mind, while we support many of the provisions in the three proposed bills on the agenda, as explained in our testimony, there are some provisions that, while well-intended, we believe would create added complexity or impose restrictions that would reduce our flexibility and ability to efficiently meet Veterans' health care needs.

The future of VA's community care program is one of the most important and possibly most difficult items on the legislative agenda. We want to work with everyone to ensure the legislation that shapes this future is as strong as possible. VA is working on developing its proposal and intends to share this with the Committee in the near future.

Question 2. What else should Congress do to cure this failure?

Response. In regards to the current program, VA has worked closely with Congress to enact changes to the original law which have created more flexibility in the Veterans Choice Program and enabled more Veterans to use the program. VA has also worked closely with our contracting partners to modify the contracts and business processes. This has enabled the contractors to make payments to community providers more timely and provide more timely appointments for Veterans. VA has also developed and implemented tools to assist in sharing health information with the community providers to ensure better care coordination for Veterans.

We believe the legislation that is ultimately enacted should embrace a few broad principles; these principles are based on lessons learned through VA's community care program and the Veterans Choice Program.

The future community care program must empower the Veteran and his or her provider to get the right care at the right time from the right provider. VA must be able to establish a high-performing network of VA and community providers who can furnish the very best care for Veterans. To do this, we must have flexibility in terms of payment rates and the types of agreements we form with providers. In addition, we must also have the flexibility to simplify our interactions with providers to ensure we pay them on time, and can easily share information with them.

It is also imperative that VA retain flexibility to adjust and adapt to an evolving health care landscape. Legislation that is too prescriptive in terms of rules, responsibilities, or processes can only limit our options, leading to frustration by Veterans and community providers alike. The law establishing the Choice Program was amended five times in less than three years. That is not a sustainable model. We believe the best legislation in this area would provide broad, general authority that VA could further narrow and implement through regulations, policy, and contracts. We have been working with your staffs and our VSO partners over the past 15 months on these proposals and will continue to do so once legislation is enacted to ensure that the best ideas are incorporated in the new program.

Last, it is critical that the legislation provide VA sufficient time for development and implementation. We know from our efforts with the current Choice Program that a rushed period of implementation will not help Veterans or VA. Ideally, we would have a full year to establish provider networks, draft regulations, and build the relationships and systems that will empower Veterans, VA, and community providers to offer the very best health care services to our Veterans.

Chairman ISAKSON. It is time for our second panel. Will they please come forward. [Pause.]

Well, thank you for being here today. We appreciate your patience, and as was said about you during the hearing, we greatly appreciate the VSOs' support, their counsel, and their input, which will be very valuable and important to us as we go forward on the legislation pending here. We are glad to have you today, and we appreciate you coming to testify.

Our four witnesses from the veterans service organizations—first of all, Mr. Lou Celli. Lou, we are glad to have you back; we always appreciate the input of The American Legion. I just sent my dues check in last week, by the way, so I am good for another year.

Mr. CELLI. We are going to check.

Chairman ISAKSON. Please do. [Laughter.]

Amy Webb of AMVETS. Amy, we are glad to have you here today. Adrian Atizado is back with us, the Disabled American Veterans; and Gabriel Stultz, legislative counsel, Paralyzed Veterans of America. Thank you all for being here.

We will start with you, Lou.

STATEMENT OF LOUIS CELLI, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. CELLI. The American Legion is proud to support the slate of bills being considered today and will touch briefly on them as we move toward the discussion on the future of Choice. As we all know, it is the big topic coming up for today's discussion.

Chairman Isakson, Ranking Member Tester, and distinguished, dedicated defenders of veterans who proudly serve on this Committee, on behalf of Charles Schmidt, the national commander of the largest veterans service organization in the United States of America, representing more than 2.2 million dues-paying members, combined with our American Legion family, whose numbers exceed 3.5 million voters living in every State and American territory, it is my duty and honor to present The American Legion's position on the bills being discussed here today.

The American Legion supports the Veterans Transplant Act. We appreciate that VA is concerned about the increase in administrative burden that this will cause, but The American Legion believes this is imperative to be able to track and monitor the biological implants that are being surgically inserted into our veterans' bodies. Infectious trends, possible recalls, longevity studies all require tracking. It just makes sense.

Senate Bill 426, the draft bill to improving hiring efficiencies all have our full support. Keeping VA staffed with equal medical and support staff is critical to ensuring VA can operate efficiently, effectively, and be the best possible steward of the taxpayers' dollars.

Every vacancy at VA pushes appointments further behind and care into the community, a trend that needs to be monitored closely. VA has some of the most advanced resources in the country and in the world and should be an employer of choice for rising physicians building their career. We need to ensure that VA and the Secretary have the tools necessary to properly staff their agency.

Senate Bill 683, the VA nursing home care is a no-brainer.

Senate Bill 833, VA has an obligation to care for us who suffer illness or injury based on their honorable service, but when their honorable service is disrespected and denigrated by fellow service-members, we not only have an obligation to support and defend our comrades by prosecuting offenders to the fullest extent of the law, we have an obligation to apologize for not protecting them and to ensure we care for them with every available resource that we have, and at a minimum, that includes VA health care. I am surprised that this even needs legislation to accomplish it in the first place, and yes, we support it.

The American Legion has always supported veteran treatment courts, and this bill will help provide the liaison services that veterans and the judicial system need to support this important program. The American Legion supports Senate Bill 946.

The Veterans ACCESS Act simply closes a loophole that puts veterans at risk. If a physician gets fired from VA for not being able to perform his or her job, why would it be OK for VA to then contract with them and send veterans to them, anyway? We sup-

port keeping bad actors away from our veterans, and we support this bill.

The Enhancing Veteran Care Act is an interesting concept and probably what the VA OIG should be doing but, sadly, does not. VA tells us that they have tiger teams that descend on poorly performing facilities to help rehabilitate them. An ounce of prevention is worth a pound of cure. The American Legion has been doing this for a very long time, over 10 years, visiting facilities, working with leadership, rendering reports, and sharing best practices through our System Worth Saving Program. We support Senate Bill 1266 because the bill exposes a need within the structure of the system that currently is unmet, but we still think that this should be a function of the Inspector General's office.

In our written testimony about the Draft Quality Employment VA bill, The American Legion discusses this proposed legislation extensively, but in short, we want to highlight to this Committee that the VA has a variety of authorities and resources at their disposal that can increase competitive staffing levels at VA without the need for additional legislation. We call on VA to start exploring these options. This includes residency programs, public-private partnerships, and space-sharing programs instituting a VA medical school, temporary physician-sharing assignments between Level 1 and Level 3 facilities, and more that are all within VA's authority to execute now.

In our written presentation, The American Legion outlines the need for consolidation and unification of community care contracting practices, recommendations for public-private partnerships, suggestions on ways to increase capacity and innovations that will support VA sustainability, and ensure VA remains a world leader in education, science, and health care, their three statutory pillars that VA was built on.

Over the past year, VA has worked closely with this Committee and veterans service organizations to come up with a plan on where the future of VA health care is headed. Through all of this, we believe the Secretary's CARE Plan most closely represents what The American Legion supports: consolidated, integrated, heads-up health care. We call on this Committee to work with the Secretary and the VSO community to put a plan in place that is comprehensive, sustainable, affordable, and veteran-centric, and we believe that the CARE Plan hits all of those points.

We look forward to our continued work together with this Committee and the Secretary to build a 21st century world-class VA health care system that your Nation's warriors have earned.

[The prepared statement of Mr. Celli follows:]

PREPARED STATEMENT OF LOUIS J. CELLI, JR., DIRECTOR, NATIONAL VETERANS
AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Bill #	Bill Name or Subject	Position
S. 115	The Veterans Transplant Coverage Act	Support
S. 426	Grow Our Own Directive Physician Assistant Employment and Education Act of 2017	Support
S. 683	Keeping Our Commitment to Disabled Veterans Act of 2017	Support
Draft Bill	To improve the hiring, training, and efficiency of acquisition personnel and organizations of the Department of Veterans Affairs, and for other purposes	Support
S. 833	Servicemembers and Veterans Empowerment and Support Act of 2017	Support
S. 946	Veterans Treatment Court Improvement Act of 2017	Support
S. 1153	Veterans ACCESS Act	Support
S. 1261	Veterans Emergency Room Relief Act of 2017	Support
S. 1266	Enhancing Veteran Care Act	Support
S. 1279	Veterans Health Administration Reform Act of 2017	Refer to Choice Program- Community Care Option Section
Draft Discussion	Veterans Choice Act of 2017	Refer to Choice Program- Community Care Option Section
Draft Discussion	Improving Veterans Access to Care in the Community Act of 2017	Refer to Choice Program- Community Care Option Section
S. 1325	Better Workforce for Veterans Act of 2017	Support
Discussion Draft	The Department of Veterans Affairs Quality Employment Act of 2017	Support

When The American Legion testified at the June 7, 2017 Senate hearing, we went on record stating The American Legion believes in a strong, robust veterans' healthcare system that is designed to treat the unique needs of those men and women who have served their country. As we testify today, The American Legion's commitment to helping Congress and VA build a strong robust veterans' healthcare system is even stronger.

Chairman Isakson, Ranking Member Tester, and distinguished Members of the Committee; On behalf of our National Commander, Charles E. Schmidt, and the over 2 million members of The American Legion, we thank you for this opportunity to testify regarding The American Legion's position on pending legislation before this Committee. We appreciate the Committee focusing on these critical issues that will affect veterans and their families.

S. 115: THE VETERANS TRANSPLANT COVERAGE ACT

A bill 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.

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has been providing transplant services since 1961 when Dr. Thomas E. Starzl, performed the first-ever transplant of a human liver at the Denver VA hospital on May 5, 1963.

This bill, if enacted into law, would authorize the Secretary of Veterans Affairs to provide organ transplants to veterans from a live donor regardless of whether that donor is a veteran. This bill would allow veterans who are waiting a lengthy

amount of time for VA transplant services to receive those services out in the community at VA expense.

In 2015, the VA Office of Inspector General (VAOIG) issued Report No. 15–00187–25, *Alleged Program Inefficiencies and Delayed Care, VHA’s National Transplant Program*. VAOIG substantiated that some patients referred for liver transplant evaluations at all VATCs experienced delays. VAOIG estimated that 6.9 percent of emergency referrals were not responded to in VHA’s electronic transplant referral system within 48 hours, as required (95 percent confidence interval (CI): 1.67–24.42). Among stable patient referrals, VAOIG estimated that 9.6 percent of referrals were not responded to in VHA’s electronic transplant referral system within 5 business days, as required (95 percent CI: 6.36–14.28). About half of stable patients who were deemed eligible for further evaluation did not receive an initial patient evaluation within 30 days, as required.¹

According to statistics obtained from the Department of Health and Human Services, as of June 30, 2017, there were 117,636 people needing a lifesaving organ transplant (total waiting list candidates).² Of those, 75,958 people are active waiting list candidates. In accordance with VHA Policy Directive 2012–018, *Solid Organ and Bone Marrow Transplantation*, VA can only accept living donors into VA’s transplant program.

Through American Legion Resolutions No. 25, *The American Legion Support of the VA Organ Transplant Program* The American Legion 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*, that the Department of Veterans Affairs (VA) 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 account.^{3 4}

The American Legion supports S. 115.

S. 426: GROW OUR OWN DIRECTIVE: PHYSICIAN ASSISTANT EMPLOYMENT AND EDUCATION ACT OF 2017

A bill to increase educational assistance provided by the Department of Veterans Affairs for education and training of physician assistants of the Department, to establish pay grades and require competitive pay for physician assistants of the Department, and for other purposes.

S. 426 will authorize the Grow Our Own Directive (GOOD) Pilot Program for five years to advance training and education opportunities for participants of the Intermediate Care Technician (ICT) program who agree to work in VA facilities in underserved states, and former servicemembers with military health experience. Once these veterans are certified as Physician Assistants, they will be required to work at the VA for at least three years.

Physician Assistants are one of the most in-demand positions at the VA. In 2016, it was reported that there is a 23 percent vacancy rate in the VA for physician assistants. According to the Veterans Affairs Physicians Assistants Association, there are an estimated 30,000 open Physician Assistant positions in the United States, making it difficult for the VA to recruit and retain physician assistants.⁵

Reports from our legionnaires who are involved in VA facilities at the state level suggest that the reason for this is not a lack of quality candidates, but rather process and pipeline barriers. For a Veterans Health Administration (VHA) facility to hire one person for a clinical position it can involve up to 18 steps—from getting approval for the job posting, to running credential checks—and can take from four to eight months to complete. By that time, candidates have often accepted a job elsewhere.

The ICT program is a common sense initiative for the VA to fill these vacancies. Created in 2012, the scope of practice for the role of an ICT is more advanced than a traditional VA EMT. ICTs are configured for the medic and corpsmen skill set and provide a high level clinical support to nurses and physicians. Additionally, the position was designed as an initial entry springboard for qualified veterans to explore further career opportunities in healthcare. Unfortunately, the program continues to

¹ VAOIG Report No. 15–00187–25 (Nov 2015): *Alleged Program Inefficiencies and Delayed Care, VHA’s National Transplant Program*

² *Organ Procurement and Transplantation Network*: <https://optn.transplant.hrsa.gov/>

³ *The American Legion Resolution No. 25 (May 2004): The American Legion Support of the VA Organ Transplant Program*

⁴ *The American Legion Resolution No. 46 (Oct. 2012): Department of Veterans Affairs (VA) Non-VA Care Programs*

⁵ *USA Today* (Aug 20, 2015): *Half of critical positions open at some VA hospitals.*

suffer from a lack of training opportunities for participants to utilize to advance their careers at the VA.

S. 426 would provide this training by establishing the Grow Our Own Directive (GOOD) Pilot Program for 5 years, which would provide scholarships to cover the cost of obtaining a master's degree in Physician Assistant Studies. This would make good on the promise and potential of the ICT Program in leveraging the skill sets of our medics and corpsmen, as well as help solve long-standing recruitment issues facing VHA.

Through American Legion Resolution 338: Support Licensure and Certification of Servicemembers, Veterans and Spouses resolves that The American Legion supports efforts to eliminate employment barriers that impede the timely and successful transfer of military job skills to the civilian labor market.⁶

The American Legion supports S. 426.

S. 683: KEEPING OUR COMMITMENT TO DISABLED VETERANS ACT OF 2017

A bill to amend Title 38, United States Code, to extend the requirement to provide nursing home care to certain veterans with service-connected disabilities.

Public Law 114–228, Section 1710A, Required Nursing Home Care, was signed into law September 29, 2016, and is due to expire December 31, 2017.⁷

The American Legion Resolution No. 377, Support for Veteran Quality of Life, supports any legislation and programs within VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care; timely decisions on claims and receipt of earned benefits; and final resting places in national shrines and with lasting tributes that commemorates their service.⁸

By extending the date and not allowing this critical authority to expire, the lives of veterans with service-connected disabilities will continue to be enhanced.

The American Legion supports the passage of S. 683.

S. 833: SERVICEMEMBERS AND VETERANS EMPOWERMENT AND SUPPORT ACT OF 2017

A bill to amend Title 38, United States Code, to expand health care and benefits from the Department of Veterans Affairs for military sexual trauma, and for other purposes.

The American Legion supports safe and dignified service for all servicemember regardless of pay category, period of service, or duty assignment. The Department of Defense has instituted a zero tolerance policy for sexual harassment cases, and The American Legion agrees. Unfortunately, despite existing laws and military regulations, sexual harassment still happens far too much, and when it does servicemembers should be able to receive appropriate counseling and care from the Department of Veterans Affairs to overcome any health-related conditions related to sexual harassment or assault. For this reason, The American Legion passed Resolution No. 67 Military Sexual Trauma and Resolution No. 15, Support Veteran Status for National Guard and Reserve Servicemembers.^{9 10}

The American Legion supports S. 833.

S. 946: VETERANS TREATMENT COURT IMPROVEMENT ACT OF 2017

A bill to require the Secretary of Veterans Affairs to hire additional veterans justice outreach specialists to provide treatment court services to justice-involved veterans, and for other purposes.

When veterans return from combat, some turn to drugs or alcohol to cope with mental health issues related to Post Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI). Thus, many returning veterans are entering the criminal justice system to face charges stemming from these issues. In 2008, a judge in Buffalo, NY, created the first Veterans Treatment Court after seeing an increase in veterans' hearings on his dockets. Veteran Treatment Courts are a hybrid of drug and mental health courts. They have evolved out of the growing need for a treatment court model designed specifically for justice-involved veterans to maximize efficiency

⁶The American Legion Resolution No. 338 (2016): Support Licensure and Certification of Servicemembers, Veterans and Spouses

⁷Public Law 114–228 (114th Congress): <https://www.gpo.gov/fdsys/pkg/PLAW-114publ228/html/PLAW-114publ228.htm>

⁸The American Legion Resolution No. 377 (Sept. 2016): Support for Veteran Quality of Life.

⁹The American Legion Resolution No. 67 (August 26, 2014): Military Sexual Trauma

¹⁰The American Legion Resolution No. 15 (August 30, 2016): Support Veteran Status for National Guard and Reserve Servicemembers

and economize resources while making use of the distinct military culture consistent among veterans.

In 2016, The American Legion approved Resolution No. 145, Veteran Treatment Courts which specifically calls for continuing to fund and expand Veterans Treatment Courts and hire more staff to expand the Veterans Justice Outreach program and policies.¹¹

The American Legion supports S. 946.

S. 1153: VETERANS ACCESS ACT

A bill to prohibit or suspend certain health care providers from providing non-Department of Veterans Affairs health care services to veterans, and for other purposes.

The American Legion plays a lead role in VA healthcare reform by working with providers, patients, the public and other stakeholders in communities to improve access, quality and accountability.

This bill, as written, would protect veterans seeking care through VA community care programs like the Choice Program, from being treated by doctors who have been terminated or who have been suspended by the VA.

The American Legion System Worth Saving (SWS) facility visits and Regional Office Action Reviews (ROAR) provide unequaled firsthand knowledge of the challenges and opportunities VA faces in the communities it serves. The American Legion's national staff also closely monitors reports from the Government Accountability Office, Congress, VAOIG, media and multiple other sources to identify facilities that are experiencing challenges so solutions can be found together.

There are numerous reasons a physician can lose their license to practice. If a VA physician hired to care for a veteran is terminated by VA for any reasons cited in this bill, The American Legion agrees with Congress, VA should not be permitted to refer veterans outside the department to these non-VA providers. No veteran should be put in a position of being referred to a non-VA physician who was terminated from the VA due to negligence of duties.

The American Legion Resolution No. 3, Department of Veterans Affairs Accountability, supports any legislation that provides the Secretary of Veterans Affairs the authority to remove any individual from the Department of Veterans Affairs if the Secretary determines the performance of the individual warrants such removal.¹² Once a VA physician is removed from VA due to performance, The American Legion believes Congress and VA has a sacred duty to ensure that our Nation's veterans are protected and receive the best health care available regardless of whether the care is provided by VA or a non-VA physician.

The American Legion supports S. 1153.

S. 1261: VETERANS EMERGENCY ROOM RELIEF ACT OF 2017

A bill to amend Title 38, United States Code, to require the Secretary of Veterans Affairs to pay the reasonable costs of urgent care provided to certain veterans, to establish cost-sharing amounts for veterans receiving care at an emergency room of the Department of Veterans Affairs, and for other purposes.

This bill would create a new section, 1725A, Payment of reasonable costs of urgent care.

Through American Legion Resolution No. 46: Department of Veterans Affairs (VA) non-VA care programs, The American Legion calls on the Department of Veterans Affairs (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.¹³ Additionally, through American Legion Resolution No. 377, Support for Veteran Quality of Life, The American Legion urges Congress and the Department of Veterans Affairs (VA) to enact legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents.¹⁴ The American Legion believes including urgent care as an option in VA's Community Care program will enhance veterans care.

The American Legion supports S. 1261.

¹¹The American Legion Resolution No. 145 (August 30, 2016): Veteran Treatment Courts

¹²The American Legion Resolution No. 3 (August 2016): Department of Veterans Affairs Accountability

¹³The American Legion Resolution No. 46 (October 2012): Department of Veterans Affairs non-VA care programs

¹⁴The American Legion Resolution No. 377 (August 2016): Support for Veteran Quality of Life

S. 1266: ENHANCING VETERAN CARE ACT

A bill to authorize the Secretary of Veterans Affairs to enter into contracts with non-profit organizations to investigate medical centers of the Department of Veterans Affairs.

Dating as far back as 2003, The American Legion has been involved in conducting System Worth Saving (SWS) site visits to VA Health Care facilities to better understand the challenges veterans face when accessing VA health care. Each year, The American Legion visits anywhere between 12 to 15 VA health care facilities. Prior to each site visit, a town hall meeting is held so veterans can have an opportunity to share firsthand their VA experience. After each visit, a report is written identifying best practices and challenges. Challenges are followed up with recommendations and the report is shared with the medical center to assist them in overcoming their challenges. Prior to The American Legion National Convention, the site visit reports are compiled into an Executive Summary, which is shared with the House and Senate Veterans' Affairs Committees, the VA Secretary, Under Secretary of Health and the President of the United States.

Through American Legion Resolution No. 105, Reiteration of the System Worth Saving Program, The American Legion supports visiting and investigating VA medical centers for the purpose of identifying gaps in services, best practices, and areas that need improvement.¹⁵ The American Legion would also want to ensure that the nonprofit organizations selected to investigate are certified, qualified, and fair and equitable. They should work closely with VA and Veteran Service Organizations to establish a criteria for investigation with a responsible metric for evaluation and data collection that highlights best practices as well as deficiencies and areas that need improvement.

The American Legion supports S. 1266.

S. 1279: VETERANS HEALTH ADMINISTRATION REFORM ACT OF 2017

A bill to amend Title 38, United States Code, to furnish health care from the Department of Veterans Affairs through the use of non-Department health care providers, and for other purposes.

(See below)

DRAFT DISCUSSION: VETERANS CHOICE ACT OF 2017

A bill to amend title 38, United States Code, to permit all veterans enrolled in the patient enrollment system of the Department of Veterans Affairs to receive health care from non-Department of Veterans Affairs health care providers, and for other purposes.

(See below)

DRAFT DISCUSSION: IMPROVING VETERANS ACCESS TO CARE IN THE COMMUNITY ACT OF 2017

A bill to amend Title 38, United States Code, to establish the Veterans Community Care Program of the Department of Veterans Affairs to improve health care provided to veterans by the Department, and for other purposes.

(See below)

CHOICE PROGRAM-COMMUNITY CARE OPTIONS

Even in the best of circumstances, there are situations where the VA health care system cannot keep up with the healthcare needs of the growing veteran population requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, or an add-on to the existing system, The American Legion has called for the Veterans Health Administration (VHA) to “develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered strategy which takes veterans’ unique medical injuries and illnesses as well as their travel and distance into account.”

Over the years, VA has implemented a number of non-VA care programs to manage veterans’ health care when such care is not available at a VA facility, could not be provided in a timely manner, or is more cost effective through contracting vehicles. Programs such as Fee-Basis, Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program (VCP)

¹⁵The American Legion Resolution No. 105 (Sept. 2015): Reiteration of the System Worth Saving Program

were enacted by Congress to ensure eligible veterans could be referred outside the VA for needed, and timely, health care services.

Congress created the VCP after learning in 2014 that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

Therefore, Congress passed the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015 after VA sought the opportunity to consolidate its multiple care in the community authorities and programs. This legislation required VA to develop a plan to consolidate existing community care programs.

On October 30, 2015, VA delivered to Congress the department's Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan seeks to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other Federal health care providers, academic affiliates and community providers. It promises to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care.

Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New Veterans Choice Program (New VCP). We believe it has the potential to improve and expand veterans' access to health care.

The American Legion has carefully reviewed each of the three bills and we would like comment on a few provisions of the bills. Under Subsection (a) of Senator Tester's bill, the bill would establish section 1703A, Veterans Community Care program, which authorizes the Secretary to furnish an eligible veteran hospital care and medical services through the Veterans Community Care program. To be eligible, a veteran must be enrolled in the VA Health Care System, which is consistent with the requirements in Senator Crapo's and Senator's Isakason's bill. However, The American Legion is concerned that under subsection (d) of Senator Tester's bill, it would require the Secretary to (Shall) enter into contracts with eligible providers for furnishing care and services to eligible veterans. The bill defines the term contracts has the meaning given that term in subpart 2.101 of the Federal Acquisition Regulation. Under section 201, it would create a new section, 1703C, referred to as Veterans Care Agreements. This section would provide the Secretary discretionary (May) authority to establish providers agreements. The American Legion believes these two sections may create challenges for VA when deciding what type of care should fall under the mandatory (Shall) authority and what type of care should fall under the discretionary (May) authority.

Section 2 of Senator Crapo's bill would amend Title 38 U.S.C. 1703's heading from "Contracts for Hospital Care and Medical Services in Non-Department facilities" to "Care in the Community Program" The American Legion believes the current heading gives a false impression that this is a contracting authority, and by retitling 38 U.S.C. 1703, it would avoid this false impression. Senator Crapo's bill would also authorize reimbursement for urgent care provided at a non-Department facility in accordance with regulations prescribed by the Secretary and would also establish a new section, titled 1703A, which would require the Secretary to enter into purchase agreements with non-Department health care providers to furnish care and services to enrolled veterans. At The American Legion 2016 National Convention, Resolution No. 114, Department of Veterans Affairs Provider Agreements with Non-VA Providers, was passed which supports legislation that would allow the Department of Veterans Affairs (VA) to enter into provider agreements with eligible non-VA providers to obtain needed health care services for the care and treatment of eligible veterans.¹⁶

All three bills includes provisions for repealing obsolete non-VA community care authorities.

The American Legion along with other Veteran Service Organizations have been working diligently with VHA to help with language to streamline their Non-VA purchase care program in order to come up with a replacement for the Choice program. While each bill is somewhat different, when you consider all three bills together, The American Legion believes they have what is needed to address the many challenges VA face in building a robust community care program.

¹⁶The American Legion Resolution No. 114 (Aug. 2016): Department of Veterans Affairs Provider Agreements with Non-VA Providers

The American Legion would like to direct this Committee's attention to the Draft Veteran Coordinating Access & Rewarding Experiences (CARE) plan, and urges this Committee to develop future legislative proposals with this proposal in mind.

The American Legion wants to thank Senator's Isakson, Tester, and Crapo for taking the lead in drafting these three bills and calls on them to work together and with The American Legion to deliver a single bill that includes all the great work each senator has contributed in their sponsored bill to make VA's Community Care program successful.

S. 1325: BETTER WORKFORCE FOR VETERANS ACT OF 2017

A bill to amend Title 38, United States Code, to improve the authorities of the Secretary of Veterans Affairs to hire, recruit, and train employees of the Department of Veterans Affairs, and for other purposes.

This draft bill will direct VA to expand its workforce, leading to more timely and efficient healthcare for veterans. The American Legion supports legislation that will increase employee capabilities at the VA. We feel that recent graduates and veterans bring much needed new talent into the VA and increased hiring will lead to improved employment opportunities for veterans within the VA. The American Legion supports policies that boosts the percentage of veterans hired in all agencies, specifically the VA, to 50 percent or above.¹⁷

The American Legion believes that an increase in VA workforce will lead to; reduced patient waiting times, improvement in employee vacancy rates, decreased senior VA medical center leadership turnover, helping ensure timely claims processing, help to reduce homelessness, minimize improper burials at VA cemeteries and; provide better assurance and compliance with national policies, rules and laws enacted to assist veterans and their families.

The American Legion has tracked and reported staffing shortages at every VA medical facility across the country since the inception of the System Worth Saving (SWS) program in 2003. The Veterans Health Administration (VHA) is still struggling to achieve the appropriate balance of primary care and medical specialists across the country. If VA continues to struggle with retention and recruitment, the trend of closures (or continued closures) for multiple departments within VA healthcare systems nationwide will continue.

Numerous reports cite VA's staffing issues. For example, in January 2015, the VA's Office of Inspector General released its determination of the "Veterans Health Administration's Occupational Staffing Shortages," as required by Section 301 of the "Veterans Access, Choice and Accountability Act of 2014." With this report, the Inspector General determined the five occupations with the largest staffing shortages were medical officers, nurses, physician assistants, physical therapists and psychologists.^{18 19}

In another study conducted by Federal H.R. experts AVUE Technologies, this legislation seeks to make it easier for the Secretary of the VA to manage his workforce, including hiring, retention, and overall talent management. There are many elements of the legislation that will be helpful to the Secretary however, there are elements that, with improvement, would contribute to making a difference in a more substantial way, such as the focus on VA first responders which is long overdue—in particular the VA Police Officers.

The VA Police Officers have been targeted by the VA's Chief Human Capital Officer (CHCO) and the CHCO's subordinates for downgrade VA-wide. The VA has taken the position that VA Police Officers should be no higher graded than GS-5 (they are currently GS-6) and that they do not perform work of law enforcement officers because the VA believes they are primarily engaged in patrols and low level security work instead of higher graded police officer or law enforcement work. In an independent study by Federal H.R. experts, the experts found this to completely mischaracterize the day-to-day work of the VA's police force. Instead the study found that for Police Officers, the full-performance level should be GS-7 in all locations where the following units are found:

¹⁷The American Legion Resolution No. 346 (Aug. 2016): Support an Investigation of Hiring Practices in the Federal Government

¹⁸The American Legion Legislative Agenda (March 1, 2017)

¹⁹The American Legion Resolution No. 317 (Aug. 2016): Enforcing Veterans' Preference Hiring Practices in Federal Civil Service

²⁰The American Legion Resolution No. 20 (Oct. 2016): Oppose Efforts to Downgrade Low-Level Wage Positions within the Department of Veterans Affairs

- Medical Centers that provide in-house, inpatient acute medical and surgical services and procedures and acute psychiatric services in addition to outpatient services.
- Vet Centers that provide readjustment counseling and outreach services to all veterans who served in any combat zone.
- Domiciliary that provide a variety of care to veterans who suffer from a wide range of medical, psychiatric, vocational, educational, or social problems and illnesses.

The study found no justification to downgrade or cap the grades of these positions on a universal basis. While certain locations like CBOCs may not exceed GS-5, that grade would misclassify other Police Officer positions in other locations. VA police officers were found to perform police patrol work and crime and incident investigation. Contrary to the VA's assertions, the study found that the police officers were engaged in responding to reports of crimes in progress; pursuing and apprehending offenders fleeing a crime scene or attempting to resist arrest; apprehending offenders and making judgments regarding the arrest, citation, or release of suspects/offenders; advising persons of their constitutional rights; advising employees of their Weingarten rights; conducting frisks and searches; responding to duress calls and interceding in physical assaults or other incidents clearly requiring police intervention to minimize the possibility of injury to all involved parties; subduing unruly individuals who pose a threat to the officer and other individuals; and subduing individuals through physical force and/or the use of non-lethal and lethal weapons, as the situation dictates.

Additionally, with regard to crime and incident investigations, the following duties, among others, were identified:

- Conducts investigations in order to: (1) determine if a crime has been committed; (2) identify the perpetrator; (3) apprehend the perpetrator; and (4) provide evidence to support a conviction in court. Conducts initial discovery and response after being dispatched to a crime scene or location of a victim. Completes the initial investigation, including the immediate post-crime activities as the responding police officer arriving on the crime scene. Secures and processes accident, crime, or disaster scenes. Interviews witnesses and questions suspects at the scene. Searches the scene for evidence and collects, preserves, and documents the chain of custody of evidence. Diagrams crime and accident scenes. Estimates values of stolen or recovered goods. Recovers and inventories lost or stolen property. Transports property or evidence.
- Conducts follow-up investigations, as required, over multiple shifts. Investigates accidents, crimes against persons and property, and complaints of drug law violations. Collaborates with internal and external sources to obtain necessary information to further investigations. Reviews information on criminal activity within jurisdictional and surrounding areas. Locates and interviews witnesses to a crime and interrogates and/or question suspects. Conducts surveillance of individuals and/or locations. Checks on status of stolen property, criminal histories, and warrants through computer network. Records and/or reviews records and pictures to aid in investigations.

Furthermore, there was no basis to lower Leader or Supervisory or Managerial positions based on the downgrades of subordinate positions. In fact, in many locations the supervisory structure may warrant a higher grade based on these new full-performance levels. For VA police officers at the locations listed above it was found that the positions not only meet all the requirements to sustain their current GS-6 grade but also, for at least some, the GS-7 level in addition to meeting all of the requirements for 6c coverage. In accordance with OPM regulation Cabinet Level Secretaries may make the determination as to which positions are eligible for 6c coverage and this is fully within the current authorities of the Secretary. Doing so will improve retention in a manner that no other action would and recognition that the work performed by the VA's police officers warrant a higher grade will similarly improve retention.²⁰

The bill informs the VA that OPM should be engaged to review the police officer positions. This is problematic for two reasons. One, OPM is chartered with writing all of the classification and qualification standards for the Federal Government. Even Title 38 positions are classified using Title 5 classification standards issued by OPM. The classification standard for Police Officers was last updated in 1988.

Through American Legion Resolutions No. 20, Oppose Efforts to Downgrade Low-Level Wage Positions within the VA that The American Legion vigorously opposes

²⁰The American Legion Resolution No. 20 (Oct. 2016): Oppose Efforts to Downgrade Low-Level Wage Positions within the Department of Veterans Affairs

any downgrading of lowest wage positions GS7 and below, and WG-4 and below, No. 317, Enforcing Veterans' Preference Hiring Practices in Federal Civil Service that The American Legion seek and support any legislative or administrative proposal that will mandate the use of automated recruitment, hiring and retention system that safeguard against hiring malpractice in the application and the hiring process, and Resolution No. 346, Support an Investigation of Hiring Practices in the Federal Government that The American Legion supports remedial legislation, as may be needed, to increase the percentage of veterans hired in all Federal agencies; specifically, the Department of Veterans Affairs to 50 percent or above.

The American Legion supports S. 1325.

DISCUSSION DRAFT: THE DEPARTMENT OF VETERANS AFFAIRS QUALITY EMPLOYMENT ACT OF 2017

To improve the authority of the Secretary of Veterans Affairs to hire and retain physicians and other employees of the Department of Veterans Affairs, and for other purposes.

This draft bill will direct VA to expand its workforce, leading to more timely and efficient healthcare for veterans. The American Legion supports legislation that will increase employee capabilities at the VA. We feel that recent graduates and veterans bring much needed new talent into the VA and increased hiring will lead to improved employment opportunities for veterans within the VA. The American Legion supports policies that boosts the percentage of veterans hired in all agencies, specifically the VA, to 50 percent or above.

The American Legion believes that an increase in VA workforce will lead to; reduced patient waiting times, improvement in employee vacancy rates, decreased senior VA medical center leadership turnover, helping ensure timely claims processing, help to reduce homelessness, minimize improper burials at VA cemeteries and; provide better assurance and compliance with national policies, rules and laws enacted to assist veterans and their families.

This draft legislation will create more accountability and efficiency within the VA's workforce management, including hiring, retention, and overall talent management. There are many elements of the legislation that will be helpful to the Secretary.²¹

The American Legion has tracked and reported staffing shortages at every VA medical facility across the country since the inception of the SWS program in 2003. As far back as 1998, The American Legion expressed concerns regarding VA physicians and medical specialists staffing shortages within the Veterans Health Administration (VHA). This was accomplished by monitoring the progress in establishing patient centered primary care within each Veterans Integrated Service Network (VISN), including both rural and urban localities as well as ensuring that the model of care features both the quality and efficient combination of medical professionals that are tailored to the needs of the local veteran's population.

As in previous testimony, The American Legion urges the VA to develop an aggressive strategy to recruit, train, and retain medical professionals to meet the inpatient and outpatient health care needs of veterans. The American Legion fully supports such programs, such as the VA's education-assistance programs for APNs, RNs, LPNs, and NA's. We also urged VA to provide equitable and competitive wages for their medical professionals.²²

VA medical centers in rural areas have often faced challenges trying to recruiting and retaining qualified medical and clinical providers due to their inability to compete with medical centers in large metropolitan areas. In The American Legion's 2012 System Worth Savings (SWS) Report on Rural Healthcare, The American Legion found that: "Department of Veteran Affairs Medical Centers (VAMCs) in rural America, recruitment and retention of primary and specialty care providers has been a constant challenge. Some clinicians prefer to practice in more urban settings with more research opportunities and quality of life that urban settings provide."²³

As an example, at the time of our December 2016 visit to the Pacific Island Health Care System, the director, and chief of human resource position were both vacant. At the time of our January 2017 visit to the Greater Los Angeles VA Health Care System, the medical center director had been in his position for less than a year, and the associate director, chief, and assistant chief, human resource positions were ALL vacant. During a follow-up call last month, the VA Pacific Island Health

²¹The American Legion Testimony (March 16, 2016)

²²The American Legion Resolution No. 305 (Aug. 2016): Support the Development of Veterans On-The-Job Training

²³The American Legion System Worth Saving Report (2012): Rural Healthcare

Care System told us that all their top management positions, except for the Director position have now been filled and that the chief of human resources position has been filled with a permanent manager who is highly experienced in human resources.

These staffing shortages are contributing to physician and staff burnout which was reinforced during our Saint Cloud, Minnesota visit. As The American Legion continues to conduct System Worth Saving Site visits across the VA health care system, we see the trend of VA staffing shortages declining rather than improving.

Things that are working well include the significant contribution of the VA's Academic Residency Program. As one of the VA's statutory missions, the VA conducts an education and training program for health profession students and residents to enhance the quality of care provided to veterans within the VHA healthcare system. For almost sixty years, in accordance with VA's 1946 Policy Memorandum No. 2, the VA has worked in partnership with this country's medical and associated health profession schools to provide high quality health care to America's veterans and to train new health professionals to meet the patient health care needs within VA and the Nation. This partnership has grown into the most comprehensive academic health system partnership in American history.

While the VA's Academic Residency Program has made significant contributions in training VA health care professionals, upon graduation, many of these health care professionals choose a career outside the VA health care system. With these realities, the VA will never be in a position to compete with the private sector as it is currently set up. To this end, The American Legion feels strongly that VA should begin looking into establishing its own VA Health Professional University and begin training their medical health care professionals to serve as a supplement to VA's current medical residency program. Conceivably, medical students accepted into VA's Health Professional University would have their tuition paid in full by VA and upon graduation, the graduate would be required to accept an appointment at a Federal health facility at a starting salary comparable to what a new medical graduate would be paid by VA based on their experience and specialty. Similar to a military service academy, a VA medical school will be highly selective, competitive, and well respected. Applicants can be nominated by their congressional representative, teaching staff can be sourced organically as well as nationally, and real estate is plentiful. This will help ensure the VA will have an adequate number of healthcare professionals to meet the growing number of veterans and their healthcare needs.

In 2014, The American Legion published a SWS report titled "Past, Present, and Future of VA Healthcare," which noted several challenges VA still faced regarding recruiting and retention such as:

- Several VAMCs continue to struggle to fill critical leadership positions across multiple departments.
- These gaps have caused communication breakdowns between medical center leadership and staff that work within these departments.

During our 2013 site visit to the Huntington VA Medical Center in Huntington, West Virginia, we recommended that, "VHA conduct a rural analysis for hard to recruit areas and look into different options to support VAMCs in getting talent they need to better serve veterans." VHA needs to ensure that veteran health care is consistent across each Veterans Integrated Service Network (VISN).

In 2015, during our SWS site visit to the VA Medical Center in St. Cloud, Minnesota, providers expressed concerns about the number of physician vacancies, and how the additional workload is impacting morale at the medical centers. During the same visit, one veteran expressed concern noting "every time [I] visit the medical center, [I am] assigned a new primary care provider because [my] last provider either quit or transfer to another VA."

There have been numerous reports citing VA's staffing issues, for example in January 2015, the VA's Office of Inspector General (VAOIG) released their determination of the "Veterans Health Administration's Occupational Staffing Shortages," as required by Section 301, of the "Veterans Access, Choice and Accountability Act (VACAA) of 2014." With this report, VAOIG determined that the five occupations with the largest staffing shortages were Medical Officers, Nurses, Physician Assistants, Physical Therapists, and Psychologists. The OIG recommended that the "Interim Under Secretary for Health continue to develop and implement staffing models for critical need occupations." Ultimately, if the VA continues to struggle with retention and recruitment, the trend of closures (or continued closures) for multiple departments within VAMCs nationwide will continue.

As The American Legion continues to conduct System Worth Saving Site visits across the VA health care system, we see VA staffing shortages getting worse rather

than improving. One reason VA may sometimes struggle to provide care within the Veterans Health Administration (VHA) is directly related to staffing. One in six positions nationally for some critical jobs remain vacant, and critical needs like psychiatric workers can see vacancy rates of 40–64 percent.²⁴

Even when VA is hiring an additional 9 percent of their workforce they are losing a similar amount to attrition. Some of this could be improved with better hiring incentives and more competitive wages, particularly in key fields of need such as psychiatric care, physician's assistants, nurses and physical therapists.²⁵

As the Office of the Inspector General recommended, VA also bears additional responsibility in the form of the development of better staffing models and examining the red tape and bureaucratic burdens that stretch hiring out into a process that can take nine months or longer. Additional examination of where VA can better incentivize prospective applicants to decide on a career serving veterans would be helpful. We need to ensure VA has proper funding to get the best and brightest team members on their medical and psychological staffs serving veterans.

The VA can further help improve their staffing, especially in leadership positions, with better succession planning for VA employees to rise to leadership levels within the organization. As an organization of advocates that has worked hand in hand with VA for decades, The American Legion notes the training programs VA had in place during the 1990's were better suited to creating the next generation of leadership than the current programs in place. The VHA training programs of the 1990's were specifically built to prepare administrative employees to assume mid-level management programs at the department level. This could include personnel, fiscal, medical administration, associate director training and other leadership training. The programs were replaced, over time, with VA's current Leadership Development Programs, but feedback The American Legion has garnered from interacting with VHA personnel during visits from our System Worth Saving Task Force has indicated these programs are not providing the tools the employees need to be the next generation leaders of VA and to lead from within.

The American Legion understands that filling highly skilled vacancies at premiere VA hospitals around the country is challenging. We also expect VA to do whatever is legally permissible to ensure that veterans have access to the level of quality healthcare they have come to expect from VA. VA has a variety of creative solutions available to them without the need for additional legislative action. One such idea could involve the creation of a medical school, another would be to aggressively seek out public private partnerships with all local area hospitals. VA could expand both footprint and market penetration by renting space in existing hospitals where they would also be able to leverage existing resources and foster comprehensive partnerships with the community. Finally, VA could research the feasibility of incentivizing recruitment at level 3 hospitals by orchestrating a skills sharing program that might entice physicians to work at level 3 facilities if they were eligible to engage in a program where they could train at a level 1 facility for a year every 5 years while requiring level 1 facility physicians to spend some time at level 3 facilities to share best practices. Currently, medical staff are primarily detailed to temporarily fill vacancies. This practice fails to incentivize the detailed professional to share best practices and teach, merely hold down the position until it can be filled by a permanent hire.

The American Legion through Resolution No. 317, Enforcing Veterans' Preference Hiring Practice in Federal Civil Service believes additional consideration to revamping this portion of training, and ensuring this training is properly funded, could be a key component to reducing VA's reliance on the complicated process of hiring from outside VA and ultimately reduce the number of unfilled leadership positions.²⁶

The American Legion supports the Discussion Draft.

CONCLUSION

As always, The American Legion thanks the Senate Committee on Veterans' Affairs 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 Mr. Derek Fronabarger at The American Legion's Legislative Division.

Chairman ISAKSON. Thank you very much, Mr. Celli.

²⁴ *USA Today* (Aug. 20, 2015): Half of critical positions open at some VA hospitals

²⁵ VAIG Report No. 15-03063-511: OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (Sept. 2015)

²⁶ The American Legion Resolution No. 317 (Aug. 2016): Enforcing Veterans' Preference Hiring Practices in Federal Civil Service

Ms. Webb?

**STATEMENT OF AMY WEBB, NATIONAL LEGISLATIVE
POLICY ADVISOR, AMVETS**

Ms. WEBB. Good afternoon, Chairman Isakson, Ranking Member Tester, and Members of the Committee. AMVETS is truly pleased to be invited to testify today.

Of the many bills being considered at this hearing, all of which are intended to improve lives of veterans, we support all but two. Before discussing those, I would like to mention that Senator Flake's Veterans Treatment Court Improvement Act speaks loudly to one of our key legislative priorities.

Many veterans have specific needs and challenges related to their military service, and AMVETS has been involved with veterans treatment courts since their inception. At that time, that was with our then Commander J.P. Brown, who worked with Judge Robert T. Russell in Buffalo, NY. Commander Brown took that knowledge and helped create a very active veterans treatment court in his own homestate of Ohio, and AMVETS appreciates that S. 946 would add more Veterans Justice Outreach specialists, particularly since there are so many solid systems in place to help veterans, but none will properly function without adequate staffing.

The two bills that we are unable to support center around Choice, and I think that some of the remarks we have prepared have already been said today by a couple of the Senators. But, allowing veterans the open-ended ability to seek care in the private sector is a concern.

On the one hand, Choice sounds like a great proposition, but on the other, we are concerned that implementing a broader Choice Program will either intentionally or unintentionally dismantle the VA health care system. This, we oppose.

As you know, Choice is currently in need of more than \$4 billion in emergency appropriations or in a shift of funds between VA accounts in order for the program to continue providing the often life-saving health care to our Nation's veterans.

We have recently heard that due to funding shortfalls within the Choice Program, that veterans are again being stacked in a line each day rather than receiving care in the community. The fact that veterans are again being forced to wait for health care, even within the program designed specifically to alleviate that, is quite a red flag. Something is broken here, and Choice is not fixing it.

Late last month, this Committee received a joint VSO letter that included AMVETS, which outlined our collaborative deep concerns. While AMVETS supports the funding needed to continue Choice through fiscal year 2018, we do not support expanding the program. It is imperative that funds are used to invest back into the VA system of care in order to remedy capacity issues and fill the over 40,000 job vacancies, so the system is able to consistently care for enrolled veterans in a timely fashion.

The joint VSO letter also noted that there are at least 27 VA health care facility leases and dozens of construction projects requiring billions of dollars in funding in order to sustain and expand VA's capacity for care. Why not invest in a system of care that has already been designed to meet the needs of veterans? Pushing vet-

erans further and further into the private sector is not going to solve anything, whether in cost savings or in health outcomes. We have only been able to ascertain that the national health care spending is growing at quite a fast clip, and the system is rife with quality and access-to-care issues.

We mentioned in our written testimony that currently over 30 percent of veterans receive their health care through fee basis and community care, and the proposed measures to expand Choice will potentially break the VA health care system, which polls do show is superior to care received in the private sector once the veteran can get in.

While AMVETS absolutely supports the public-private partnership where it makes sense, often in the rural and highly rural areas, in order to serve the health care needs of veterans, what we hear is that veterans want VA health care to work for them. Pushing the funding to the private sector instead of within this large system of specialized care seems more like a bleed-em-dry strategy that concerns us.

We look forward to working with this Committee to address the many issues facing our veterans in today's complex and challenging health care environment, and thank you again for the opportunity to testify today. I am open to answer any questions you may have.

Thank you.

[The prepared statement of Ms. Webb follows.]

PREPARED STATEMENT OF AMY WEBB, NATIONAL LEGISLATIVE POLICY ADVISOR,
AMVETS

S. 115 Veterans Transplant Coverage Act	Support
S. 426 Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017	Support
S. 683 Keeping Our Commitment to Disabled Veterans Act of 2017	Support
S. 833 Servicemembers and Veterans Empowerment and Support Act of 2017	Support
S. 946 Veterans Treatment Court Improvement Act	Support
S. 1153 Veterans ACCESS Act	Support
S. 1261 Veterans Emergency Room Relief Act	Support
S. 1266 Enhancing Veteran Care Act	No Position
S. 1279 Veterans Health Administration Reform Act of 2017	Support
S. 1325 Better Workforce for Veterans Act	No Position/ Support
Veterans' Choice Act of 2017	Oppose
Improving Veterans Access to Community Care	Oppose
VA Quality Employment Act of 2017	Support

Chairman Isakson, Ranking Member Tester, and all members of the committee; thank you for the opportunity to testify on behalf of AMVETS' 250,000 members. We are particularly thankful for your efforts to address some of the most challenging and longstanding veteran policy issues. We appreciate the dedication of your staff members who are working diligently to formulate policies that ensure we are taking care of our Nation's veterans and their families.

S. 115: Veterans Transplant Coverage Act

AMVETS supports S. 115.

S. 115 would 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, notwithstanding that the live donor may not be eligible for health care from the VA. AMVETS supports any legislation that helps to ensure a veteran is getting the health care they need.

S. 426: Grow Our Own Directive: Physician Assistant Employment Act of 2017

AMVETS supports S. 426.

S. 426 is creating a pilot program to ensure that military training meets civilian certification. This not only provides training that can lead to employment for veterans, but Sec. 2(f) helps ensure that those being trained will provide a service for the Veterans Health Administration. AMVETS supports the strongest veterans' preference laws possible at all levels of government and values the level of care provided at VA Medical Centers.

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

AMVETS supports S. 683.

This bill extends the requirement to provide nursing home care to certain veterans with service-connected disabilities.

AMVETS has long fought for increased assistance for veterans in home healthcare where it makes sense. As such we will support legislation that provides nursing home care to those who are eligible and in need.

S. 833: Servicemembers and Veterans Empowerment and Support Act of 2017

AMVETS supports S. 833.

AMVETS is specifically invested in this bill, as it has been a National resolution on our legislative agenda for many years. We would like to commend Senators Tester, Blumenthal, Brown, and Murray for introducing the bill.

Military sexual trauma is a heinous crime which is a disgrace to all of those who have ever worn the uniform of the Armed Services. The effects of untreated MST can be devastating to the overall health of veterans and their transition back to their families and communities.

Continued dialogue and discussion is incredibly important when discussing issues such as MST. We are thankful to the committee's leadership for taking their role of oversight seriously when it comes to military sexual trauma.

S. 946: Veterans Treatment Court Improvement Act

AMVETS supports S. 946

S. 946 would require the Secretary of VA to hire additional Veterans Justice Outreach (VJO) Specialists, and AMVETS enthusiastically supports this bill. Many veterans have specific needs and challenges that are related to their military service. AMVETS has been involved with veteran treatment courts since their inception – starting with our then Commander J.P. Brown who worked with Judge Russel in Buffalo New York. Commander Brown took that knowledge and helped to create a veteran treatment court in his home state of Ohio where about 100 veterans have gone through the system. Of those, only four have had to leave due to noncompliance. The 96 others have completed two years of treatment which combines VA services, Social Services, veteran and family counseling, and four mental health agencies. The veteran is also paired with a mentor. The court itself acts just like a regular

court, and if the veteran client pleads guilty and completes the 2-year program, then the charges are dropped. It is a key legislative priority of ours to see these courts expanded and we appreciate that the bill would add more VJO Specialists. There are many solid systems in place to help veterans, but they will not properly function without adequate staffing.

S. 1153: Veterans ACCESS Act

AMVETS supports S. 1153, under the auspice that VA's are fully funded at levels to address their capacity shortfalls.

AMVETS is concerned with the care offered at VA Medical Centers, which is why we support the Secretary's decision to prohibit or suspend certain health care providers from providing non-Department of Veterans Affairs health care services if they were removed from employment with the VA due to conduct that violated a policy of the Department, violated the requirements of a medical license of the health care provider, or violated a law for which a term of imprisonment of more than one year may be imposed.

However, we do not view non-VA providers as the only, or even the preferred, answer to the capacity of care issue plaguing the VA. We are hopeful that this committee and the administration will start looking for ways to close the VA budget shortfalls on VA infrastructure and capacity.

S. 1261: Veterans Emergency Room Relief Act of 2017

AMVETS supports S. 1261, under the auspice that VA's are fully funded at levels to address their capacity shortfalls.

S. 1261 would require the Secretary to enter into contracts with urgent care providers so they could be paid reasonable fees for treating eligible veterans so that veterans could receive reasonable and local care.

However, as stated above we do not view non-VA providers as the only, or even the preferred, answer to the capacity of care issue plaguing the VA. We are hopeful that this committee and the administration will start looking for ways to close the VA budget shortfalls on VA infrastructure and capacity.

S. 1266: Enhancing Veteran Care Act

AMVETS has no current position on S. 1266

AMVETS agrees that the VA Secretary needs to have the power, when appropriate, to remove or demote VA employees based on performance or misconduct. However, it is unclear to AMVETS as to what purpose this new investigatory authority would provide that is not already accomplished, or intended by, the VA Office of the Inspector General, Government Accountability Office, and Congress in their oversight capacity roles.

S. 1279: Veterans Health Administration Reform Act of 2017

There are 5.3 million rural veterans who face a unique combination of factors that create disparities in health care found in urban areas, such as inadequate access to care, limited availability of skilled care providers, and additional stigma in seeking mental healthcare.

More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas and to date, more than 60,000 service members have become injured, wounded, or ill during their deployment. 36 percent (more than 2.2 million) of all VA health-care users reside in rural areas, including 76,955 from 'highly rural' areas.

This becomes a problem when only 25 of the 144 VA medical centers are considered to be located in rural or highly rural places.

S. 1279 would provide care and services to eligible veterans from non-Department health care providers through the use of Veterans Care Agreements. Eligible veterans are those who would experience an "undue burden" if the veteran seeks care or services from the Department. An undue burden can be an excessive driving distance, geographical challenges, or environmental factors that impede the access of the veteran to care or services from the Department.

Because of the agreement to provide non-Department care for those living an excessive distance from Department medical centers, AMVETS is happy to support this legislation and thank Senator Crapo and the committee for acknowledging the issue.

S. 1325: Better Workforce for Veterans Act

AMVETS has no current position on Title I

Title I of S. 1325 deals with the hiring process within the VA, but this subject falls outside of the specifics that AMVETS members have focused on.

Title II also falls outside of the specifics that AMVETS members have focused on, but I would like to comment on Sec. 208 (c)(2), as AMVETS has made VA Accountability a priority. In light of the ongoing VA health care and budget crisis, it is more important than ever that

we, as an organization and as concerned Americans, ensure that Congress provides the strongest oversight of all VA operations.

Discussion Draft: Veterans Choice Act of 2017.

The draft legislation states in its findings that “the Department of Veterans Affairs provides outstanding health care services but there are areas, such as rural America, where giving veterans a clear choice of where to receive care will help improve the quality of treatment both for veterans and the Department.”

The bill provides for the establishment of an expanded Veterans Choice Program, provides authorization of agreements between VA and non-VA providers, addresses payment issues to non-Department of Veterans Affairs health care providers, modifies VA authority to enter into agreements with State homes to provide nursing home care, provides for the assignment of primary care provider to veterans upon registration in the patient enrollment system, addresses national contracts for furnishing dialysis treatments to veterans in the community and veteran choice of dialysis treatment provider, requires an assessment of demand for health care services from the VA, establishes uniform access standards for health care services from the Department of Veterans Affairs, and requires the purchase of an off-the-shelf electronic health record platform.

AMVETS supported Choice as a stop-gap measure to allow veterans to receive their needed health care in a timely manner. We do not support open-Choice as a viable option to address the capacity and patient care issues. Diverting funds to the Choice program 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 their care through fee basis and 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. In fact, AMVETS is concerned that a broad bleed VA dry strategy is underway.

Discussion Draft: Improving Veterans Access to Community Care Act of 2017.

This legislation would provide options for all eligible veterans to either be seen by a VA physician or to access care from a non-VA practitioner if they choose to.

In addition, the legislation addresses payment of health care providers under the Veterans Community Care Program, and benefits for persons disabled by treatment under the Veterans Community Care Program.

AMVETS currently has a resolution supporting enhancements to health care for those veterans who reside in rural and remote areas of our Nation. Thirty six percent of VA health-care users reside in these areas and we support alternative options for their care. However, we have significant concerns with proposals that would take resources from an already overwhelmed and underfunded VA healthcare system. As we stated in a joint letter with our fellow VSO's on June 28,

“Specifically, we call on you to reach agreement on an emergency appropriation and authorization bill that would address urgent resource shortfalls endangering VA’s medical care programs—including Choice, community care and medical services. Further, in order to prevent these problems from recurring in the future, we call on you to equally invest in modernizing and expanding VA’s capacity to meet rising demand for care, as well as finally address the glaring inequity in law that prevents thousands of family caregivers from getting the support they need to care for their veterans severely disabled before September 11, 2001.”

While Choice can be an excellent option for veterans who reside in rural and remote areas, Choice is not an adequate replacement for fixing existing VA capacity and infrastructural shortfalls.

Discussion Draft: Department of Veterans Affairs Quality Employment Act of 2017.

The bill proposes to assist VA in hiring and retaining employees by: modifying the annual determination of staffing shortages in Veterans, establishment of an “Executive Management Fellowship Program,” creating new accountability requirements for VA leadership, providing policy changes that would encourage reemployment of former employees at Department of Veterans Affairs, creating a recruiting database at Department of Veterans Affairs, training for human resources professionals of Veterans Health Administration on recruitment and retention, providing promotional opportunities for technical experts at Department of Veterans Affairs, requiring the Comptroller General of the United States conduct an assessment of succession planning at Department of Veterans Affairs, providing employment opportunities to students and recent graduates via internships or other associations with VA, requiring exit surveys, encouraging transition of military medical professionals into employment with Veterans Health Administration, and requiring the Secretary of the VA to provide a plan in 120 days to hire directors of medical centers.

Quality recruitment at VA has been a longstanding and complex challenge for VA. We believe that many of the sections included in this effort offer some excellent and well thought of policy proposals. **As such AMVETS supports this proposal.**

Chairman ISAKSON. Thank you, Ms. Webb.
Mr. Atizado?

**STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL
LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS**

Mr. ATIZADO. Chairman Isakson, Ranking Member Tester, and Members of the Committee, I want to thank you for inviting DAV to testify on the legislation and draft bills under consideration for today's hearing.

DAV is a non-profit veterans service organization dedicated to a single purpose, which is to empower veterans to lead high-quality lives with respect and dignity.

Today's hearing is critically important to DAV's 1.3 million war-time service-disabled veterans. Most of them choose and rely heavily or entirely on the VA health care.

For the sake of brevity, I will limit my comments to a few of those bills which DAV supports on the agenda today.

DAV endorses S. 683, the Keeping our Commitment to Disabled Veterans Act of 2017, which would extend until 2018, the requirement for VA to provide nursing home care to certain service-connected disabled veterans. As Senator Hirono had mentioned, over 22,000 severely disabled service-connected veterans would benefit from this bill.

DAV supports S. 833, the Servicemembers and Veterans Empowerment and Support Act of 2017, which would expand military sexual trauma counseling and treatment and ease some of the evidentiary requirements for veterans filing claims for service connections, for conditions related to military sexual trauma.

DAV supports S. 946, the Veterans Treatment Court Improvement Act, which would require VA to hire additional Veterans Justice Outreach Specialists to provide treatment court services. As an organization, DAV recognizes the importance of veterans treatment courts and are pleased to inform you, this Committee, that many of our DAV members across the country have and continue to volunteer to serve as mentors for justice that involve veterans in these courts.

DAV supports S. 1261, the Veterans Emergency Room Relief Act. This would require VA to include urgent as well as emergency care as part of VA's medical benefits package. To further strengthen this important measure, we ask the Committee to consider inserting language, allowing VA to also enter into agreements in addition to contracts with urgent care providers.

Finally, DAV is pleased to support the draft bill titled "Improving Veterans Access to Community Care Act of 2017," this pursuant to DAV Resolution 238. Mr. Chairman, that resolution calls on the Nation to honor the service and sacrifices of our Nation's ill and injured veterans by strengthening, reforming, and sustaining a modern, high-quality, accessible, and accountable VA health care system. It also asks that in order to provide timely and convenient access to enrolled veterans, the VA health care system must evolve. It must become and it must create integrated health care networks with high-quality community providers where needed. This includes DOD and academic affiliates as VA acting as a network coordinator and principal provider. This is to ensure integrated, high-quality, comprehensive, and veteran-focused health care for our Nation's veterans.

Our members recognize that despite improvements in the VA health care system over the years, some veterans are experiencing uneven and delayed access to quality veteran-centered care. Even before the Choice Program was implemented, VA's legacy purchased care programs were both cumbersome and operated as local endeavors. The problems with these include no central support structure to track not only how long it took for veterans to get care in the community, but whether the care they received in the community is equivalent to the care that they receive in VA, that it is a positive impact on veterans' health outcomes and whether the veterans are satisfied with that care.

The Improving Veterans Access to Community Care Act of 2017 contains many provisions and aligns with the overall approach proposed by DAV, the Independent Budget, other VSOs, as well as the Commission on Care, and the VA. While there are some improvements we would recommend and work with the Committee on, this bill seeks to preserve those critical components of the VA health care system beyond just delivering care. VA has other missions such as research, education, and training. Members here just talked about the problems with health care staffing in the Nation, of which VA plays a critical role in supplying that to the Nation's patient population. This bill allows VA to modernize, which must happen if it is to be a true partner in an integrated, high-performing health care network.

Mr. Chairman, there is so much more to discuss. We look forward to working with you and your staff to address this issue as well as improve other VA health care services for our Nation's veterans.

This concludes my statement. I would be happy to answer any questions you or other Members of the Committee may have.

Thank you.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE
DIRECTOR, DISABLED AMERICAN VETERANS

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

S. 115, THE VETERANS TRANSPLANT COVERAGE ACT

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

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

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

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

S. 426, THE GROW OUR OWN DIRECTIVE: PHYSICIAN ASSISTANT EMPLOYMENT AND EDUCATION ACT OF 2017

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

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

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

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

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

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

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

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

S. 683, THE KEEPING OUR COMMITMENT TO DISABLED VETERANS ACT OF 2017

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

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

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

Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay nursing home services and in-home and community based services. Currently, World War II and

Korean War era enrollees are in the age bands that are the highest users of LTSS. Likewise, Vietnam era veterans will be needing and seeking a greater share of LTSS, with most having aged beyond 75 over the next ten years.

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

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

Under this bill, a covered mental health condition would be defined as Post Traumatic Stress Disorder (PTSD), anxiety, depression, or other mental health diagnosis described in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that the Secretary determines to be related to MST. MST is defined as a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred during active military service.

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

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

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

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

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

More than a decade ago, VA relaxed its policy of requiring medical or police reports to show that MST occurred. 38 CFR 3.304 (f)(5) provides for a liberalization

of requirements for establishment of service connection due to personal assault, including MST, even when documentation of an “actual stressor” cannot be found, allowing evidence in other records to serve as a “marker” indicating that a stressor may have occurred instead. Nevertheless, since 2002, VA has denied many claims for mental health conditions resulting from MST because claimants were unable to produce evidence that an assault or harassment occurred. Between 2008 and 2012, VA verified that grant rates for PTSD resulting from MST were 17 to 30 percent below grant rates for PTSD resulting from other causes.

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

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

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

S. 946, THE VETERANS TREATMENT COURT IMPROVEMENT ACT

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

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

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

S. 1153, THE VETERANS ACCESS ACT

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

provider to provide non-Department health care services to veterans if the health care provider has already been suspended from practicing within VA.

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

S. 1261, THE VETERANS EMERGENCY ROOM RELIEF ACT OF 2017

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

This bill, authorizing VA to provide reimbursement to veterans who receive urgent care services, fills an important coverage gap for veterans who rely upon VA for care. It also has the potential to create cost savings for VA by allowing veterans to seek care in non-VA urgent care centers which are less costly than hospital emergency rooms. The National Center of Health Statistics found that almost half of emergency room patients (48%) came there because their primary care doctors were not available. Urgent care fills the gap between the truly emergent care for conditions that may result in the loss of life or limb (which require advanced trauma care treatment), and less complex acute conditions, such as respiratory and skin infections, sprains, back pain or other minor injuries, that require attention and treatment, but would normally be addressed by primary care doctors if they were available. To further strengthen this important measure, we ask the Committee to consider inserting language allowing the VA to enter into agreements in addition to contracts with urgent care providers.

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

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

S. 1266, THE ENHANCING VETERAN CARE ACT

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

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

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

S. 1279, THE VETERANS HEALTH ADMINISTRATION REFORM ACT OF 2017

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

provider agreements for VA to engage community health care providers. Administration of the program and coordination of veterans health care would remain within VA.

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

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

S. 1325, THE BETTER WORKFORCE FOR VETERANS ACT OF 2017

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

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

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

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

DRAFT BILL, DEPARTMENT OF VETERANS AFFAIRS QUALITY EMPLOYMENT ACT OF 2017

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

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

DAV Resolution 238 calls on the Nation to:

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

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

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

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

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

The Commission’s economists estimated that the recommended limited choice option would increase VA spending by at least \$5 billion in the first full year, though they cautioned that it could be as high as \$35 billion without strong management control of the network. The Commission’s economists also analyzed an unfettered choice option to allow veterans the ability to choose any VA or non-VA provider—without requiring them to be part of any defined network. The economists estimated

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

such a plan could cost up to \$2 trillion more than current projections for VA expenditures over the first ten years. Based on the premise that the draft bill would provide unfettered choice for all enrolled veterans, create an extremely broad—almost universal—network, and lacks any effective coordination mechanisms, it seems likely the costs to implement such a proposal would be significant, somewhere between the estimates for the two Commission options discussed above. In today's fiscal environment, it seems unrealistic such dramatic spending increases would be appropriated or sustained, and even if approved, the cost shift and patient migration to private care would ultimately endanger the viability of the VA health care system.

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

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

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

To ensure the overall quality of health care provided to enrolled veterans, VA must retain responsibility as the coordinator and principal provider of veterans care. Decisions about veterans' access to community network providers should be based on clinical determinations and veteran preferences. Such shared decisionmaking would involve veteran patients as active partners with the clinician in treatment decisions, to clarify acceptable medical options and choose appropriate treatments. While not all patients want to play an active role in choosing a treatment, most want clinicians to inform them and take their preferences into account. The draft bill, however, would result in a system in which veterans who choose to use community care are often left on their own to make critical decisions about health care treatment options, without clinical guidance.

The draft bill also lacks mechanisms to assess the value of care VA purchases from non-Department providers, to review the quality of community care veterans receive, how it impacts veterans' health outcomes, and veterans' satisfaction in the same manner as the care VA directly provides veterans. Without such metrics it is difficult, if not impossible, to ensure the highest levels of quality and safety for vet-

erans. Moreover, because the draft bill lacks strong coordination between VA and community providers, the quality of care could be adversely affected if important clinical information is not promptly and clearly communicated between VA, Federal and community providers.

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

DISCUSSION DRAFT, IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT OF 2017

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

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

I. Restructure our Nation's system for delivering health care to veterans, relying not just on a Federal VA and a separate private sector, but instead creating local Veterans-Centered Integrated Health Care Networks that optimize the strengths of all health care resources to seamlessly integrate community care into the VA system to provide a full continuum of care for veterans.

Veterans-Centered Integrated Health Care Networks

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

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

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

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

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

Care Coordination

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

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

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

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

Community Care Eligibility

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

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

DAV is supportive of VA’s approach in determining when veterans should be given the option to receive care in the community through shared decisionmaking leveraging the relationship between a veteran and their doctor, and using business intelligence about clinical performance and quality of care. This new focus will strike a better balance in using community care to fill gaps in service than unfettered choice. This approach is more likely to be sustainable, a hallmark of good governance, as well as garner higher patient satisfaction.

Veterans Care Agreements

Section 201 of this draft measure would authorize the establishment of “Veterans Care Agreements,” and would prescribe the types of providers eligible for participation. We support the establishment of such agreements, but we are concerned that

³Proposed section 1730A(b)(1)(B)(ii)

VA would be required to first exhaust other acquisition strategies before being allowed to pursue such agreements. In addition, different terms are used for paragraph (4) in both bills. We appreciate the use of the term “provider” be used rather than “health care provider” for consistency and ease of implementation of this section by the Department. We agree with VA’s assessment regarding the need for this authority to be enacted into law without further delay and applaud the inclusion of this provision.

Emergency and Urgent Care

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

Emergency Care Defined

Carrying out the multiple and complex authorities⁴ for VA to pay or reimburse emergency care under title 38 are a source of continuous complaints and can drive ill and injured veterans and their families to financial ruin.

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

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

“A medical [or behavioral] condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. With respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.”

Claims Processing and VA as Primary Payer

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

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

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

⁴38 U.S.C. §§ 1703, 1725 and 1728

prompt payer for care and services. We appreciate this measure reaffirming this policy.

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

First and Third-Party Collections

We urge this Committee to include language statutorily requiring VA to offset a veteran's copayment debt with monies VA receives from billing the veteran's health insurance plan. Under current law, service-connected veterans are required to pay their share of costs created as a result of medical treatment rendered as inpatient, outpatient, extended care, or medication for a nonservice-connected disability or condition. VA is also authorized by law to recover the reasonable cost of medical care furnished to a veteran for the treatment of a nonservice-connected disability or condition when the veteran or VA is eligible to receive payment for such treatment from a third-party.

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

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

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

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

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

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

Chairman ISAKSON. Thank you very much.

Mr. Stultz?

STATEMENT OF GABRIEL STULTZ, LEGISLATIVE COUNSEL, PARALYZED VETERANS OF AMERICA

Mr. STULTZ. Chairman Isakson, Ranking Member Tester, and Members of the Committee, on behalf of Paralyzed Veterans of

America, thanks for the opportunity to offer our views on legislation affecting the delivery of veteran health care.

I recognize that there are numerous bills on the agenda today, but I am going to focus my comments on the Choice Program.

Should veterans have unfettered choice in when and where they receive health care? Three bills being considered dealing with the Choice Program diverge primarily on this question.

About a week ago, I heard Senator Cruz comment during a town hall with Concerned Veterans for America that nobody understands your health care needs better and cares more about you and your family than you do. You are in the best position to make the decision about where to get the best health care.

Any veteran sitting in a hospital waiting room would naturally feel this way. It feels right, it makes sense, and it is hard to argue with. But, what he is really trying to say is that veterans know better and care more than the rigid bureaucracy, the red tape, incomprehensible rules that fail to take into account a particular veteran's circumstances when determining how that veteran can access care.

He cannot seriously be suggesting that doctors, clinicians, social workers, and other aspects of a care team do not play a critical role in educating veterans and ensuring that they fully understand the specific health care services that they actually need. For some reason, this part is always left out of the talking points.

We and our VSO partners have constantly stressed the importance of coordinated care, regardless of who provides it, because it has proven to lead to better health care outcomes for patients. That is why we have long called for moving away from arbitrary wait time and distance standards toward a clinically based determination that takes a full look at each individual veteran's unique circumstances.

We support the Secretary's attempt to move the VA in this direction. As he said in a recent budget hearing, his hope is to provide care when veterans need it and where they need it, which includes the community. Developing an integrated, high-performing network is the fiscally responsible way to achieve this. It will get us to a place where veterans have meaningful choices while maintaining an apparatus that facilitates access and prevents fragmented care that can result in disastrous consequences.

For some of our members, Choice works well. One of our veterans who normally uses VA for comprehensive care in his annual evals used Choice to treat a recent bout of pneumonia close to home, a condition that can easily be fatal for someone with a spinal cord injury. His care was excellent, but not everyone can easily navigate the system.

We recently represented a paralyzed Army veteran who also suffered from an opioid addiction and Traumatic Brain Injury. After VA cut back his access to opioids, he made a conscious but ill-fated decision to seek care elsewhere through the Choice Program. After years of patchwork-style care in the private sector, he reached back out to VA. Days before his appointment, he was found dead outside of his apartment, bleeding from his feet. With his specific comorbidities, ones commonly associated with combat veterans, VA

was uniquely suited to treat him in a holistic manner. In hindsight, Choice was not the answer for him.

While that situation illustrates an uninformed choice, we cannot forget that in some areas, there simply is not a choice for catastrophically-disabled veterans. When comparable care does not exist in the community, our members are simply stuck waiting. This is why it is essential that as we expand available options, we give VA the tools it needs to strengthen its specialized services and compete with the private sector.

We are seeing early signs of VA taking steps to invest in its foundational services, such as spinal cord injury and blinded rehab, while expanding care in the community. The Secretary authorized the hiring of 800 to 1,000 more nurses in these areas, and he is going to do it by eliminating redundancies at VA Central Office to free up resources. These are the kinds of actions that show VA is serious about getting its own house in order and building a system that cares for all veterans, including those who may not be best served through care in the community.

So, as we debate expanding choices for veterans and reforming the way VA delivers health care, what do we owe our veterans? I think we owe them the support to make an educated choice. We owe them a coordinated choice that ensures appropriate follow-up care is delivered, a choice that ensures each doctor you see has the full picture of your medical history, not just a snapshot, and we owe them a choice that does not bankrupt us with a price tag that clears over a trillion dollars in the first 10 years.

I am borrowing words when I say this, but it is an important point. Congress owes our veterans a system that is optimized for those who need it most, not those who want it least. Let us not forget that.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you have.

[The prepared statement of Mr. Stultz follows:]

PREPARED STATEMENT OF GABRIEL STULTZ, LEGISLATIVE COUNSEL,
PARALYZED VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE COMMITTEE, On behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today on the legislation being considered by the Committee. There is no doubt that the bills addressing the Choice program could have a significant impact on the delivery of health care services to veterans going forward. Additionally, many of the bills on the agenda can improve access to critical services needed by veterans.

THE "VETERANS CHOICE ACT"

THE "IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT"

S. 1279, THE "VETERANS HEALTH ADMINISTRATION REFORM ACT"

There are three bills that directly address the next iteration of the Choice Program. We appreciate the Committee's significant efforts in this matter and the Senators for sponsoring the legislation being considered during today's hearing. To better construct a debate on their merits, we will address the bills together in one discussion.

PVA strongly supports the concept of developing an integrated, high-performing network that would seamlessly combine the capabilities of the Department of Veterans Affairs (VA) health care system with both public and private health care providers in the community. This approach has gained consensus among stakeholders, including the most recent and current VA Secretaries, the *Independent Budget (IB)*,

most major Veteran Service Organizations (VSO), the Commission on Care, and congressional leadership. As stakeholders continue to coalesce around this concept, though, the dynamics that govern the boundaries of this network need to be thoroughly explored.

These three bills collectively demonstrate the need for scrutiny—how the network is developed and governed is limited only to the imagination. The devil is in the details; they are critical and will have a dramatic impact on VA's future health care landscape. 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.

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.

Establishing appropriate eligibility standards will be an integral part of a sustainable network. This is the most significant point on which these three proposals diverge. Chairman Isakson's draft proposal, the "Veterans Choice Act," provides unfettered choice to all veterans enrolled in the VA health care system. However, it remains unclear how this proposal would be funded. The cost is staggering, and the impact on VA and its ability to serve veterans who most need care is predictable. The Commission on Care's economists found that the cost of unmitigated choice throughout a loosely-managed network, a concept most closely reflected by the "Veterans Choice Act," would yield a price tag of well over \$1 trillion over a decade. In a case such as this proposal, it will not be enough to simply say that VA has enough resources to manage this option. That is an absolutely false assumption.

In recent months, proposals such as billing veterans' other health insurance for service-connected care, Medicare subvention, and elimination of Individual Unemployability payments to service-connected disabled veterans over the age of 62 have been floated to potentially offset the \$3 billion price tag of the Choice Program. If the administration had to consider taking from the most vulnerable groups of veterans to meet this projected cost, where can we expect to find the money for this expansion? What money would be left to sustain VA's foundational services, let alone general health care services for the veterans who choose VA as their provider?

Alternatively, Ranking Member Tester's draft proposal, the "Improving Veterans Access to Community Care Act," and Senator Crapo's bill, the "Veterans Health Administration Reform Act" (S. 1279), structure eligibility standards in line with PVA's vision of employing a clinically-based determination. This is also the path the Secretary wishes to take. This approach requires us to confront the difficult question of how a decision is reached in the absence of arbitrary, but clear, delineations for eligibility. As we mentioned, variations in how liberally access is granted to community care providers can have a drastic impact on cost.

These two proposals call for case-by-case determinations and include a variety of parameters for VA practitioners to consider when consulting with the veteran. Providers should be able to sit down with a veteran and consider circumstances such as access and availability of services and the urgency of that veteran's situation. The veteran should also have the opportunity to voice concerns over how a certain care plan will adversely or inadvertently impact him or her. Access to transportation, geographic distance and travel time can often present unreasonable obstacles to care for veterans. For example, a 30-mile trip to a VA facility might seem reasonable on paper, but a doctor administering a treatment plan that requires the veteran to commute three times per week may have good grounds to object to that determination.

Providers should have the ability to help educate veterans and make decisions in the context of the patient's specific circumstances. They should be able to take action when it is clear that VA offers a needed service, but a particular veteran's situation requires a higher level of expertise than what that doctor or facility can offer. Arbitrary standards should not prevent a doctor from sending a veteran out to the community when the need is urgent and VA is not prepared to administer the care in a timely fashion.

Some veterans might have reservations about their provider, i.e. VA, having the final say in whether they are eligible to utilize the Choice Program, but it is a marked improvement over the current process where bean-counting bureaucrats

make decisions behind closed doors for veterans who appear to be just another number in the queue. A more pointed concern is the past institutional bias exhibited by VA employees for administering care directly in VA at all costs. VA has long had authority to contract for care, but in prior years employees demonstrated a reluctance to utilize this tool to the point that it eventually prevented timely access to care for many veterans. This behavior, though, was largely attributed to mid-level bureaucrats making decisions driven by how the funding was administered. The current funding arrangement under the Choice Program produced a welcome side-effect of removing the incentive to avoid contracting care out to the community. Over the last two years, VA's institutional behavior has been modified to a degree, and it has become more comfortable with contracting for care when the need exists.

Once the clinical parameters are determined, eligible veterans will have meaningful choices among the options developed within the high-performing network and the ability to schedule appointments that are most convenient for them. When you pair this decisionmaking process with a well-managed, integrated network and the structural flexibilities discussed above, it becomes possible for VA to be a competitive and sustainable enterprise.

We applaud Senator Tester's explicit provision extending medical malpractice protections under 38 U.S.C. § 1151. This is an especially important signal to veterans that Congress and VA are not abandoning oversight and responsibility for the quality of care delivered 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 § 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. This protection currently does not attach to a veteran 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. 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. To keep all veterans on an equal footing, we insist that this provision be incorporated in any legislation that moves forward. We recognize that there will be questions on the mechanics of this protection and to what extent this provision would expand VA's liability exposure. We stand ready to have that conversation and to assist the Committee in sorting through these issues.

S. 1279 offers a unique idea for expanding choices for veterans by allowing VA practitioners to refer Medicare-eligible veterans to Medicare providers. It also encourages greater information sharing efforts between the two systems. In addition to capitalizing on an already-existing network of providers, this adjustment to the law could reduce instances of fragmented care for veterans who normally use VA for primary care but take advantage of Medicare to receive specialty care for a non-service-connected condition close to home. We certainly recognize the value in shifting some of the financial burden that would otherwise be absorbed by VA on to the Medicare rolls, but we are concerned that a turf war between these two financially-stressed systems will likely result. An additional concern is also the potential for Congress to simply reduce funding for VA in an amount that corresponds to any cost savings realized instead of allowing VA to reinvest that money in its own medical services.

These three proposals contain the tools necessary to achieve an end-state at VA where veterans have meaningful choices and quick access to quality care. As the Committee moves toward a final bill, we will continue to support measures that encourage VA to retain ownership and responsibility for care provided to veterans, no matter where it is received. VA's role in care coordination, no matter how expansive the network, must be clear. It is one of the most important features that makes VA care not only competitive with the private sector, but in many segments better. Simply listing in statute that a third-party administrator is responsible for "managing the network" is not enough to identify where that responsibility lies.

We will yet again raise the most important questions for our members: What are Congress and VA doing to ensure that as the Choice Program expands, VA's foundational services remain competitive? What steps are being taken to deal with scenarios where access to care in specialized services is dismal, but there are no comparable services offered in the community to fill the void? Is VA focused on ensuring that VA specialized services are staffed appropriately based on demand, or is it more focused on providing ever-greater convenience to veterans who already

have options? We have stated on multiple occasions before this Committee that care delivered in the community is an essential component of VA's health care system. But it is simply that, a component. This Committee needs to demand comprehensive answers to these questions, on the record, instead of settling for platitudes and vague promises to "take care of that later." A member of the Commission on Care warned against designing a health care system that is "optimized for people who do not rely on veteran-specific health care."¹ The Commissioner captured our perspective, as representatives of the highest per-capita users of VA and its specialized services, when he stated, "[w]e must design our veteran health care system for those who need it most, not for those who want it least."²

S. 115, THE "VETERANS TRANSPLANT COVERAGE ACT"

PVA supports S. 115, 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.

S. 426, THE "GROW OUR OWN DIRECTIVE: PHYSICIAN ASSISTANCE EMPLOYMENT AND EDUCATION ACT OF 2017"

PVA supports S. 426, the "Grow Our Own Directive: Physician Assistance Employment and Education Act of 2017." This bill would set up a five year pilot program to provide education assistance to veterans training as physician assistants (PAs) in VA. The goal is to train veterans with medical or military health experience to be readily employable physician assistants at VA. Section 2 of the bill explains the prioritization of veteran participants who are in the Intermediate Care Technician Program and those individuals who plan to work in medically underserved states with a high population of veterans. To meet these goals the bill provides funding and support staff to the Office of Physician Assistance Services. It would also require VA to establish a strategic plan to recruit and retain PAs and adopt the standards leading to competitive pay for PAs employed by VA. Currently the vacancy rate of PAs at VA is 25 percent, the third largest shortage throughout the health care system. Recruiting and retaining PAs at VA is critical to improving access to high quality care. Further, this bill will provide job opportunities for veterans with medical work histories that are hard to translate to the civilian sector.

S. 683, THE "KEEPING OUR COMMITMENT TO DISABLED VETERANS ACT OF 2017"

PVA supports S. 683, the "Keeping Our Commitment to Disabled Veterans Act of 2017." This legislation would extend the requirement to provide nursing home care to certain veterans with service-connected disabilities to December 31, 2018. Without an extension, VA reimbursement of nursing home care will end December 31, 2017.

S. 833, THE "SERVICEMEMBERS AND VETERANS EMPOWERMENT AND SUPPORT ACT OF 2017"

PVA strongly supports S. 833, the "Servicemembers and Veterans Empowerment and Support Act of 2017." This legislation would expand VA coverage of counseling and treatment for military sexual trauma (MST). This bill would codify the idea that MST does in fact include the experience of "cyber harassment of a sexual nature." Currently, these victims are ineligible for VA counseling and benefits. The experience of cyber harassment is varied for its victims and distressingly unclear in our laws. But the intent of a perpetrator, as in any sex crime, is the assertion of power over someone and the degradation of their humanity. Most often the harassment takes the form of "revenge porn," nude or sexual photos or videos, taken with or without consent, and used to harm its subject. The possessor of the material may

¹Blecker, Michael. "Explaining decision not to sign the Report of the Commission on Care." Letter to Commission on Care. 29 June 2016. Available at <https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commissioner-Alternative-Viewpoints-06302016.pdf>. (Last accessed July 7, 2017).

²Id. (Emphasis added).

blackmail, control and/or threaten the victim. Often it is used for humiliation by sending the material to the victim's family or coworkers, or, like 'Marines United,' to buildup a culture of male camaraderie by degrading and threatening the safety of their female peers.

The goal of cyber harassment is to cause maximum distress. While someone may not be interpersonally exploitable, that effort can be exacted through social media, to greater and longer lasting effect. To be the victim of cyber harassment of a sexual nature is to be exploited by thousands of people, forever unknowable. Such an experience denies any hope of accountability or acknowledgement of injustice.

Recent qualitative analyses of mental health effects on the civilian victims of cyber harassment of a sexual nature consistently reveal very serious effects; high prevalence of PTSD, anxiety, depression, suicidal ideation and increased likelihood of physical assault. Only 34 states and the District of Columbia have laws criminalizing the practice of cyber harassment. The Uniform Code of Military Justice does not directly address this issue. Veterans who are victims of this kind of sex crime will often have no recourse. This bill is a greatly needed step to ensure VA is able to meet the needs of those who served honorably and came home carrying wounds ignored for too long.

S. 946, THE "VETERANS TREATMENT COURT IMPROVEMENT ACT OF 2017"

PVA firmly believes in the rule of law and that anyone convicted of a crime should be held accountable. Our criminal justice system, though, has long recognized the existence of aggravating and mitigating circumstances that play an important role in influencing the administration of penalties. While advocacy before a sentencing judge following conviction is critical, prosecutorial discretion is also vast. Veterans Justice Outreach Specialists can help veterans use their honorable service, as well as mitigating circumstances arising from that service, to ensure both the prosecutor and judge see more than just a rap sheet when making decisions.

If the specialist demonstrates that the veteran is entitled to health care or disability benefits, the judge or prosecutor might be able to fashion a sentence or plea offer that incorporates utilization of these services in lieu of imposing solely punitive sanctions. It could also lead to an outright deferment of prosecution conditioned on the veteran exploring and obtaining all services available to him or her. This scenario is especially enticing to the judicial system given the constant struggle to find resources, particularly for in-patient substance abuse rehabilitation programs and mental health care.

For some veterans, this path might help them avoid being permanently stigmatized with a criminal conviction. For others, it might be the ticket that lifts them out of homelessness and the corresponding criminal recidivism, specifically with petty and/or vagrancy crimes. It is no secret that some veterans go years before realizing they were entitled to certain benefits that might have helped them avoid poverty and dejection. A court order pointing the veteran to the Department of Veterans Affairs can sometimes turn into a life-changing event. At the least, more veterans touched by this program will re-engage productively with society. That is a goal worth pursuing.

S. 1153, THE "VETERANS ACQUIRING COMMUNITY CARE EXPECT SAFE SERVICES ACT OF 2017"

PVA generally supports S. 1153, the "Veterans Acquiring Community Care Expect Safe Services Act of 2017," or "Veterans ACCESS Act." This legislation would deny or revoke the eligibility of a health care provider to be a community care provider if they have been fired from VA, violated their medical license, had a department credential revoked, or were imprisoned for one year or more.

S. 1261, THE "VETERANS EMERGENCY ROOM RELIEF ACT OF 2017"

PVA supports S. 1261, the "Veterans Emergency Room Relief Act of 2017." This legislation would require VA to contract with urgent care providers and pay reasonable costs for care provided to veterans who are enrolled at VA and have received care there within the preceding two years. It would also establish cost-sharing amounts for certain veterans receiving care at a VA emergency room. We have consistently advocated 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. It would help address issues of long distance travel for veterans needing immediate attention, and mitigate long term costs for VA by providing quick attention to medical needs that would otherwise compound in both cost and severity if the

veteran were to wait to be seen at VA. Additionally, this has the potential to decrease the current burden at VA emergency rooms, freeing up capacity to properly address their patient loads.

We do, however, continue our opposition to any requirement that a veteran have received VA care within the preceding 24 months in order to qualify for emergency and urgent care benefits. The strict 24-month requirement is problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to appointment wait times, despite their timely, good-faith efforts to procure one. This barrier has caused undue hardship on veterans and has resulted in some receiving unnecessarily large medical bills through no fault of their own. Additionally, this provision discriminates against healthier veterans who otherwise do not need as much health care as other veterans and may go more than two years without being seen. This bill's authorization to impose cost-sharing should be enough to compensate for dropping the 24-month requirement as a cost control mechanism.

S. 1266, THE "ENHANCING VETERAN CARE ACT"

PVA generally supports S. 1266, the "Enhancing Veteran Care Act." This legislation would authorize the Secretary of Veterans Affairs to enter into contracts with nonprofit organizations to investigate medical centers and report deficiencies. This legislation allows the Secretary to delegate the contracting authority for an investigation to the VISN director or the director of the medical center to be investigated. The Office of Inspector General has at times demonstrated a bureaucratic rigidity too cumbersome to address localized needs for investigation. This bill ostensibly aims to meet that need. While the Secretary is already able to contract with third party investigators, this bill extends that ability to lower leadership positions. We also believe it is an appropriate step to require the Secretary, Inspector General and Comptroller General of the United States be notified of an investigation for the purposes of coordination.

S. 1325, THE "BETTER WORKFORCE FOR VETERANS ACT OF 2017"

PVA supports S. 1325, the "Better Workforce for Veterans Act of 2017." This legislation would improve the authorities of the Secretary to hire, recruit, and train employees at VA. In order to transform the culture and timeliness of care, Congress must enable VA to quickly hire a competent workforce with competitive compensation that ensures VA is a first-choice employer among providers.

The access to care issues plaguing Department of Veterans Affairs (VA) can almost always be traced back to staff shortages, and the systemic consequences of those shortages, within the health care system. The current 45,000 vacancies are a result of improper staffing decisions, a lack of sufficient resources, and the misallocation of existing resources. No reformation of staffing or capital infrastructure processes will increase access without appropriate resources.

No one is more affected by provider shortages than those veterans with complex injuries who rely on VA to treat their specialized needs. Unfortunately, VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disorder, blindness, amputations, and mental illness—as mandated by Public Law 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996." As a result of this law, VA developed policy that required the baseline of capacity for Spinal Cord Injury/Disease System of Care to be measured by the number of available beds and the number of full-time equivalent employees assigned to provide care. VA was also required to provide Congress with an annual "capacity" report to be reviewed by the Office of the Inspector General. This reporting requirement expired in 2008, and was reinstated in last year's "Continuing Appropriations and Military Construction and Veterans Affairs Appropriations Act for FY 2017." This report, a critical tool of oversight, should be made available to Congress by September 30 of this year. We suspect this report will verify the willful disregard for staffing shortages that exist in our most critical specialties.

It is worth noting that the SCI/D System of Care is the only specialty service line with its own staffing mandate, implemented in 2000, as a standardized method of determining the number of nursing staff needed to fulfill all points of patient care. VA has not met this statutory mandate. For years, PVA has identified chronic staff shortages, resulting bed closures, and denied admissions. Since 2010, VA has operated at only 60% of the capacity mandate. Further still, the mandate itself is 17 years old, and in need of an update to reflect the aging population of veterans. Such an update would provide a starker picture of unmet need for the most vulnerable population of veterans.

A modernized and effective human resources operation is vital to any organization, especially one as large as VA. The multiple authorities governing the VHA personnel system are incompatible with a high-performing health care system. Hiring managers and their employees must attempt to understand the end-to-end hiring process under four separate rules systems. This unnecessarily adds complexity to the hiring system which is difficult for both the potential employee and the human resources staff to navigate. The unnaturally slow hiring process also ensures VA loses talented applicants. It is not reasonable to expect a quality provider to wait up to six months for VA to process an application. Similarly, when an employee announces his or her forthcoming retirement or departure from VA, H.R. is unable to begin the recruiting or hiring process for that position until it is actually vacated. This not only causes an unnecessary vacancy, exacerbated by the lengthy hiring time, but it also prevents a warm handoff between employees and any chance for training or shadowing.

Mid-level management at the VISN level seems to have obfuscated all responsibility for clinical staff shortages, while maintaining themselves handsomely. The 21 VISNs, managed by directors and senior managers control the funding for all 1,233 VA health facilities, and are required to oversee the performance for their VA facilities and providers. Currently a nominal appointment, this structure was intended to decentralize decisionmaking authority and integrate the facilities to develop an interdependent system of care.

In 1995 the total number of VISN staff was 220. In fiscal year 2011, the total number of VISN employees had climbed to 1,340, a 509% increase, while bedside clinician and nurse staffing in specialized VA services plateaued, then fell behind demand. Meanwhile, the VA failed to request from Congress the resources to meet health care demand, particularly in specialized services such as spinal cord injury and disorder care and inpatient mental health.

PVA believes that veterans have suffered from VA's inability to be competitive with its private sector health care counterparts who do not face the same restrictions on pay and benefits. In the face of a nationwide provider shortage, and an aging generation of baby boomers, VA must be competitive now in order to have any chance of meeting the needs of veterans.

While the personnel challenges facing VA, are numerous, and often frustrating, it is important to remember these staffing issues and how they are resolved will have an immediate impact on the life and well-being of catastrophically injured veterans. For the thousands with complex needs, there is no private sector alternative where they can seek care until VA's access problems are solved.

DRAFT BILL, THE "DEPARTMENT OF VETERANS AFFAIRS QUALITY EMPLOYMENT
ACT OF 2017"

PVA supports the proposed draft legislation the "Department of Veterans Affairs Quality Employment Act of 2017." This legislation would improve the authority of the Secretary of VA to hire and retain physicians and employees at VA. PVA is particularly interested in a couple sections included in the bill. Section 3, which would require the Secretary to select at least 18, but no more than 30, employees to participate in a one year fellowship with a private sector company or entity that administers or delivers health care or other services similar to those provided within VBA and VHA. PVA generally supports this idea. In the current environment there could be a benefit to sending VA senior executives into the private sector to better understand best practices from both sides. At the same time, sending already limited resources and talent outside of VA could further undermine the existing training programs within the Department.

Section 4 would require the Secretary to conduct an annual performance plan of VA's political appointees. The plan would be similar to those employees who are members of the Senior Executive Service and would assess recruitment and retention of qualified employees, engagement and motivation, and performance and accountability. While surprised there is not already a performance plan for VA political appointees, PVA considers this a reasonable provision.

Section 5 would allow the Secretary to noncompetitively reappoint a former VA employee to any position within the Department as long as the position is not more than one grade higher than their former position and as long as the employee left the Department voluntarily within the prior two years and maintained necessary licensures and credentials. PVA has concerns about bringing back a former employee to a higher grade through a noncompetitive process. While PVA supports the intent to easily fill critical vacancies, we are not convinced hiring former employees through a noncompetitive process is the most appropriate path to filling those vacancies.

Section 6 would require the Secretary to create a single recruiting database to list any vacant positions the Secretary determines are critical to the mission of VA, or difficult to fill, or both. It would keep information on applicants not selected for initial positions but who are qualified for other positions in the department. The Secretary would be required to use the database to fill any vacant positions. PVA questions whether such a recruiting database is necessary. Presumably, the 'mission critical' positions the proposed database would house are currently residing in USAJobs.gov.

Section 7 would improve training for Human Resources professionals and include virtual training. The development and implementation of defined goals for recruitment and retention (to include promotions, continuing education, etc.) should be components of H.R. staff's performance plans. VA H.R. management staff are not accountable to direct service providers. PVA believes they should be held accountable. H.R. performance is not measured by the degree to which they meet hiring and recruitment goals. As a consequence, failure to fill a critical vacancy in a timely manner carries no adverse effect on the involved H.R. staff.

VA must be able to recruit and retain qualified staff by providing competitive compensation and opportunities for professional and technical development. The Association of American Medical Colleges estimates the United States will have a shortage of 130,600 physicians by 2025. Today, the most vulnerable populations, including rural communities and veterans with specialty needs, are the first to feel the effects. While VA recruitment efforts are improving, the inexcusably long process it takes to bring an employee onboard continue to turn away highly qualified candidates. VA must provide its human resources management staff with the resources and training necessary to correct these issues.

Mr. Chairman, thank you for the opportunity to offer our organizations views on these bills. We would be happy to answer any questions you or your colleagues may have.

Chairman ISAKSON. Well, thank you very much for your testimony, and to all of you, thank you very much for your patience and for your input, which was absolutely phenomenal, as we move toward dealing with the issue of choice.

You have all raised some points that I want to refer to real quickly, if I can.

Mr. Stultz, let me just thank you for mentioning coordinated care. You talked about the Secretary's desire to give the veterans the care they need where they need it. You need a coordinated care system where the veteran who needs the care and the doctor who is providing it are responsible and the VA cooperate together to see to it they get the very best possible care that they can.

I think Dr. Yehia, in some of his conversations before, that is exactly what he was referring to. The patient or the veteran and the doctor are a team, and their goal together is the best health care possible for the veteran that they serve. That is exactly what all of us on this Committee want to see happen too, whether it is a rural or urban veteran or whatever it might be.

Ms. Webb, you made a number of outstanding points. One, the letter from the VSOs, which we received some time ago, thank you very much for that joint letter. We paid a lot of attention to that.

We do recognize that some people are suspicious that there is an attempt to bleed the system dry. I think that is the terminology you used. There is no game plan on this Committee whatsoever to bleed any system dry, but there is one to make sure we have a realistic and highly visible funding system.

You referred to the—you did not call it seven; it is seven—different funding baskets out of which VA pays for the benefits and how we have these constant crises with that. We run out of money in one; we have money in others, but we are running out of money. So, everybody ends up in panic mode.

I am committed, as I indicated in my question to Dr. Yehia earlier in the testimony, to get all that money in one pot, to have one central source that will be accessible, and see to it if we are running out of money, we are really running out of money. It is not just some fake crisis that somebody put up.

One of the biggest problems we have had is in that area, and one of the biggest things I want to try and address is to see to it that that is corrected. I really appreciate your testimony and your input and what you had to say.

In terms of the 2.2 million dues-paying American Legion members, of which I am, as I told you earlier today, still one of them because I paid my dues again, thank you for the input that you all made. But, I have a question that I want to ask of you.

Do you poll or in any other way survey, on an annual basis or on an issue basis, your veterans with regard to the veteran health services?

Mr. CELLI. We do. As a matter of fact, we conduct several visits a year, somewhere between 10 and 13 at different VA medical centers around the country. We hold town halls. We speak to the patients who are actually in the VA hospitals, and we speak to the providers to figure out what challenges that they are having. We use that information in a best practices report that we issue not only to the VA, but we also send it up here to Congress and to the President of the United States.

So, we do speak to them on a regular basis through our town hall meetings. Of course, we get calls, just like all the other VSOs do, every single day, but our System Worth Saving Program is our boots-on-the-ground access to our veteran's voice.

Chairman ISAKSON. How responsive is the VA health system to you when you give them input from these polls?

Mr. CELLI. They are extremely responsive. As a matter of fact, whenever we—I mean, we deal directly with Dr. Yehia. We deal directly with Dr. Alaigh. We deal directly with the Secretary. Our access is pretty much unfettered. We enjoy a great partnership with the Department of Veterans Affairs and a great partnership with our veterans. When there is a problem, we bring that to their attention and they work tirelessly to ensure that that problem is satisfied.

Sometimes it is a perceived problem by the veteran, in which case we just have to recognize that the veteran may or may not have access to what it is that they want, but more times than not, it is a payment problem like with Choice or it is an access-to-care problem because they have been waiting too long, and we are able to get those satisfied.

Chairman ISAKSON. How long have you been doing the job you do at The American Legion?

Mr. CELLI. About 5 years now.

Chairman ISAKSON. Have you seen any trend line in terms of that responsiveness over the last 5 years?

Mr. CELLI. I think it has gotten extremely better over the past 2 years. The access and the transparency has gotten extremely better over the past couple years.

Chairman ISAKSON. We did not talk before this hearing, did we?

Mr. CELLI. Not at all. [Laughter.]

Chairman ISAKSON. The reason I made that comment, as I was listening to you talk—and I think this should go back to the Secretary, Doctor, as well—there is a visible improvement in the VA's responsiveness—as a Committee Member, I think Senator Tester would agree with the same thing—to us as well as I sense to the VSOs. As we move forward to fix Choice and fix veterans' health care and ensure veterans get the health care they need, where they need it, and when they need it, which is the goal of the Secretary, that we would be responsive to the problems that are brought to us by the VSOs and be responsible to the veterans who come to us with those. If we do that, we will have a 21st century health care system for the 21st century veterans of the United States of America.

Thank you, all of you, for your testimony.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

I would just add that I think the VA has been very responsive, except in one area, and that is funding for the Choice Program, because we have ping-ponged all over the place, and I think that I need to bring that up because, as a Committee, we need more time than what we received on this.

We were supposed to be funded through November or October, and then it was June, and then it was August. You get my drift. Other than that, good job.

I want to go off of a script for a second from these bills that are on the agenda today. I want to talk about a different bill, and so I would just ask for your attention just for a minute—it is not that complicated—because I want to get your opinion on it.

Earlier today—first of all, you guys all know that Choice needs additional funding for fiscal year 2017 and 2018. Right? [No response.]

Earlier today, I dropped a bill that would get the Department the money that it needs for the Choice Program. It would bolster VA's internal capacity to provide care. It would make it easier for VA to provide care to vets closer to home by authorizing leases and getting pre-9/11 caregivers the help that they have needed for decades.

So, I would like to have your reaction to this legislation, because there are some folks that do not believe that we should be tackling internal VA care and caregivers in the same legislation as providing funds for private care on an emergency basis. Remember what I just said. They do not believe we should be tackling internal VA care and caregivers in the same legislation as providing funds for private sector care on an emergency basis, that is.

I am going to start with you, Mr. Celli. Could you give me your perspective on that bill, whether you think it is good, bad, or—

Mr. CELLI. Well, thank you, Senator. The challenges that you face are administrative on your end. We absolutely support your bill. We support the caregiver portion of the bill. We support paying for it and whatever means is necessary.

Senator TESTER. OK.

Mr. CELLI. We support pre-9/11 caregivers getting the same services and the same benefits and the same access to resources that post-9/11—

Senator TESTER. OK. Ms. Webb?

Ms. WEBB. I was able to glance over that this morning and have not had a chance to read the entire bill, but all the provisions that you lay out sound—

Senator TESTER. OK.

Ms. WEBB [continuing]. Acceptable and like AMVETS, we would support.

Senator TESTER. I guess the big question is, would you guys support building VA capacity on an emergency basis? That is really the question.

Ms. WEBB. Yes.

Senator TESTER. OK.

Mr. ATIZADO. Senator Tester, thank you for that question.

You know, Ms. Webb had mentioned the letter that the VSOs had sent over—

Senator TESTER. Yes.

Mr. ATIZADO [continuing]. To the Senate, and I think that covers a little bit of your question about what our opinion as a reaction is to—

Senator TESTER. Yep.

Mr. ATIZADO [continuing]. Some of this perspective, and I think it is an emergency.

Senator TESTER. Thank you.

Mr. ATIZADO. You know, for many years now, we have been talking about how veterans are not getting access to care from VA, and it is not because VA does not want to give them care. They do not have the people. They do not have the capacity, and frankly, sometimes they do not have the authority. I think this has constituted an emergency, such as the Congress' response to the access crisis in Arizona. I think this comes to that level as well.

Senator TESTER. Got you.

Mr. Stultz?

Mr. STULTZ. I would really want to know who they are because I think it says a lot about priorities, and for us, I represent veterans with the most catastrophic disabilities. As I have said repeatedly, whether in written statements or here in front of the Committee, there are no comparable services everywhere.

Senator TESTER. Yeah.

Mr. STULTZ. The Choice Program is not the fix for everybody. For us, internal capacity has to get better—

Senator TESTER. Yep.

Mr. STULTZ [continuing]. With the Choice Program.

Senator TESTER. Yep. Especially with the population that you represent, absolutely critical.

I just got to ask something—this is off script—but it goes to your statement, Ms. Webb. When I was in Missoula, MT, having a veterans listening session, one of the people that I had on my panel—and I did not pre-read anything that they had to say—stood up and said, “The best thing you guys on the VA Committee could do would be to disband Choice and put every dollar into the VA and focus on the VA.” How many of your members would have that same feeling? Could you tell me that without putting you too much on the spot?

Ms. WEBB. Well, I think that there is a lot of nuance that we try to communicate with our members, and I think there is room and there is a need for a public-private partnership.

The point for us is the expansion of Choice. We do not support that because I think any of that extra money should be invested back into VA.

Senator TESTER. OK.

Ms. WEBB. But, there is some need for some of the funding to go elsewhere.

Senator TESTER. Yeah. I have got several other questions, but we have got other Members present, so, I yield Mr. Chairman.

Chairman ISAKSON. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chairman, and, Mr. Chairman, I meant to mention in the first round that *The New York Times* article we talked about briefly today at lunch. I want to thank you and the Ranking Member for creating a distinctive environment on this Committee that is producing some really consequential legislation on a bipartisan basis. I thank you both for that.

Mr. Stultz, I have a question for you, which relates to that situation about the veteran who passed away after he opted out. Have you done much work in looking at the electronic medical record implementation that we are working on? How we would ultimately extend that to the broader caregiver community and implement intervention strategies to make sure that at the end of the day, the VA will still continue to own, I think, the responsibility for a good health care outcome? Has your organization given any thought to how we could do that by having that holistic model of care that veteran may be receiving if they choose to go outside of the VA?

Mr. STULTZ. Are you asking for specific implementation or the ramifications of tighter integration between the community and VA?

Senator TILLIS. Well, I am saying if we have that tighter integration, we may know what is occurring once they go out—

Mr. STULTZ. Right.

Senator TILLIS [continuing]. Of the VA to either a non-VA provider or to a Choice option. I am assuming that a part of the—and I am looking forward to seeing the details of the electronic medical record strategy, but it is then fully exploiting that 360 view of the medical activities that that veteran may be going through. I was just curious if your organization has thought that through, because in your particular case, that is where having the absolute latest information may actually require an outreach to a veteran to say, “We know you made this decision at some point, but perhaps there is a better option now.” I would think that has got to be key to some of the things we are doing for longer-term managed care and better access to medical information.

Mr. STULTZ. I think that is a great point, sir, and if you look back at VA’s Choice Consolidation Plan from, I think, over a year ago now at least, one of the pieces that they discussed was care coordination. They had an idea that they would—if care went out into the community, based on the acuity level of your care and the needs that you had—this gentleman, for example—they would stay involved, even though they were not administering the actual care.

So, tools like this can really make those ideas go a long way to prevent things like this.

Senator TILLIS. Well, I hope as we get information back from the VA that that does become—you have got to get the baseline in place, which has to become a priority, because I think that will help make the Choice Program work, and also make them aware of options and service levels where either non-provider care or VA-centered care will work.

Mr. Celli, you made a comment that I want to come back to. I do not want to parse your words, but it is something that I think is important. I have said it. I know you have been in the Committee hearing when I have said it before, and it was with respect to one of Senator Tester's comments about the caregivers bill, I think. You said we need to fund it by all means necessary. I do not think you meant at the expense of something else that you think needs to be funded by all means necessary.

Mr. CELLI. Senator Tillis, thank you for pointing that out. That is true. I do not mean by cannibalizing existing programs within the VA. I mean that there are funds available through emergency means that as to Gabe's point would be appropriate to fund this program.

Senator TILLIS. I think the key here is so that when we move forward on things that I happen to agree with as a matter of policy, that we provide sustainable, predictable funding, so that a crisis does not emerge, which causes us to make some sort of knee-jerk reaction for other programs that we think are equally important.

I have said before to the VSOs, you may hear me be cool to a net new idea, not because I oppose the idea, but I want to make absolutely certain we were talking about that with the veterans treatment court that we are doing it in a way that pays for itself, not at the expense of something else that you all have fundamentally supported.

Ms. Webb, I wanted to go back. The Chair brought it up, but in North Carolina it is really interesting because I hear the States that are urban States talk about what their priorities are and I hear the rural States talk about what their priorities are. In North Carolina, we are literally 51 percent urban, 49 percent rural. When we get rural in North Carolina, we get really rural. I know it is hard to imagine, but if you go in western North Carolina or eastern North Carolina, there are all kinds of challenges there.

I, for one, just want to give you some assurance that someone like me who believes that there are things that we can do to really make Choice a key piece of the puzzle. I see the whole outside of that puzzle always continuing to be the VA, whether it is brick-and-mortar presence, where men and women who have the sorts of profound injuries that Mr. Stultz's organization would represent have that environment that is unique to the situation that they have experienced. There are very few people who have not served that could possibly understand or comprehend. They congregate with caregivers; they congregate with other soldiers or veterans. I think that is critically important. The therapeutic value of that alone means that we have to maintain that full circle of care and visibility, and I think most of the Members here get it.

So, as we move forward with the discussion on getting the Choice Program right, I think that you have a consensus among these Members that we have got to get that right too. Thank you all for your time here today.

Ms. WEBB. Thank you.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Blumenthal?

**HON. RICHARD BLUMENTHAL, U.S. SENATOR FROM
CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you all for being here today. You are here constantly at our hearings, and we are grateful to you for your presence, your insightful testimony, and your service to our Nation.

I want to focus on the criteria and decisionmaking process for Choice, because I think we are all in agreement that we want the Choice Program to provide the best possible care. There should be alternatives outside the VA system where necessary, and necessary should be defined as being in the best interest of the veteran; that is, where the veteran can receive care that is the most timely and expert. Obviously, timeliness depends on difficulty of access, geographic distance, as well as waiting times, and quality depends on the expertise; for example, criteria of professional qualifications at federally qualified health centers or Medicare providers or the VA facilities themselves that may approve certain providers.

Should these decisions be made by the VA in setting criteria and choosing outside providers, or should there be some independent means of doing so?

Mr. CELLI. So, Senator Blumenthal, time and time again, we focus on the smaller picture like Choice rather than the bigger holistic picture of where VA health care is going.

You have asked the Secretary to sit down and come up with a comprehensive plan on where the future of VA health care should go, and he has done that. He has got together with his team. He has run it past the veterans service organizations, and he has come up with a comprehensive program. CARE is probably not the acronym we would have used, but the program itself is solid. The recommendations in there look at exactly what it is that you just touched on, which is how do we come to these decisions, how has VA grown over the past several years, what lessons have we learned from the Phoenix scandal? The outcome of that has been a more coordinated and comprehensive care model that we all support.

So, to continue to throw up the word "Choice" I think just misses the bigger picture, and I think we are all ready to move on.

Mr. ATIZADO. Senator Blumenthal, thank you for that question.

To your point and question about where VA should be in regards to when a veteran will be able to access a community, I think VA needs to be exactly where it has been but empowered more.

VA providers tend to be—tend to spend a lot more time with veteran patients as a whole. Part of the recruitment tool for clinicians is that they tell these budding and new doctors that we want our providers to spend more time, 30 minutes on average as opposed to 20 minutes, in the private sector. That extra 10 minutes actually

allows that doctor to sit down and know their patients, because VA as an organization firmly believes in a lifelong relationship with veterans.

In that relationship, the VA has to be, I guess, a force multiplier. They need to help guide the veteran to inform them, to educate them, to be the best consumer of health care they can be, to not only be healthy, but to lead a better life.

I think they have to play a role, sometimes more active depending on the situation and sometimes a little bit more passive, but certainly not far from the side of the veteran when they make that decision.

Senator BLUMENTHAL. Let me ask you on a related topic. You mentioned the Phoenix scandal. Have you been satisfied with the results of the Inspector General investigation?

Mr. CELLI. It is a complicated question; there are a lot of things that went wrong that caused Phoenix to happen. A lot of those things have not yet been fixed. The scheduling program, the IT, the software that runs that—what we have done is taken the focus away from incentivizing no wait times, and we have encouraged the employees to be more forthright and honest. While I do not want to take anything away from what happened and the depravity of veterans not being seen when they need to be seen, we also need to recognize that the secret wait list, if you will, was the scheduler's ways of trying to take care of a veteran when their supervisors told them that they cannot. So, there is a lot that went wrong, a lot that went right, and a lot that we have learned from that.

Am I satisfied with where we are today? I think it is still a work in progress.

Senator BLUMENTHAL. Thank you very much.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

Adrian, I am going to go to you because I am going to read from your testimony, and I want you to comment on this. Talking about the commission that the Choice Act made happen:

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

dramatic spending increases would be appropriated or sustained, and even if approved, the cost shift and patient migration to private care would ultimately endanger the viability of the VA health care system.

Those are your words. Talk to me about them.

Mr. ATIZADO. Senator, thank you for pointing out that section of our testimony.

I think what we are trying to do here is find a reasonable and sustainable solution for VA care, and it really stems from the idea that as Congress, this Committee considers legislation to expand access—more access points for veterans to receive care in the community—costs will go up. We have seen that in the Choice Program.

Depending on how that structure is set up from unfettered, which is literally give a veteran a card to go forth and be on your own and find your own way, that has not only tremendous cost implications, but it has some human costs as well. Private sector—the long debate in Congress about U.S. health care and the delivery of care tells us that when providers do not work together with patients as a team, that can be quite disastrous, not only costly for the patient in terms of money and life, but on the economy of the U.S. health care system.

So, when you have a system where you have unfettered choice and veterans can go anywhere, the costs will go up, which is clearly not sustainable. It does not serve us well, when we know there are better ways to construct a way for VA to allow veterans to get care in the community.

Senator TESTER. Thank you.

Mr. Stultz, I want to talk about VA accountability. I just want to go with you very briefly, and then if anybody has something to add—I pointed this out to Dr. Yehia in the questions to the previous panel that if we are going to have community care programs, I think the VA can transfer that care. However, I do not think they can ultimately transfer the responsibility for the veteran's well-being.

You are dealing with paralyzed veterans. You talked about an instance where the pneumonia treatment was successful. You talked about another one where the veteran ended up dying.

Could you tell me what happens in the VA when something goes wrong? Then tell me what happens in the private sector when something goes wrong for a veteran.

Mr. STULTZ. In the VA, you have a non-adversarial process. You submit it like a disability claim. They adjudicate it. They are not working against you. In the private sector, you are going through standard litigation and subject to all those rules in the adversarial process. VA also comes with the added package of service-connected treatment for that and things like adaptive equipment for your car, adaptive equipment for your house. For the rest of your life, they take care of the fact that you have become more disabled based on whatever care you got.

Senator TESTER. Right. How long does the process through VA normally take versus how long it would take in the private sector—

Mr. STULTZ. That is a—

Senator TESTER [continuing]. To get your—

Mr. STULTZ [continuing]. A very interesting question because I like to talk about appeals reform. [Laughter.]

It can range for a number of years, but at the same time, collecting a judgment in the civilian world can take a number of years as well. So, the tradeoff is there. I am not sure on time or really what we are after.

Senator TESTER. OK, OK.

Anybody else like to comment on that? Mr. Celli? Amy?

Mr. CELLI. So, I mean, real quick, I mean, to your question, Senator—

Senator TESTER. Yep.

Mr. CELLI [continuing]. It could happen in a matter of weeks if you had a fully-developed claim.

Senator TESTER. Yep.

Mr. CELLI. The VA would be on the hook to make sure that they cared for that veteran and those with increased disabilities for the rest of their life. That does not exist in the private sector, so it could happen quickly, or it could take years.

The one thing that I just wanted to touch on when you were talking to Mr. Atizado is—

Senator TESTER. Sure.

Mr. CELLI [continuing]. Including the increased cost, the risk of increased cost to privatization, something would have to give. We cannot continue to just pay more and more. What would ultimately happen is we would start restricting availability and veterans would not be able to have the same access to care that they have today.

Senator TESTER. That is a solid point, and I am glad you said that, because I think, ultimately, in the end, what everybody on this Committee wants to have is we live up to the promises made when you signed the dotted line. I think there will come a time, if we are not smart today, where tomorrow, veterans may not be able to be on the list that are fully deserving of the benefits.

I want to thank you all for being here today. Thank you very much.

Chairman ISAKSON. Thank you, Jon.

Let me say, Mr. Stultz, I want to—you prompted me to think of something for a minute. Are you familiar with Project SHARE in Atlanta?

Mr. STULTZ. I am not.

Chairman ISAKSON. At the Shepherd Spinal Center?

Mr. STULTZ. Yes. I am sorry.

Chairman ISAKSON. I just was going to say we were talking about VA care and private care and Choice and things of that nature, and in your self-introduction, you said you represented the most profoundly injured veterans that we have who have the most unique special circumstances.

One thing I want to be sure to mention is, we just dedicated in Atlanta, thanks to the gift of Bernie Marcus, the founder of Home Depot, the largest center dedicated to veterans that I know of anywhere in the country that is taking veterans that VA can no longer help and were really falling between the cracks and not getting the best care possible.

So, if you ever get a chance to come to Atlanta to visit Project SHARE at the Shepherd Spinal Center, it will warm your heart and also show you what a combination of private-sector and public money can do to help our veterans.

Thank you for what you do. We appreciate it.

Mr. STULTZ. Thank you, sir.

Chairman ISAKSON. It is a pleasure to serve with Jon Tester, the Ranking Member. We are going to find common ground in the next few months and get a Choice bill that works for everybody, which ensures the longevity and the future of the VA health services with the expansion of access to care that is needed to bring about the Secretary's dream, and that is better care for veterans who have care accessible to them.

Thank you all for being here. We will leave the record open for a week for any additional submissions.

We stand adjourned.

[Whereupon, at 4:40 p.m., the Committee was adjourned.]

A P P E N D I X

MIKE CRAPO
U.S. SENATOR
IDAHO

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JOINT COMMITTEE ON TAXATION

United States Senate
WASHINGTON, DC 20510

Testimony of Senator Mike Crapo
Veterans Health Administration Reform Act (S. 1279)
Senate Veterans Affairs Committee
July 11, 2017

COMMITTEES:
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Chairman Isakson, Ranking Member Tester, and Distinguished Members of the Committee:

Thank you for the opportunity to testify on S. 1279, the Veterans Health Administration Reform Act. This legislation is drawn from two statewide veterans surveys, hosting more than 200 town meetings, and reviewing official reports suggesting how veterans health care can be improved.

Idahoans use four Department of Veterans Affairs' medical centers (VAMCs) across two Veterans Integrated Services Networks (VISNs): Spokane VAMC, Walla Walla VAMC, Boise VAMC, and Salt Lake City VAMC. Some Idahoans use urban facilities; others use rural facilities. Having Idaho veterans fall within both urban and rural settings, as well as in two different VISNs, impacts the way I approach reforming the Veterans Choice Program and the other non-VA care programs.

We need accessible non-VA community care that is responsive to the needs of veterans in both communities with many resources and communities with fewer services and providers.

S. 1279 would improve veterans' access to care by consolidating the multiple and overlapping non-VA care programs, including the Veterans Choice Program, into one new program with veteran-centric eligibility criteria. The new Care in the Community program would allow the VA to send veterans to non-VA local care when facing one of the following important circumstances:

- 1) it is in the clinical best interest of the veteran to access care or services outside of the VA;
- 2) the veteran would experience an undue burden if he or she continued to seek care from the VA, which would include being forced to travel long distances because the local VA does not offer the particular service needed by the veteran; or
- 3) it is not economical for the VA to provide the veteran the care or services needed by the veteran.

It is important that veterans have access to this kind of care they need. For Idahoans, it is particularly important that care in the community is available when the services veterans need are not available at a VA facilities nearby.

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Twin Falls, ID 83301
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The Veterans Health Administration Reform Act would require the VA to pay providers in a timely fashion and to ensure providers have a streamlined way to submit claims and track payment. These provisions are critical to ensuring providers in local communities, particularly in smaller and rural areas, can afford to continue serving veterans. Long repayment times and lack of clarity in the claims process make it difficult for some providers to both serve veterans and continue to make ends meet.

The measure also would facilitate a formal partnership between the VA and the Centers for Medicare and Medicaid (CMS) share information on best practices. In 2015, the American Community Survey found that 11.3 million veterans out of 22.5 million veterans nationwide reported having health coverage through Medicare. About 6.4 million veterans reported having care through the Veterans Health Administration (VHA), and many veterans may be dual eligible under Medicare and the VA. CMS has significant experience modernizing its health care delivery. Instead of having the taxpayer continue to pay for studies, it is wise to have CMS share with the VA how it approached modernizing claims processing and how it developed auto-adjudication for claims.

Beyond the technical assistance CMS could provide, there is a lack of knowledge both among veterans and VA staff on how Medicare benefits interact with (and may be different from) VA benefits. Through casework, I have seen veterans decline Medicare Part B, have a non-service-connected emergency, and then discover that the VA will not pay the expenses when Medicare (or another insurance) would have. It is important to educate veterans and staff on how the two programs work together, particularly as a larger percentage of the veteran population becomes older than 65.

If a veteran wishes to see a specialist outside of the VA, the veteran should have the freedom to choose to use Medicare benefits to receive outside care. Some senior veterans I have talked with in Idaho like their primary care provider at the VA. They do not want to exclude their VA provider by using Medicare for a specialty care need in the community. Currently, there seems to be confusion on the VA's ability to have providers refer veterans into the community for care without incurring a financial obligation.

S. 1279 would require the VA to administer an education program that helps veterans know about their health care options. This program should inform the veteran of the services for which he or she might be eligible, more information about the VA's priority group system, and information about the veteran's co-pays or other financial obligations. The program should clearly explain to veterans how health insurance programs (private, Medicare, Medicaid, TRICARE, etc.) interact with the services provided by the VA. And the program should also inform the veteran of what to do with a complaint about health care received from the VA. The information must be accessible to veterans who do not have access to the internet. Education about the health care options and limits through the VA is critical to ensuring that veterans are more satisfied with the VA and that they have the information to make wise health care decisions before an expensive emergency.

I thank the committee for its thoughtful consideration of this legislation and look forward to working together to come up with reforms that meaningfully impact the lives of servicemembers.

Thank you, Mr. Chairman.

LETTERS SUBMITTED BY HON. JEFF FLAKE, U.S. SENATOR FROM ARIZONA



VETERANS OF FOREIGN WARS OF THE UNITED STATES

www.vfw.org | info@vfw.org

February 2, 2017

The Honorable Jeff Flake
Judiciary Committee
United States Senate
413 Russell Senate Office Building
Washington, DC 20510

Dear Senator Flake:

On behalf of the nearly 1.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, I am writing in support of the *Veterans Court Improvement Act of 2017*.

According to the most recent data from the Bureau of Justice statistics, over 130,000 veterans are incarcerated in state and federal prisons, representing approximately eight percent of the total prison population. While the VFW realizes that veterans who are convicted of crimes must suffer the consequences, we also recognize that having veteran advocates or individuals to represent them before sentencing and act in their best interests is invaluable.

Expanding the amount of Veterans Justice Outreach Specialists will help our justice-involved veterans navigate the legal system, and hopefully attain outcomes that are best suited for each individual veteran. The VFW is proud to endorse this bill and we look forward to this helping many veterans facing legal hardships in the future.

Thank you again for your leadership on this issue. The VFW looks forward to working with you and your staff to pass this much needed piece of legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Ray C. Kelley".

Raymond C. Kelley, Director
VFW National Legislative Service

NO ONE DOES MORE FOR VETERANS.

National Headquarters | 406 W. 34th Street | Kansas City, MO 64111 | 1.816.758.3390 | Fax: 816.969.1157
Washington D.C. Office | VFW Memorial Bldg. | 200 Maryland Ave. N.E. | Washington, D.C. 20002 | 1.202.543.2239 | Fax: 202.543.6719



**Paralyzed Veterans
of America**

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Washington DC 20006 3517
OI 202 872 1300
TTY 202 474 7622
FI 202 785 4452
www.pva.org

Chartered by the Congress of the United States

February 23, 2017

Senator Jeff Flake
Judiciary Committee
413 Senate Russell Office Building
Washington, DC 20510

Dear Senator Flake:

On behalf of Paralyzed Veterans of America (PVA) and its members, I would like to offer our support for the "Veterans Court Improvement Act of 2017." PVA firmly believes in the rule of law and that anyone convicted of a crime should be held accountable. Our criminal justice system, though, has long recognized the existence of aggravating and mitigating circumstances that play an important role in influencing the administration of penalties. It is important to note that while advocacy before a sentencing judge following conviction is important, prosecutorial discretion is also vast. Veterans Justice Outreach Specialists can help veterans use their honorable service, as well as mitigating circumstances arising from that service, to ensure both the prosecutor and judge see more than just a rap sheet when making decisions.

If the specialist demonstrates that the veteran is entitled to health care or disability benefits, the judge or prosecutor might be able to fashion a sentence or plea offer that incorporates utilization of these services in lieu of imposing solely punitive sanctions. It could also lead to an outright deferment of prosecution conditioned on the veteran exploring and obtaining all services available to him or her. This scenario is especially enticing to the judicial system given the constant struggle to find resources, particularly for in-patient substance abuse rehabilitation programs and mental health care.

For some veterans, this path might help them avoid being permanently stigmatized with a criminal conviction. For others, it might be the ticket that lifts them out of homelessness and the corresponding criminal recidivism, specifically with petty and/or vagrancy crimes. It is no secret that some veterans go years before realizing they were entitled to certain benefits that might have helped them avoid poverty and dejection. A court order pointing the veteran to the Department of Veterans Affairs can sometimes turn into a life-changing event. At the least, more veterans touched by this program will re-engage productively with society. That is a goal worth pursuing. If you have any questions, please do not hesitate to contact me.

Respectfully,

Sherman Gillums, Jr.
Executive Director



MILITARY ORDER OF THE PURPLE HEART
CHARTERED BY CONGRESS

NATIONAL HEADQUARTERS
5413-B BACKLICK ROAD
SPRINGFIELD, VA 22151-3960
Phone: (703) 642-5360
Fax: (703) 642-2054

March 15, 2017

The Honorable Jeff Flake
413 Russell Senate Office Building
Washington, DC 20510

Dear Senator Flake:

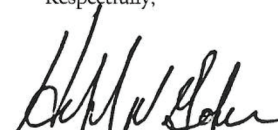
On behalf of the Military Order of the Purple Heart (MOPH), whose membership is comprised entirely of combat wounded veterans, I am pleased to offer our support for the Veterans Court Improvement Act of 2017.

MOPH strongly believes in the rule of law, and that those who commit crimes should be held accountable. Still, we recognize that veterans who commit minor offenses due to addiction or mental health issues should be given every opportunity for rehabilitation before incarceration.

For this reason, we strongly support the Department of Veterans Affairs (VA) initiative to employ Veterans Justice Outreach (VJO) Specialists to help connect justice-involved veterans with the treatment and resources they need. The Veterans Court Improvement Act would provide funding to hire additional VJO Specialists where they are needed, ensuring that VA is able to provide as many justice-involved veterans as possible with these critical services.

MOPH thanks you for your leadership on this issue and your continued commitment to veterans and their families. We look forward to working with you to ensure the passage of this important legislation.

Respectfully,


Hershel Gober
National Commander



May 2, 2017

The Honorable Jeff Flake
United States Senate
413 Russell Senate Office Building
Washington, D.C. 20515

On behalf of the Association of the United States Navy, we would like to pledge our support for S. 946 the Veterans Treatment Court Improvement Act. This bill requires the Department of Veterans Affairs to hire additional Veterans Justice Outreach specialists in order to ensure veterans have greater access to effective and tailored treatment.

The Veterans Justice Outreach program was created by the VA to provide veterans with timely access to VA services and engage justice-involved veterans in specialty treatment courts. The Veteran's treatment court model removes Veterans from the regular criminal justice process and helps to address symptoms that are unique to Veterans, such as post-traumatic stress disorder and substance abuse. In a Veteran's treatment court, the presiding judge works alongside the Veteran and the VJO specialist to establish a structured rehabilitation program that is tailored to the specific need of that Veteran.

This act would authorize \$5.5 million for each fiscal year from 2017 to 2027 for the VA Secretary to hire additional VJO specialists to work with justice-involved Veterans in Veteran treatment courts. The Secretary must identify cost reductions within the Department to offset the authorized amount. It also requires that the Secretary periodically report on the Department's implementation of the bill and its effect on the VJO program.

Thank you for taking an active role in such an important issue to the Military and Veteran community by working to improve the lives and careers of those who served our great nation. Please feel free to contact me with any questions or concerns at 703-548-5800 or at michael.little@ausn.org.

Sincerely,

A handwritten signature in blue ink that reads "Michael J. Little". To the right of the signature, there is a small, circular stamp containing the text "APR 27 2017" and "USNR".

Michael J. Little
Director of Legislative Affairs



March 28, 2017

Senator Jeff Flake
Judiciary Committee
413 Senate Russell Office Building
Washington, DC 20510

Dear Senator Flake,

On behalf of the Association of Prosecuting Attorneys (APA), I am writing to express my support of the Veterans Court Improvement Act of 2017. APA is a private non-profit whose mission is to support and enhance the effectiveness of prosecutors in their mission to create safer communities. It serves as a forum for collaborating with our criminal justice partners across the globe; and to advocate on behalf of prosecutors on emerging issues related to the administration of justice.

A 2000 Bureau of Justice Statistics report found that prior to incarceration in jail or prison, 81% of veterans report drug use problems. Prior to incarceration in jail, 35% were identified as having current alcohol dependency, 23% were homeless at some point in the prior year, and 25% were identified as mentally ill. The initiation of Veteran Treatment Courts has been instrumental in treating veterans and reducing the recidivism rate among the veteran population.

The Veterans Court Improvement Act of 2017 recognizes the importance of Veteran Treatment Courts as well as Veteran Justice Outreach Specialists in providing services and treatment to veterans. By providing sufficient resources to these courts, this unique population will be best served, as will the communities that they live in.

As prosecutors, we are key stakeholders in the criminal justice system. We believe that prosecutors can be advocates and change agents for innovative criminal justice efforts, such as Veteran Treatment Courts. We proudly endorse this bill and its efforts. Thank you for your leadership on this important issue.

Respectfully Submitted,

David LaBahn
President and CEO

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National District Attorneys Association
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www.ndaa.org

March 21, 2017

The Honorable Jeff Flake
United States Senator
413 Russell Senate Office Building
Washington, DC 20510

Dear Senator Flake,

On behalf of the National District Attorneys Association (NDAA), the largest and oldest prosecutor organization representing 2,500 elected and appointed District Attorneys across the United States as well as 40,000 Assistant District Attorneys, I write in support of the Veterans Treatment Court Improvement Act of 2017. This legislation would ensure that our nation's veterans that have become involved with the criminal justice system have access to services and resources they need to become productive members of society.

Specifically, the legislation would require the Secretary of Veterans Affairs to hire additional Veterans Justice Outreach program specialists to work with veterans involved in the criminal justice system through veterans treatment courts. Veterans treatment courts have been set up across the country to help veterans involved in the criminal justice system get the help that they need and deserve as well as access the benefits they should receive due to their military service. It is well documented that many in our veteran community suffer from mental illness, including PTSD, and other substance use disorders, and veterans treatment courts provide a necessary venue to address those issues.

Congress has highlighted the deficiencies in the resources and care we provide our military veterans through the VA, and this legislation can serve as a small step to help those that are part of the criminal justice system. We look forward to working with you and your staff on this important issue.

Sincerely,

A handwritten signature in cursive script that reads "Michael A. Ramos".

Michael A. Ramos
President



ARIZONA PROSECUTING ATTORNEYS' ADVISORY COUNCIL

March 1, 2017

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MICHAEL B. WHITING
Apache County Attorney

ELIZABETH ORTIZ
Executive Director

The Honorable Jeff Flake
Judiciary Committee
United States Senate
413 Russell Senate Office Building
Washington, DC 20510

Dear Senator Flake:

On behalf of the Arizona Prosecuting Attorneys' Advisory Council (APAAC), this letter is sent in support of the **Veterans Court Improvement Act of 2017**.

The APAAC Council is composed of twenty-three members, including the Arizona attorney general, the fifteen elected county attorneys, five municipal prosecutors, a representative of the supreme court, and the dean of one of the state's law schools. In addition to training and advocacy, APAAC provides a variety of services for the more than 800 prosecutors across the state of Arizona who serve as "Ministers of Justice."

APAAC applauds your efforts on behalf of veterans in Arizona and other states. This important legislation will assist veterans in navigating the criminal justice system and accessing critical benefits that are due them. APAAC proudly endorses this important legislation.

Sincerely,

Elizabeth Ortiz
Elizabeth Ortiz
Executive Director

"Empowering Arizona's prosecutors to administer justice and contribute to public safety through training and advocacy."

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MARK BRNOVICH
ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL
STATE OF ARIZONA

March 28, 2017

The Honorable Jeff Flake
United States Senate
2200 East Camelback Road
Suite 120
Phoenix, AZ 85016

Re: Veterans Court Improvement Act of 2017

Dear Senator Flake:

As Attorney General for Arizona, and as a former officer with the United States Army Judge Advocate General's Corps, I write to express my support for the Veterans Court Improvement Act of 2017. Your legislation draws attention to a growing problem in our nation.

Our country faces an incredible challenge in the coming years to properly care for and protect our veterans, especially the men and women who served the United States during the longest war of its history. At this time, we are not properly prepared to handle the specific physical, mental, and emotional challenges that these soldiers confront. Your legislation is one step toward giving back to those who gave their all.

As you know, our state is home to more than 500,000 veterans. We currently have twelve Veterans Courts operating across Arizona to assist veterans who are involved with the criminal justice system. The Veterans Justice Outreach Specialists play a key role in addressing the needs of these veterans, and we welcome the prospect of having more of them at work in our state.

Thank you again for raising this issue, and for advocating for our veterans.

Sincerely,

A handwritten signature in black ink that reads "Mark Brnovich". The signature is written in a cursive style with a long, sweeping underline.

Mark Brnovich
Arizona Attorney General



COCONINO COUNTY ARIZONA
OFFICE OF THE COUNTY ATTORNEY

We serve the public by advocating for justice.

WILLIAM P. RING
COUNTY ATTORNEY

JANE NICOLETTI-JONES
CHIEF DEPUTY ATTORNEY

TAMI M. SUCHOWIEJKO
SENIOR MANAGER

DEPUTY ATTORNEYS

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MICHAEL TUNINK

ROSE WINKLER

The Honorable Senator Jeff Flake
Judiciary Committee, United States Senate
413 Russell Senate Office Building
Washington, D.C. 20510

March 2, 2017

Re: *Veterans Court Improvement Act of 2017*

Dear Senator Flake,

On behalf of the Coconino County Attorney's Office I am writing to offer our strong support for the *Veterans Court Improvement Act of 2017*.

Our jurisdiction is an early adopter of alternative resolution courts for justice-involved Veterans. This was done in recognition of two principle facts: (1) Veterans are uniquely situated to understand and appreciate the experience of honor and discipline in service to our Nation; and (2) Through powers of recollection we can utilize that foundation, which was once instilled, to return a sense of honor and to then empower the Veteran to do what is needed, what is right, and what justice requires. Our *Veterans Court* is a diversionary court and an alternative to standard criminal prosecution. We form a Justice Team around the Veteran composed of the judge, prosecutor, public defender and a Veterans Justice Outreach Specialist. *When presented with a menu of coordinated services from the VA and the Veterans Justice Outreach Specialist* a successful graduate has seized the opportunity to change their lives.

Of course, success depends wholly upon the availability of a Veterans Outreach Justice Specialist in our rural area. Your Bill assures continuation of our programming and we strongly endorse it.

Before closing it is important to recognize the work of three individuals in our program who represent the VA or assist our program Veterans. They are VJOS Mark McLaughlin, VRC Mike O'Donnell, and Mr. Terry Couch. I want to thank these gentlemen for their service. If you should need further information on our program or testimony in support of your Bill, please feel free to contact me and I will do all that is necessary to return to Washington, to explain our experience and positively support the programming.

Very truly yours,

William P. Ring
Coconino County Attorney



COCONINO COUNTY ARIZONA
OFFICE OF THE COUNTY ATTORNEY

Cc:

Raymond C. Kelley, Director
VFW National Legislative Service
VFW Memorial Building
200 Maryland Avenue N.E.
Washington, D.C. 20002

Commander Robert Noel
Mr. Rex Sturmer
VFW Post 1709 San Francisco Peaks
409 W. Santa Fe Avenue
Flagstaff, Arizona 86001

Commander JT Thompson
The American Legion
Mark A. Moore Post #3
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Flagstaff, Arizona 86001

Northern Arizona Veterans Resource Center
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Flagstaff, Arizona 86001



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February 22, 2017

The Honorable Jeff Flake
United States Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, D.C. 20510-6050

Dear Senator Flake,

As the Chief Prosecutor for Maricopa County, and as a former United States Army officer, I am writing to express my support for the Veterans Court Improvement Act of 2017.

Arizona is home to over 600,000 veterans, and celebrates those who have served, are currently serving, and will serve in the United States military. Arizona's large population of veterans led the state, counties, and cities to recognize the need for veterans' treatment courts and establish them at the outset of the national movement.

Today, Arizona has 12 active veterans' treatment courts at the superior and municipal court levels. A primary objective of those courts is to supervise veterans in the criminal justice system and help them obtain the federal benefits that they earned as a result of their military service.

It is well documented that the Department of Veterans Affairs (VA) has failed many veterans in Arizona by delaying the delivery of healthcare. Unfortunately, the VA only employs 8 Veterans Justice Outreach Specialists (VJOs) in Arizona, which is too few and which will likely delay the delivery of benefits to veterans subject to court supervision, and the timely receipt of those benefits is critical to their successful completion of probation or diversion programs.

Your legislation will fix this shortage in Arizona and other states by requiring the VA to hire additional VJOs, who will assist veterans under court supervision in obtaining important benefits in a timely manner. Access to these benefits is critical to their success, and I thank you for sponsoring a bill that will help Arizona veterans succeed in the criminal justice system and beyond by helping them obtain the benefits they earned and need.

Sincerely,


Bill Montgomery
Maricopa County Attorney



Barbara LaWall
Pima County Attorney

Pima County Attorney's Office
32 N. Stone Avenue, #1400
Tucson, AZ 85701

Phone: 520-724-5800
www.pcaaz.gov

February 28, 2017

The Honorable Jeff Flake
United States Senate
2200 East Camelback Road
Suite 120
Phoenix, AZ 85016

The Honorable Jeff Flake
United States Senate
Judiciary Committee
413 Russell Senate Office Building
Washington, DC 20510

Dear Senator Flake:

As the chief prosecutor in Pima County, and on behalf of my constituents, I write to express support for the *Veterans Court Improvement Act of 2017*. I welcome Veterans Courts as an intelligent alternative to incarceration that focuses on treating veterans' physical, mental, and behavioral health issues, including post-traumatic stress disorder and drug and alcohol addiction.

Arizona is home to more than 500,000 military veterans, and Arizona's veterans led the state, counties, and cities to recognize the need for veterans' treatment courts and establish them at the outset of the national movement.

Arizona has 12 active veterans' treatment courts at the superior and municipal court levels. A primary objective of veterans' courts is to supervise veterans in the criminal justice system and help them obtain the federal benefits they earned as a result of their military service. In Pima County, the Justice Court operates a Veterans Court, and the City of Tucson also operates a Regional Municipal Veterans Court serving five municipalities. The Regional Municipal Veterans Court currently relies heavily upon temporary grant funding, and both misdemeanor veterans' courts in Pima County are in need of ongoing financial support.

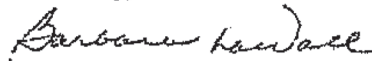
It is well documented that the Department of Veterans Affairs (VA) has failed many veterans in Arizona by delaying the delivery of healthcare. Unfortunately, the VA employs only eight Veterans Justice Outreach Specialists (VJOs) in Arizona. While the VJO in Pima County does an excellent job, he coordinates with both veterans' courts, as well as with our Drug Treatment Alternative to Prison in Superior Court. The demands on his time are ever-increasing. Having too few VJOs in Arizona will likely delay the delivery of benefits to veterans subject to court supervision; yet the timely receipt of benefits is critical to their successful completion of probation or diversion programs.

Your legislation will fix this shortage in Arizona and other states by requiring the VA to hire additional VJOs who will assist veterans under court supervision in obtaining important benefits in a timely manner. Access to these benefits is critical to their success.

The Honorable Jeff Flake
February 28, 2017
Page 2

Thank you for sponsoring a bill that will help veterans succeed in the criminal justice system and beyond by helping them to obtain the benefits they earned and need. It is an honor to support those who have served and are currently serving in the U.S. military.

Sincerely,

A handwritten signature in cursive script that reads "Barbara LaWall".

Barbara LaWall
Pima County Attorney

**VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)
DEPARTMENT OF ARIZONA**

06 February 2017

Jim Ellars
12261 W. Grier Rd.
Marana, AZ 85653
520-904-7755
ignatz4in@aol.com

To: Senator Jeff Flake
SR-413

Subj: VFW, DEPARTMENT OF ARIZONA, LETTER OF ENDORSEMENT TO SUPPORT VETERANS COURT IMPROVEMENT ACT OF 2017

Senator Flake,

My name is Jim Ellars. I am the National Legislative Officer for the over 25,000 members of the Veterans of Foreign Wars of the United States (VFW), Department of Arizona.

The VFW has been an early and strong supporter of Veterans Courts, sometimes called Veterans Treatment Courts, here in Arizona, whether they are set up and run by the VA or by local municipalities. Military members throughout history have been subjected to and survived some of the most horrible and dangerous experiences any human has ever experienced. When they leave the service, under administrative or medical direction, many of these veterans are or may be suffering from military service connected medical and/or mental health issues. I say 'may', because some of these issues are hidden, suppressed or latent in their affect on the service member and do not manifest until later, sometime quite a while later. However, the symptoms, when they do manifest themselves, can make the veteran react in a highly negative manner, either physically, mentally, or both, often unbeknownst to the veteran. When certain manifests knowingly or unknowingly cause the veteran to do wrong things and break laws, there must be stop-gaps and safeguards in place within our various law enforcement and judiciary systems to recognize when veterans are not displaying criminal intent, but rather suffering the results of an undiagnosed and/or untreated symptom. This is where Veteran Courts are critically needed.

The VFW, as well as other VSOs, welcome Veteran Courts as intelligent alternative systems of intervention that focuses on treating a veterans physical and/or mental health issues, some of which may be undiagnosed, latent or suppressed in nature, instead of criminalizing what is in reality an untreated patient. Giving these veterans a second chance, one where they can optionally choose to enter into a controlled rehabilitating treatment program in lieu of entering the normal court system, is a huge challenge for some veterans. These courts absolutely do provide troubled veterans the best place for a troubled veteran to be with a group of like-experienced people who understand, care, and have the resources available to rehabilitate them utilizing a familiar guise of military jargon and protocols in order for the veteran to take on a different mission, one of self improvement. Our nation must never harm, only to re-harm, those who served as our defenders. We believe, as do the veteran courts, that rehabilitation through treatment is the proper approach to someone who may or may not recognize the problems that got them in trouble with the law.

Some of the stand-out procedures used in the veteran court I observed are:

The court is staffed by personnel who are connected to military service in one capacity or another. The Judge was a retired Marine. The court staff are all former military members or dependents/family member of military members. Some were once attendees of a veterans court themselves. The public defenders are all supervised law students and prior military (great use of GI Bill benefits).

A semi-military atmosphere is maintained in order to give a feeling of familiarity to the proceedings, and to remind the individual that their military service is honored. RESPECT and courtesies are adhered to from both sides of the bench. Each person's personal dignity is regarded foremost by all people in the courtroom. When a defendant's name is called to approach the judge, all activity in the courtroom stops and everyone, even those seated in the audience, stands at attention. The defendant gives the judge their name and branch of service. The judge acknowledges and thanks them for their service and usually has a little something extra nice to say to any Marine.

Those people who run the courtroom were not just court staff or public defender people. There are also representatives from several public, local and state social service agencies and the VA in attendance. If you need a place to live, a job, specialized treatment, etc, the court wants those who accept the treatment program to get the care they need, and the representatives of these agencies are there to help.

All of the stand-out procedures mentioned above are keyed to one vital thing: the right people doing the right jobs. But, that is also where a large problem arises.

The problem is this - we have this wonderful system, run by some great people, but very few veterans know of its existence or how to access it. That is the largest complaint I've heard from the court I observed. Without having the human resources required to outreach into our veteran community about entitled services such as Veterans Court, we are not achieving the proper level of intended service to our most vulnerable veterans.

For this type of program to work as well as it needs to, it does require increased continuity, outreach and education, and that is where the VFW feels the Veterans Justice Outreach (VJO) Program must provide more specifically trained and actively involved specialists in order to better educate veterans of the program and to also help more veterans achieve access to it. The Veterans Court Improvement Act of 2017 proposed by Senator Jeff Flake, we feel, will provide both the increased quantity of VJO specialists and funding necessary to do just that. To that end, the VFW, Department of Arizona, is highly pleased to provide this letter of endorsement to support the Veterans Court Improvement Act of 2017.

Please contact me for any questions or comments. We thank the Senator and his staff for all they do for veterans and their families.

Yours,

Jim Ellars, VFW, Dept. of Arizona
Nat'l Legislation Officer.



Supreme Court
STATE OF ARIZONA

FROM THE CHAMBERS OF
SCOTT BALES
CHIEF JUSTICE

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February 22, 2017

The Honorable Jeff Flake
United States Senate
2200 East Camelback Road
Suite 120
Phoenix, AZ 85016

Dear Senator Flake:

I write in support of the Veterans Court Improvement Act of 2017. Your timely legislative proposal affords a good opportunity to review Arizona's progress in expanding the number of Veterans Courts and the need for additional federal resources.

As you know, Arizona is home to more than 500,000 veterans. Unfortunately, some veterans find themselves in court facing charges for offenses such as driving under the influence, domestic violence, criminal damage, and drug possession. Often these individuals are suffering from PTSD or otherwise having trouble reintegrating into civilian life. Instead of processing the criminal case in the usual course, Veterans Courts assist the veteran in dealing with any underlying issues and, if successful, resolving the pending charges. These courts also help veterans with obtaining employment, finding safe housing, and applying for VA benefits.

Veterans Courts are now operating in these Arizona courts: Maricopa Superior Court, Chandler Municipal Court, Mesa Municipal Court, Tempe Municipal Court, Phoenix Municipal Court, Scottsdale Municipal Court, Coconino Superior Court, Flagstaff Municipal Court, Tucson Municipal Court, Pima County Consolidated Justice Court, Lake Havasu City Municipal Court, and Kingman Municipal Court. In addition, at least two other Arizona courts are working towards establishing Veterans Courts.

The Veterans Court Improvement Act of 2017 would importantly help address the limited number of VA-assigned Veterans Justice Outreach Coordinators (VJO) assigned to qualifying VA medical centers in Arizona and elsewhere. VJOs are critical to the success of Veterans Courts. VJOs are VA staff members who attend court hearings, meet with veterans, and coordinate VA

Senator Jeff Flake
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services. Without sufficient VJOs, more Veterans Courts cannot be established and existing ones will be limited in their effectiveness. Although the VA has not set a specific guideline for how many courts or veterans a VJO can serve, in our experience one VJO can serve between 50 and 75 eligible veterans.

Within the last two years the VA added four VJOs in Arizona. We believe, however, that six more VJOs are needed over the next two years to accommodate the creation of new courts across the state. If tribal Veterans Courts are created, additional VJOs will be needed.

In 2015, we contacted other states to see if they are encountering a similar roadblock in expanding Veterans Courts. We quickly heard that Florida, Guam, Hawaii, Kentucky, Maryland, Massachusetts, Missouri, New Hampshire, and Texas all similarly need additional VJOs. We understand that in recent years Congress significantly increased the VA's budget. We also understand that the Veterans Court Improvement Act of 2017 does not seek an increase in funding, but instead requires the VA to allocate more resources to VJOs. We fully support the bill and its effort to ensure that more VJOs are available to support veterans and Veterans Courts.

Respectfully,



Scott Bales

SB/mk

cc: Dave Byers, Administrative Director
Arizona Administrative Office of Courts



Association of American Medical Colleges
Statement for the Record on Pending Health Care Legislation
Senate Committee on Veterans Affairs
July 11, 2017

For more than 70 years, U.S. medical schools and teaching hospitals have supported the Department of Veterans Affairs to improve access and quality of care for our nation's veterans.

This partnership helps ensure veterans have access to specialized clinical services at academic medical centers that are scarcely available elsewhere, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services. By working with the VA, medical schools and teaching hospitals help to promote veteran-specific clinical and cultural competencies while training the next generation of physicians. Additionally, veteran-centric research collaborations have advanced innovations in health care.

The discussion draft bills, "The Veterans Choice Act of 2017" and "Improving Veterans Access to Community Care Act of 2017," aim to address VA's workforce challenges by enhancing veterans' access to health care services in the community. While this is a laudable goal, if not structured properly, we believe there are potential unintended consequences that will adversely impact veterans. Mainly, we caution against reducing veterans' choice of clinical care settings by eliminating VA's authority to directly contract with academic medical centers and solely relying on fee-basis mechanisms that do not recognize the value of VA-academic affiliations.

We also urge the Committee to protect each of VA's statutory missions of 1) patient care; 2) health professions education and training; and 3) research, and that the current focus on patient care is not at the expense of VA's other missions to educate and train the U.S. clinical workforce and to advance veteran-specific research.

The Association of American Medical Colleges (AAMC)¹ recommends that the discussion draft bills preserve the VA's authority to directly contract with academic affiliates for specialized clinical services and to improve the process for sole-source contracting that puts veterans first in line for the best care in the world at academic medical centers.

¹ The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 VA medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Direct Contracting with Affiliates Ensures Services are Available for Veterans

Veterans require the entire spectrum of clinical care services: preventive services, primary care, and highly-specialized clinical treatment. When the VA is unable to provide those services,² VA medical centers are authorized under VA Directive 1663, in accordance with 38 U.S.C. § 8153, to enter into contracts with academic affiliates on a non-competitive or “sole-source” basis. Sole-source contracts help ensure that academic medical centers support the clinical service lines that are most important to veterans, but are scarcely available through other providers in the community.³ Indeed, a 2016 Government Accountability Office (GAO) report found that “[Sole-source affiliate contracts] serve an important role in helping to ensure that VAMCs can provide specialty health care services for our nation’s veterans and support the residency training of a new cadre of physicians.”⁴

The nation’s medical schools and major teaching hospitals — frequently with regional campuses and co-located near or directly connected to VA medical centers — provide around-the-clock, onsite, and fully-staffed standby services for critically-ill and injured patients, in particular highly-specialized complex clinical care. For example, 5 percent of all U.S. hospitals are AAMC-member teaching hospitals, but they provide 23 percent of all clinical care and 37 percent of hospital charity care, including 100 percent of the nation’s Comprehensive Cancer Centers, 68 percent of burn unit beds, and 79 percent of accredited level-one trauma centers.

The VA’s ability to directly contract with academic affiliates allows for planning, staffing, and maintaining infrastructure for complex clinical care services. Without these service agreements, it is more difficult for academic medical centers to anticipate the unique clinical service needs of veterans, which are less-visible when veterans are aggregated with the broader patient population. Ultimately, sole-source contracts ensure academic medical centers and the advanced care they provide remain a choice for veterans.

Partnering with Academic Affiliates Improves Efficiency and Quality of Care

Sole-source contracting with academic affiliates improves coordination of care, providing immediate access to clinical services without the need of a third-party administrator or leaving veterans to manage their own care. These agreements also facilitate robust clinical information sharing and care coordination with VA facilities. Additionally, nearly 70 percent of VA physicians have joint appointments with a medical school or teaching hospital, which facilitates integration of veteran patient care between the VA and its academic affiliates. These

² “Prior to initiating a contract, the facility must ensure that a clinician could not be hired to fill the clinical requirements.” VA Directive 1663

³ “All health care resources contracts that do not require the acquisition of the Affiliated University faculty members’ services to perform the contract services must be awarded competitively when two or more qualified providers (may include the Affiliate) of the health care resource are available that can fulfill the VA contract requirements.” VA Directive 1663

⁴ GAO-16-426: Published: May 6, 2016. Publicly Released: Jun 6, 2016.

appointments also serve as an important tool to recruit and retain the nation's best and brightest physicians.

Further, the high-volume and expertise at academic medical centers improves quality of care and reduces redundancies. For highly specialized complex clinical care, for example cardiac by-pass surgery, we know that academic medical centers that do high volumes of cardiac by-pass procedures have better outcomes than those who have less volumes. Academic medical centers around the country make tremendous investments in their cardiovascular service lines, including capital equipment, human capital investment and protocol management to ensure topflight care.

Many VA medical centers and community providers don't have the budgetary strength, patient volumes, or human capital to invest in these types of services in order to have comparable outcomes. Just as commercial and managed care organizations who preferentially contract with academic medical centers to ensure that their beneficiaries receive top line care, these same principles should be encouraged and embraced by the VA.

VA-Academic Affiliations Enhance Veteran Care through Education and Research

U.S. medical schools and teaching hospitals enjoy reputations as best in the world precisely because of their tripart missions: research, education, and patient care. Like a three-legged stool, these missions are fully integrated and dependent on one another — to separate them is to jeopardize the advancement of care that routinely originate in academic medical centers. VA's similar tripart missions are enhanced by close relationships with academic medical centers. As such, sole-source contracts with affiliates are critical to fostering veteran-centric research innovations and maintaining a well-prepared physician workforce to care for veterans. Conversely, eliminating VA sole-source contracting with affiliates weakens the relationships and puts all three missions at risk.

The VA is an irreplaceable component of the U.S. medical education system. Each year, the VA helps train more than 20,000 individual medical students and more than 40,000 individual medical residents within its walls. As a system, the VA represents the largest training site for physicians, and funds approximately 10 percent of national graduate medical education (GME) costs annually. The GME relationship between the VA and academic affiliates does more than benefit learners and training programs. Under the supervision of faculty, many of whom have been jointly recruited by the medical school and the VA, residents and fellows provide substantial and invaluable direct patient care.

VA Directive 1663 recognizes the immediate value added by sole-source contracts with affiliates, "Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the services contracted). ... The decision to compete contracts for services that overlap programs in which the facility has graduate medical education training in place must be weighted by additional factors beyond the contract costs. The decision must consider all implications to the business,

including the impact to the facility’s training program, which is a direct contributor to the facility’s productivity and may provide offsets.”

Physicians who train with veteran patients are also better prepared to treat veterans in any future practice setting, whether at the VA, academic affiliates, or other community providers. The VA patient-learner dyad is a cultural anchor for many young physicians who have never served in the nation’s armed forces. VA rotations and sole-source clinical contracts ensures with affiliates expands residents’ empathic understanding of what it means to “serve and sacrifice” for the nation. Without this GME partnership, care for veterans inside and outside the VA system would be diminished.

Now is not the time to divest in veteran research. Young veterans are returning from recent engagements with polytrauma, mental health concerns, and complex clinical needs from injuries they may not have survived in the past. Aging veterans from previous wartime periods require additional care and resources to treat chronic conditions. VA’s research mission improves the quality of care and the effectiveness of health systems that treat veterans.

Academic medical centers, in collaboration with VA medical centers, cultivate a culture of research curiosity and innovation. Medical faculty must be skilled in the latest clinical innovations to train the next generation physicians that will care for veterans. State-of-the-art technology and groundbreaking treatments jump quickly from the research bench to the bedside to the care delivery system. The VA’s intramural research program serves as a recruitment tool and sponsors numerous projects in areas that specifically benefit veterans and the unique challenges they face — research that might otherwise be neglected in the private sector. Treatment at academic affiliates also increases veterans’ access to a majority of National Institutes of Health (NIH)-funded clinical trials, while also increasing the opportunity for collaborative VA and academic affiliate clinical trials.

Without strong clinical ties to academic affiliates, VA’s tripartite mission is put in jeopardy, and the substantial benefits of education and research are lost.

With Process Improvements, Direct Sole-source Contracts Can Reduce Bureaucracy

The AAMC supports streamlining and improving the efficiency of VA contracting with the nation’s medical schools and teaching hospitals. Unwieldy and drawn-out clinical contracting process often hinders these relationships, despite their potential to greatly expand veterans’ options for care. Many AAMC members report that they have the capacity to help address patient access issues, but are stymied due to contracting hurdles — delaying, and in some cases preventing, veterans’ access to health care.

Fee-basis care through a predecessor to the Veterans Choice Program, the “Patient-Centered Community Care (PC3)” program, inserted a middleman between longtime partners, resulting in delayed and misdirected referrals due to skewed third party incentives, additional costs for the VA and affiliates directed to the third party, and unnecessary administrative burden for all. The

AAMC appreciates that the VA has now recognized the inefficient processes for onboarding physicians/institutions through third party administrators, which further delayed veteran access to care.

One of the most frequently identified barriers to improving veterans' access to care at academic medical centers through sole-source contracts is the additional review of contracts greater than \$500,000 by the VA Office of Inspector General (OIG). VA must recognize the unique costs and circumstances associated with clinical contracting compared to other goods and services. The size of clinical services contracts varies greatly, but AAMC members report that virtually all 5-year contracts with the VA are between \$2 million and \$10 million, far exceeding the current \$500,000 threshold for additional review. As an example, the AAMC estimates that contracts for the following clinical services would surpass \$500,000 and trigger additional review:

- 10 uncomplicated cardiac surgeries
- 4 burn cases
- 5 intensive care unit cases
- 10 outpatient radiation cases
- 10 esophageal cancer surgery cases

Local VA medical centers and their academic affiliates see the benefits of these relationships, but are stymied by a process mired in misplaced oversight. Sole-source contracting with trusted academic affiliates should not take longer than the competitive bid process. The AAMC recommends adjusting the \$500,000 threshold in a manner that better reflect clinical costs and recognizes the value of long-term agreements with academic affiliates (e.g., at least \$2.5 million for 5-year clinical contracts).

As referenced in the VA's 2015 consolidation plan, the AAMC appreciates VA's willingness to develop pre-approved template contracts that reimburse certain services with at least Medicare rates.⁵ Additionally, we have discussed the development of standardized overhead rates to eliminate unnecessary negotiations and contract administration.

Involving individuals with academic appointments in the contracting process should not be considered a conflict of interest, but rather recognized for the value they add to VA leaderships' ability to contract for clinical services. The AAMC recommends allowing VA officials with academic appointments to participate in contract negotiations with the academic affiliate, as long as they don't have a specific role at the affiliate that would create a conflict.

Academic affiliates also have a role to play in improving these negotiations. We have committed to working with our institutions to develop single points of contact instead of renegotiating the same contract with each program head.

⁵ Already, VA Directive 1663 states, "Contracts should be based on market prices as assessed by appropriate local and regional market analyses. Contracts should not exceed applicable Medicare rates unless there is adequate justification documented in the contract file."

Establishing Joint Ventures With Academic Affiliates

To better align the VA and the nation's medical schools and teaching hospitals, the AAMC supports the Enhanced Veterans Healthcare Act of 2017 (H.R. 2312). Our shared missions can be strengthened through joint ventures in research, education, and patient care. Already our institutions and medical faculty collaborate in these areas, but often VA lacks the administrative mechanisms to cooperatively increase medical personnel, services, equipment, infrastructure, and research capacity.

Current authority for VA to coordinate health care resources with affiliates has been narrowly interpreted by VA Office of General Counsel and the OIG. VA can occupy and use non-VA space for limited purposes, but only under 6-month sharing agreements, 6-month revocable licenses, or 5-year leasing agreements — all of which have failed in practice.

Conclusion

Mr. Chairman and Members of the Committee, thank you for the opportunity to submit this statement on these important issues. The VA is at a crossroads. Retaining and improving veterans' access to care at academic medical centers through sole-source contracting can strengthen the 70-year history of VA-academic affiliations and prepare our country for the next chapter of VA health care. The AAMC and our member institutions will continue to work with the Congress and the VA to address the challenges and opportunities to ultimately improve care for veterans and all Americans.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PAs



**Statement for the Record
Submitted to
U.S. Senate Committee on Veterans' Affairs
July 11, 2017
On Behalf of the American Academy of PAs**

On behalf of the more than 115,000 nationally-certified physician assistants (PAs), the American Academy of PAs (AAPA) appreciates the opportunity to submit a statement for the record regarding S. 426, the "Grow Our Own Directive (GOOD): Physician Assistant Employment and Education Act of 2017." AAPA strongly endorses this critically important legislation, and we commend Ranking Member Tester (D-MT) and Senator Moran (R-KS) for working together on this bipartisan initiative to improve the quality of healthcare available for our nation's veterans. We also sincerely thank Chairman Isakson for his dedication to improving healthcare for veterans and his work on the GOOD Act.

Timely access to quality patient care is one of the most critical issues facing our nation's veterans. PAs are a key part of any plan for increasing access to quality medical care at VA medical facilities. PAs provide high quality, cost-effective medical care in virtually all health settings and in every medical and surgical specialty. The rigorous education and clinical training of PAs enables them to be fully qualified and equipped to manage the treatment of patients who present with both physical and mental illnesses. PAs are educated to seamlessly work in a healthcare team, and they manage the full scope of patient care, often handling patients with complex diagnoses or multiple comorbidities, situations which commonly occur within the nation's veteran population.

The PA profession has long been connected and committed to veterans and veterans' healthcare. The first PA students were Navy Corpsmen who served in the Vietnam War; and recruitment of and support for veterans in PA educational programs continues to this day. As of 2014, nearly 12% of all PAs are veterans, active duty or retired military, or in the National Guard and Reserves, and more than 2,200 PAs are currently employed full-time by the U.S. Department of Veterans Affairs.

Given the critical role of PAs at the Veterans Health Administration (VHA), AAPA has significant concerns that PAs are one of the top five medical professions experiencing shortages within the VA healthcare system. Multiple recent reports from the VA Office of Inspector General (OIG) on staffing issues at the VHA acknowledge the importance of PAs as part of VHA's healthcare team, and identify PAs as one of the five occupations with the "largest staffing shortages" in the VHA. Additionally, the 2015 VHA Workforce Planning Report identifies PAs as having "one of the highest administrative quit rates, retirement rates and total loss rates of any of the mission critical occupations" within the VHA.

S. 426 proposes a two-part approach to improving efforts to recruit and retain a VA PA workforce – the GOOD pilot program and a VHA commitment to recruiting and retaining PAs by offering fairer and more competitive compensation.

GOOD Pilot Program

The Good Pilot Program is designed to create a pathway for veterans to become educated as PAs, and to add to the supply of PAs in VA medical facilities.

This pilot program would establish a scholarship program for veterans under the VA's educational programs, giving veterans who received medical training while serving in the military an opportunity to use their skills to find jobs after separating from the military. Many veterans who served as medics or corpsmen in the military find that their training does not immediately translate to a job in civilian life. This pilot program would allow such candidates to enroll in a PA program and work towards earning a degree that would let them use those skills to transition to employment as within the VA system.

In addition to helping veterans find employment after they separate from military service, the GOOD pilot program would help alleviate the provider shortage for PAs that the VHA is currently facing, thus removing a barrier to care for the veterans who rely on the VHA for their medical needs.

Additionally, we are particularly pleased that the GOOD Pilot Program will provide priority to veterans who are from rural communities or who are willing to commit to providing care as PAs in VA facilities located in rural communities. This program would mirror the National Health Service Corps, a successful model that has been educating PAs and other healthcare professionals for decades in exchange for a commitment to serve in medically underserved areas.

Competitive Pay for PAs

A critical component of S.426 is its requirement that the VHA implement a long overdue update for PA compensation. Under the current system, VA compensation for PAs simply does not compete with the salaries offered outside the VA.

In the private sector, PAs are highly regarded and in-demand healthcare providers who command competitive salaries. According to the National Certification Commission for the Physician Assistant, the average salary of PAs in the United States for 2016 was \$104,131. According to the 2015 VHA Workforce Planning Report, in 2015 starting pay for new PA graduates was usually 20-30% higher in the private sector than it was in the VA. This same report recommended that the VA update its compensation practices for PAs in order to become more competitive with the private sector. It is hard for the VA to recruit, hire, and retain PAs when the starting salary being offered for many PA positions is often significantly lower than what can easily be found in the private sector. The private healthcare market has embraced and rewarded the use of PAs to alleviate healthcare provider shortages; it is time for the VA to do so as well.

To AAPA's knowledge, the VHA has not expanded recruitment and retention initiatives related to fair compensation for PAs in response to the identification of PAs as one of the VA's top five critical occupation shortages. The VA has the authority to include PAs in the Locality Pay for Nurses and other Healthcare Professionals pay scale, but thus far has not taken action to do so. The addition of PAs to the VA locality pay system could assist the VA in recruiting PAs to replenish the ranks of approximately 40 percent of the VA PA workforce eligible for retirement within the next several years.

Additionally, PAs and nurse practitioners (NPs) employed by the VA frequently perform nearly identical functions and are employed in the same manner, but PAs are often paid significantly less than NPs for performing the exact same job. Because of inconsistencies in pay scales, NPs often start at a higher salary than PAs, and it is not uncommon for NPs in the VA to be compensated by as much as \$30,000 more than PAs while providing similar, if not identical, medical services.

Examples of this pay discrepancy are unfortunately very easy to find. A job posting on 3/16/2017 for a position at the Chillicothe (Ohio) VA Medical Center, for a position that could be filled by either PA or a NP, advertises a salary range of \$69,207-\$82,185 for PA candidates, while the salary range for an NP was \$93,065-\$123,766. At the William Jennings Bryan Dorn VA Medical Center, in Columbia, SC, a position posted on 5/18/2017 was open to both PAs and NPs, with the salary range for a PA starting at \$49,626 and the starting salary range for an NP starting at \$76,992. In addition to these recent listings, there are disparities in pay ranging from \$13,000 to \$26,000 per year for PAs versus NPs in cities such as Augusta, GA, New Orleans, LA, and Las Vegas, NV. Ensuring compensation for PAs takes into consideration local wages, as the VA does for NPs, is critical to improving access to care by ensuring the VA is able to better recruit and retain PAs.

Conclusion

S. 426, the "Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017," represents a significant step forward in building and strengthening the VA's PA workforce through proposals to create a five year pilot program to educate veterans as PAs and to require the VA to adopt standards leading to competitive pay for PAs employed by the VA. As the Committee moves forward with efforts to improve the quality of care available at the VHA, AAPA would be pleased to continue to serve as a resource. Thank you again for the opportunity to submit a statement for the record in support of S. 426.

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PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

The American Federation of Government Employees, AFL-CIO and its National VA Council (AFGE) appreciates the opportunity to submit a statement for the record on the bills under consideration today. AFGE represents nearly 700,000 employees in the Federal and D.C. government including 250,000 rank and file employees at the Department of Veterans Affairs who provide vital care and services for our veterans.

S. 1153—VETERANS ACCESS ACT

S. 1153 would bar providers from participating in VA purchased care programs if they have been fired from the VA for certain misconduct, violated requirements of their medical license, lost a VA credential, or committed certain crimes.

AFGE supports S. 1153. When VA privatizes care, the standards must be as high as they are inside the VA.

S. 1261—VETERANS EMERGENCY ROOM RELIEF ACT

AFGE opposes S. 1261 as currently written. Absent specific guidelines for when veterans can use non-VA urgent care centers, this bill could lead to more fragmented and uncoordinated care, and lead the VA further down the road of privatization. In addition, too many veterans are already subjected to harsh collection practices through Choice and through VA third party collection processes.

AFGE urges the Committee to first conduct an inventory of emergency departments and urgent care centers within VA medical centers; a number of facilities have closed emergency departments over the years without adequate justification. This study should also examine the feasibility of expanded urgent care centers within VA medical centers. Urgent care provided directly by the VA will be far more veteran-centric than urgent care provided in the private sector.

S. 1266—ENHANCING VETERAN CARE ACT

This bill would give the VA authority to contract with non-VA entities to investigate deficiencies at VA medical centers.

AFGE opposes S. 1266. The VA has adequate internal capacity to investigate its medical centers, alone or in conjunction with other independent governmental entities. Contracting out this responsibility is likely to be used to lay the groundwork for further privatization.

S. 1279—VETERANS HEALTH ADMINISTRATION REFORM ACT OF 2017

AFGE opposes S. 1279 because the criteria that would be used to determine if a veteran can seek care outside the VA are too vague (e.g. clinical best interest, undue burden, not economical). VA medical centers across the Nation continue to be deprived of adequate staff and resources to provide all veterans with the timely, veteran-centric care they have earned and that they prefer. The conditions resulting from chronic underfunding and short staffing need to be addressed by strengthening the VA rather than further depleting resources away from the VA to provide more fragmented, nonspecialized care to veterans.

S. 1325—BETTER WORKFORCE FOR VETERANS ACT OF 2017

AFGE concurs that it is critical to fill the reportedly 49,000 vacancies at the VA. However, in AFGE's view, some of the provisions in the underlying bill—as currently written—fall short of improving hiring, recruiting, and training efforts within the VA and may have unintended consequences.

Sections 101 and 102 of the bill gives the Secretary more direct-hire authority to fill current staff level vacancies. AFGE has serious concerns about how this increase in direct-hire authority will impact current Federal employees. If this bill were to become law, AFGE fears that an unintended consequence could be preferential treatment given to outside candidates, thereby bypassing current VA employees who seek a promotion. Without adequate protections in place for current Federal workers who have worked diligently to move up the VA ladder, the bill could have a negative impact on efforts to strengthen the VA workforce.

Section 106 of the underlying bill directs the VA to collect data on hiring effectiveness and Section 107 calls for the VA to design a standardized exit survey that would be voluntarily administered to outgoing employees. AFGE wants to stress the importance of having stakeholder input throughout the process of developing these mechanisms. It is critical that the VA consult with labor organizations who represent their employees as well as the many Veterans Service Organizations (VSOs) whose members rely on the VA for vital care and services when developing these survey tools. By incorporating input from both labor and the VSO community, the VA will be able to develop tools that adequately address issues at the worker, manager, and patient level.

One goal that appears throughout the underlying bill is the notion of transparency. AFGE appreciates the inclusion of this provision in the bill and the acknowledgment that the VA should be more transparent as it relates to staffing levels and vacant positions. With that in mind, AFGE would like to see the bill go further by posting not just nurse staffing levels, but all staffing levels at every VA fa-

cility. In addition to the VA being transparent with its current workforce, AFGE would like to see the VA be transparent with posting job openings. AFGE highlighted its concern with new direct-hire authority above, and in that vein, wants to express its desire that necessary oversight is exercised so that the Secretary does not use this new direct-hire authority to fill positions without those jobs being publicly posted with an open announcement.

Another area where AFGE has significant concern with the underlying bill relates to the proposed use of non-Federal employees to provide care and services to our Nation's veterans. As it's currently written, Section 202 of the bill would allow the VA and private sector companies to essentially swap employees for a period that can range from three months to four years. AFGE has long opposed allowing the private sector to enter the Federal Government and then return to their original job outside of the government. This is an unnecessary step down the path to privatization, and AFGE opposes the section in its entirety.

AFGE opposes Section 204 as currently written. Section 204 establishes a two-tier payment system of base pay and market pay for directors of medical centers and Veterans Integrated Service Networks (VISN). The bill would set market pay for directors on a case-by-case basis through a process that requires the Secretary to consult at least two national surveys and takes into account managerial experience, complexity of the facility, and labor market conditions among other considerations.

Under Section 204, medical center and VISN directors—who would no longer have to be physicians themselves (as a result of Section 203)—would gain a significant right that was taken away from every VA physician and dentist last year. Public Law 114-315 repealed the requirement enacted in 2004 that “the Secretary shall consult two or more national surveys of pay” (Public Law 108-445).

In addition, Public Law 114-315 eliminated the requirement to set market pay through peer-based compensation panels, a valuable system for ensuring pay fairness, that protected providers from abuse of discretion by managers. According to reports from our physician members, the Secretary has not established any new policies to replace the compensation panels.

AFGE is ready and willing to work with the Committee to amend Section 204 to ensure that VA physicians and dentists reacquire adequate market pay protections, which in turn will strengthen recruitment and retention and enable the VA to provide medical care to more veterans on a timely basis.

AFGE also opposes Section 207 of the bill that would allow the Secretary to enter into a Memorandum of Understanding (MOU) with the Surgeon General to allow not less than 500 Public Health Service (PHS) commissioned officers to enter the VA. Allowing PHS to come into the VA would erode frontline workers collective bargaining rights and move the VA one step closer to privatization. PHS does not appear to have any significant expertise in treating veterans. In addition, Congress has provided VA with ample tools over the last two decades to recruit and retain nurses within the Federal workforce. The VA should be focused on recruiting, hiring, and retaining high quality medical professionals who will make a career out of serving veterans, not finding creative stop-gap measures. The United State Government must keep the promise it made to our veterans by rewarding their dedication and sacrifice with the best care and services imaginable, and the only way to do that is through hiring staff at every level who will be there long-term to care and provide for our veterans. AFGE opposes this section of S. 1325 in its entirety.

AFGE opposes Section 212 as currently written. Section 212 would require a review of the job descriptions, position classifications and grades for all VA police officers and firefighters to ensure compliance with Office of Personnel Management (OPM) classification standards. This section also mandates the development of staffing models and an audit of recruitment and retention efforts for both positions, and a report to Congress regarding the Department's use of special pay to address its critical shortage of police officers.

AFGE shares the concerns of lawmakers and veterans' groups that the outdated police officer job duties increase safety risks to the VA community. However, after consultation with classification experts, AFGE strongly urges the Committee to adopt a more comprehensive and aggressive approach to modernizing the VA police officer position, i.e. mandating that the Secretary exercise his existing statutory authority to convey law enforcement officer (LEO) status to all VA police officers. Only this major overhaul of VA police officer positions will ensure that VA has the capacity to adequately respond to the wide range of violent and non-violent incidents that arise on a regular basis at its facilities.

A recent expert analysis of VA police officer duties indicates that VA police officers already meet the statutory definition of law enforcement officer based on their primary duties and training requirements (5 CFR 831.902; 5 CFR 842.802).

AFGE previously requested that former VA Secretary Robert McDonald exercise this authority. AFGE stands ready to work with bill sponsors and other Members of the Committee to develop a stronger statutory solution to this significant VA safety issue.

S. _____—DISCUSSION DRAFT, THE VETERANS CHOICE ACT OF 2017

AFGE strongly opposes the Veterans Choice Act of 2017. This bill would vastly increase the use of non-VA care through a massive expansion of the Choice Program. Like the Concerned Veterans of America plan that was soundly rejected by the Commission on Care, this bill would erode the critical core of the VA health care system and put such an enormous financial strain on the VA so as to threaten its very survival.

The bulk of veterans' care, and all primary care and mental health care must continue to be provided within the VA system, to ensure that veterans continue to receive the world-class integrated care they have earned and prefer. Only the VA, as the coordinator of care, can ensure that non-VA care is used in a smart way to ensure that veterans can receive the most appropriate care for their circumstances.

In contrast, this bill would not result in a smart use of non-VA care but rather an unlimited use of non-VA care that would likely lead to worse care for veterans in both the short and long term, and the severe weakening of our Nation's leader in health care training and research.

AFGE also opposes this bill because it would not ensure the VA is the primary coordinator and arranger of non-VA care.

S. _____—DISCUSSION DRAFT, IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT OF 2017

AFGE generally supports the Improving Veterans Access to Community Care Act of 2017. This bill enables the VA to modernize its services, which will both allow the VA to better integrate a truly smart use of non-VA care with VA's own world class services, but also allow the VA to meet increased demand from higher functioning and consolidated non-VA care programs.

AFGE also supports this bill's provisions for ensuring that the VA is the primary coordinator of non-VA care. The integrated networks created by this bill would allow veterans to more seamlessly move between the VA and non-VA providers when the use of non-VA care to supplement VA's own care is warranted.

The VA has made great progress in making needed improvements to its health care system and other operations over the past three years. This bill ensures that veterans will continue to be well served by the VA and integrated networks providing non-VA care when the VA cannot meet the need itself. This bill also is the far better option for protecting the critical resources that the VA must retain in order to keep its promise to veterans.

S. _____—THE DEPARTMENT OF VETERANS AFFAIRS QUALITY EMPLOYMENT ACT OF 2017

AFGE does not support this bill as a whole, though it includes several positive management improvement provisions included in previous legislation.

Like some of the provisions that raised concerns from AFGE in S. 1325, as already discussed, this bill relies too heavily on the private sector to improve the Department. For example, Section 3 would provide management training to VBA and VHA employees in a private sector setting. VA managers need to learn the best practices of other VA managers and when applicable, exemplary managers from other agencies. That is why AFGE supports management improvement provisions that strengthen VA's own managers through better training and performance evaluation.

AFGE supports a public database on vacancies, but the database in Section 6 of this bill has too narrow a scope. Veterans, the public, employee representatives, and all stakeholders need access to complete data about vacancies throughout the Department, not just vacancies that are determined to be critical by the Secretary.

The human resources training proposed by Section 7 is greatly needed, but to ensure that it is truly effective, labor representatives, and other stakeholders must have regular input in the design and delivery of training curriculum. Without the perspective of front line employees, any H.R. training will continue to fall short.

AFGE has similar concerns in this bill regarding provisions for exit surveys and succession planning studies as we have for S. 1325, i.e. it is essential that these workforce improvement efforts reflect the regular input of representatives of front line employees.

Thank you for the opportunity to share the views of AFGE.

LETTER FROM COL. JAMES T. CURRIE, USA (RET.) PH.D., EXECUTIVE DIRECTOR,
COMMISSIONED OFFICERS ASSOCIATION OF THE U.S. PUBLIC HEALTH SERVICE



Commissioned Officers Association
of the U.S. Public Health Service

July 14, 2017

The Hon. Johnny Isakson
Chairman
Veterans Affairs Committee
United States Senate
Washington, DC 20510

The Hon. Jon Tester
Ranking Member
Veterans Affairs Committee
United States Senate
Washington, DC 20510

Dear Chairman Isakson and Ranking Member Tester:

We are a non-profit association that since 1951 has represented the interests of the Commissioned Corps of the United States Public Health Service. These uniformed officers comprise what is perhaps our country's best-kept secret when it comes to a group of professionals who are prepared to respond on a military-quick basis to public health disasters in our country, whether those disasters are natural or manmade. PHS teams have, in fact, responded over 800 times in the past ten years alone.

Providing a ready response to immediate public health needs is the reason the Commissioned Corps of the U.S. Public Health Service was created in 1889. Beginning initially as an all-physician group, this uniformed service quickly expanded, and through the ensuing 128 years it has come to embrace every category of public health specialty. These officers are formed into teams which can deploy as soon as twelve hours after they are alerted.

When they are not deployed, however, these officers have what we refer to as "day jobs." The largest number of them, over 1900, are clinicians within the Indian Health Service. The second largest number are stationed at the Food and Drug Administration, where they conduct studies and analyses of medicines and medical devices, working alongside their civilian colleagues. The Centers for Disease Control and Prevention is the third largest employer of PHS officers, with close to 1000 uniformed officers assigned there. Until recently the acting Director of the CDC was a Rear Admiral physician in the USPHS. The fourth largest number of PHS officers, some 800 total, are assigned to billets within the Federal Bureau of Prisons.

Other officers provide healthcare to the US Coast Guard and to NOAA officers. The Defense Department has its share of officers, as do the National Park Service and the Department of Agriculture. Indeed, PHS officers are assigned to some two dozen federal departments and agencies. The department that is conspicuously missing from the listing above is Veterans Affairs. Despite the fact that all PHS officers are, by federal law, veterans, there have not been full-time billets opened for PHS officers at the VA. As the association that represents close to 4500 active duty PHS officers (out of a total active duty population of just over 6500), we can tell you that there are many—perhaps hundreds—of PHS officers who would very much like to serve our country's veterans by working at a VA clinic or hospital.

Commissioned Officers Association
of the U.S. Public Health Service

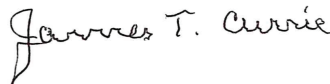
We understand that the Department of Veterans Affairs and the Department of Health and Human Services (HHS) signed a Memorandum of Understanding (MOU) earlier this year under which a handful (fewer than six) PHS officers will be assigned to VA clinical positions. As we are not privy to the contents of the MOU, we don't know whether it calls for such a limited number of PHS officer assignments to the VA or whether this small number is generated by some other forces. We understand that there has been some reluctance within the Department of HHS to fully embrace VA billets because of the fear that officers might leave a key HHS entity—the Indian Health Service—and go to the VA. We are completely sympathetic to this fear.

As we read the proposed language in this bill, we see nothing that would preclude any new MOU between the VA and HHS from including a provision that would open VA billets only to officers not currently serving in the Indian Health Service. The inclusion of such a provision would presumably allay the fear that emanates from within HHS that the Indian Health Service would be stripped of its clinicians if VA billets were opened to PHS officers.

As the one association that exclusively represents Commissioned Corps USPHS officers, we are continually pushing for new opportunities for our members to serve their country. We believe that veterans serving veterans is a natural relationship. We, in fact, reached out to then-Under Secretary Shulkin in December 2015 and raised with him the possibility of having PHS officers assigned to the VA. Our enthusiasm for the opening of VA billets was only slightly-mollified by what is apparently the limited nature of the current MOU.

We are therefore completely supportive of section 207 of the *Better Workforce for Veterans Act of 2017* (S. 1325).

Respectfully,



Col. James T. Currie, USA (ret.), Ph.D.
Executive Director

PREPARED STATEMENT DEVELOPED BY FIGHTING FOR VETERANS HEALTHCARE, ASSOCIATION OF VA PSYCHOLOGIST LEADERS,* ASSOCIATION OF VA SOCIAL WORKERS,* AND NURSES ORGANIZATION OF VETERANS AFFAIRS*

*An independent organization, not representing the Department of Veterans Affairs

PROPOSALS FOR THE VETERANS CHOICE PROGRAM REDESIGN AND THEIR
IMPACT ON VETERANS' HEALTH CARE

BACKGROUND

Over the last decade, as the rising demand for veterans' healthcare services outpaced the Veterans Health Administration (VA)'s capacity to meet it, excessive delays developed at some VA facilities. In 2014, Congress enacted the temporary Veterans Choice Program whose goal was to reduce delays by offering non-VA options to veterans who had to wait long or travel far for care. To date, over 1.6 million veterans have utilized the program.¹

The demand for veterans' healthcare services is predicted to continue to climb during the next several years.² There are two basic ways to address VA's lack of capacity to meet this demand—bolster the VA by augmenting its number of clinicians and support staff, or purchase more services in the private sector. Those two options offset each other, since increases in Choice would be carved out of the VA.

As Congress deliberates Choice program redesign, policymakers should consider not only the plan's ability to remedy access problems, but also its broad impact. Congress must ensure that the next Choice program does not compromise VA's overall quality of health care—care that has been demonstrated, with geographic variations, to be at least equal to and often superior to non-VA care. Congress must ensure that the VA's innovative, integrated care model is preserved. It must assure that the system for clinically training the majority of U.S. healthcare professionals is maintained. It must make sure that the VA is able to sustain its research mission that benefits not only veterans, but also every American. It must ensure that the private sector has the capacity to absorb an influx of veterans in a timely manner, and delivers excellent care. Given that non-VA care is more expensive than VA care, Congress must ensure that Choice is used judiciously so that there is no reduction in the level of services available to veterans. Finally, it must ensure that the VA is improved, not dismantled, because that's what veterans overwhelmingly prefer, and have been promised by administration and Congressional officials. Our analysis of major policy ideas for the next version of Choice concludes that only one proposal does all this.

PROPOSALS FOR VETERANS CHOICE PROGRAM RENEWAL

At least four ideas for modifying Choice have been proposed by policymakers and veterans' stakeholders. One—which we endorse—would fortify VA-delivered care and its management of the network of Choice providers. The other three concepts, although structured differently and still lacking specific details, would eliminate distance and wait time requirements, purchase far more care in the private sector, cut VA services and incrementally privatize veterans' healthcare.

The following are the four ideas, and their potential impact on veterans' healthcare if enacted:

1. Strengthen VA Delivered Care

The VA eliminates third party administrators and assumes direct management of high performing, integrated networks. Disparities between supply and demand are addressed first by resourcing VAs. External providers are used only to fill in gaps that local VAs cannot provide. Eligibility for Choice is based on distance and wait time criteria that are convenient for the veteran.

Impact:

- Builds and strengthens the VA system for the long term.
 - Hires VA front line and support staff in locations where demand outstrips supply.
 - Increases VA appointment capacity.

¹*Budget Request for Fiscal Year 2018: Presentation before the House Committee on Veterans' Affairs*, House, 114th Cong. 1 (May 24, 2017) (Testimony of David Shulkin).

²Eibner, C., Krull, H., Brown, K., Cefalu, M., Mulcahy, A. W., Pollard, M., . . . Farmer, C.M. (2015). Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs [Product Page]. Retrieved June 8, 2017, from https://www.rand.org/pubs/research_reports/RR1165z1.html

- Maintains quality assurance.
- Supplements care when needed.
 - Ensures that when timely, nearby VA care is not available, care is outsourced to the community.
- Is fiscally efficient.
 - Eliminating 3rd party administrative middlemen saves money and streamlines initiation of Choice care, when needed.
 - Hiring VA staff rather than purchasing more expensive private sector care reduces costs.
 - Gives VAs the ability to manage utilization and control expenses.
- Supports the comprehensive integrated care approach.
 - VA generalists treat veterans in primary care clinics and then walk them down the hall to meet with a behavioral health professional, pharmacist, social worker, nutritionist or other specialist.
 - The VA's coordinated, integrated care is not only more effective than the private sector's, it's far more convenient to veterans because everything is handled in one location.

2. Make Choice Cards Universal

Allow eligible veterans to seek unrestricted care from any outside, certified provider, without needing to obtain pre-authorization.

Impact:

- Fragments, diminishes and delays quality care.
 - Relies on community providers who are not vetted for quality and/or are less knowledgeable about veteran specific healthcare issues.
 - Increases wait times in the private sector for veterans as well as non-veterans. There aren't enough primary care, specialist, or mental health services in the community. By 2030, the U.S. will face a shortage of between 40,800 to 104,900 physicians.³
 - Because many physicians are unwilling to accept Choice payment rates,⁴ veterans may have difficulty finding a qualified provider.
 - Creates uncoordinated administrative structures in which accountability is diminished.
 - Spreads treatment across the private sector, thereby reducing care coordination and integration. The Commission on Care Final Report⁵ (page 28) 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."
 - The private sector virtually never screens for PTSD, MST or many other veteran problems, so many cases will be missed and untreated.
 - Suicide prevention programs in the community are generally far less comprehensive than in the VA.
- Leads to downsizing of VA delivered care.
 - Allows veterans to bypass the VA for services and send the bill to the VA for payment, even if the VA can provide prompt care that is closer and of higher quality. VA would cover the expenses of outsourced care by reducing their staff, programs, and services.
 - Allows eligible veterans who previously have been receiving care outside the VA using their own health insurance to send their bills directly to the VA for payment. That will further drain the VA budget.
 - Impairs VA's ability to continue to outperform the public sector, since funds are diverted to pay for Choice.
 - Secretary Shulkin's testimony at the June 7, 2017 Senate Committee on Veterans Affairs hearing affirmed: "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. It would put vet-

³IHS Markit, *The Complexities of Physician Supply and Demand 2017 Update: Projections from 2015 to 2030*. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges. February 28, 2017

⁴Bishop, T, Press, M.J., Keyhani, S. & Pincus, H.A. (2014). Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry*, 71(2), 176–181.

⁵Commission on Care. (2016). *Commission on Care: Final Report*. Retrieved from https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

erans with very difficult problems out into the community with nobody to stand up for them and to coordinate their care, and the expense of that system is estimated to be at the minimum \$20 billion dollars more a year than we currently spend on VA healthcare.”⁶

3. Limit the VA’s Core Mission To Foundational Conditions

Redefine the VA’s core mission as focusing on the treatment of foundational conditions, such as PTSD, Traumatic Brain Injury, polytrauma, blindness, spinal cord injury, pain, limb loss and mental health. Outsource most of the remaining care to providers in the private sector.

Impact:

- Diminishes the quality and comprehensiveness of veterans’ healthcare.
 - Outsourcing services to the private sector could mean many veterans may not receive high quality care. In study after study that contrasts private sector services to those of the VA, (including again in *Definitive Healthcare’s* 2017 summary⁷), the quality of government-run VA care has been shown to be as good as and often better than private sector care. That’s true across the spectrum, including for diabetes, heart disease, geriatric care, serious mental illness, PTSD, depression, safety practices, preventive care, surgical complications, infection control, hospital readmissions, hospital mortality and medication compliance.^{8–14}
 - Private sector providers have less expertise in detecting and treating underlying conditions to which veterans are highly vulnerable. For example, a general practitioner is less likely to explore PTSD as the reason for chronic insomnia, the impact of Traumatic Brain Injury on mood and decisionmaking, or that a particular condition—asthma induced by burn-pits or diabetes produced by Agent Orange exposure—is related to military service.
 - Many veterans have comorbid physical and mental health problems, which require integrated care. This is especially true of the large number of aging veterans.
- Increases wait times for veterans and non-veterans in the private sector.
 - As in #2, this plan leads to longer wait times in the private sector, which is already struggling to keep up with demand. There aren’t enough private sector doctors available to treat veterans or willing to accept Choice payment.
- Severely impacts poor, mentally ill and homeless veterans.
 - The VA has substantial programs that have had a significant impact on veteran homelessness. VA actively attempts to locate homeless veterans and en-

⁶*Examining the Veterans Choice Program and the Future of Care in the Community. Presentation before the Senate Committee on Veterans’ Affairs, 114th Cong. 1 (June 7, 2017) (Testimony of David Shulkin).*

⁷Foltz, W. (2017, April 24). The VA Healthcare System—Definitive Healthcare. Retrieved June 8, 2017, from <https://www.definitivehc.com/hospital-data/the-va-healthcare-system-a-broken-system-with-superior-quality>

⁸Farmer, C. M., Hosek, S. D., & Adamson, D. M. (2016). Balancing Demand and Supply for Veterans’ Health Care [Product Page]. Retrieved February 14, 2017, from http://www.rand.org/pubs/research_reports/RR1165z4.html

⁹Association of VA Psychologist Leaders. (2016, March 23). Comparison of VA to community healthcare: Summary of research 2000–2016. Retrieved from <http://avapl.org/advocacy/pubs/FACT%20sheet%20literature%20review%20of%20VA%20vs%20Community%20Health%20Care%2003%2023-16.pdf>

¹⁰O’Hanlon, C., Huang, C., Sloss, E., Price, R., Hussey, P., Farmer, C., & Gidengil, C. (2017). Comparing VA and Non-VA Quality of Care: A Systematic Review. *Journal of General Internal Medicine, 32*(1), 105–121. <https://doi.org/10.1007/s11606-016-3775-2>

¹¹Ho, P.M., Lambert-Kerzner, A., Carey, E.P., Fahdi, I.E., Bryson, C.L., Melnyk, S.D., . . . Del Giacco, E. J. (2014). Multifaceted intervention to improve medication adherence and secondary prevention measures after acute coronary syndrome hospital discharge: a randomized clinical trial. *JAMA Internal Medicine, 174*(2), 186–193. <https://doi.org/10.1001/jamainternmed.2013.12944>

¹²Tanielian, T., Farris, C., Batka, C., Farmer, C.M., Robinson, E., Engel, C.C., . . . Jaycox, L.H. (2014). *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/pubs/research_reports/RR806.html

¹³Kavanagh, K.T., Abusalem S., & Calderon, L.E. (2017). The incidence of MRSA infections in the United States: Is a more comprehensive tracking system needed? *Antimicrobial Resistance & Infection Control, 6*(34)/DOI: 10.1186/s13756-017-0193-0

¹⁴Nuti, S.V., Qin, L., Rumsfeld, J.S., Ross, J.S., Masoudi, F.A., Normand, S.-L.T., . . . Krumholz, H.M. (2016). Association of Admission to Veterans Affairs Hospitals vs. Non-Veterans Affairs Hospitals With Mortality and Readmission Rates Among Older Men Hospitalized With Acute Myocardial Infarction, Heart Failure, or Pneumonia. *JAMA, 315*(6), 582–592. <https://doi.org/10.1001/jama.2016.0278>

sure they are housed and cared for. The VA employs peer specialists who routinely reach out to veterans diagnosed with schizophrenia and other serious mental illness who have stopped showing up to appointments. Few private sector facilities offer the level of robust wrap-around psychosocial services that are standard in the VA.

- Reduces VA clinics and access for veterans who value and choose VA.
 - Major segments of VA healthcare would be outsourced to the private sector.

4. Allow Choice Eligibility Based On A Composite Community Standard Metric

Bases eligibility for Choice on a community standard metric, which will be a composite of patient satisfaction, wait time and quality measures. Where the composite score for a local VAMC non-foundational service line falls below that number, all veterans in that local clinic will automatically be eligible for Choice. Independent of whether VAMC service lines exceed that number, individual veterans can be granted Choice once they discuss VA and Choice options with their VA provider. Uses high-performing integrated networks for outsourced care.

Impact:

- Changes Choice eligibility to be based on a composite measure (comprised of wait time + patient satisfaction + quality metrics).

Individual veteran level eligibility: Once veterans and their providers discuss and compare VA and community alternatives, veterans may be granted Choice. However:

- Neither the VA's Access and Quality Tool website <http://www.accesstocare.va.gov/> nor Medicare's Hospital Compare website <https://www.Medicare.gov/hospitalcompare/search.html> have the data that veterans need to make informed decisions. In most cases, comparative metrics don't exist.
- There is no available data on a facility's effectiveness in reducing symptoms or functional deficits.
- There is no data on outpatient care.
- Many diagnoses aren't included.
- There is no data on use of evidence-based psychotherapies.
- There is no data about private practitioners.
- Although wait times at VA facilities are published, community wait times are unknown.

Clinic level eligibility: When a VA non-foundational service line's composite score falls below their community's score, all veterans in that clinic will automatically be eligible for Choice for that service. However:

- The algorithm to compute this composite metric has not been developed.
- Including patient satisfaction in this metric is inherently problematic, since patient satisfaction scores have not been found to relate to the provision of good health care.^{15 16}
- Comparing VA with community composite scores is misleading, since they are not apples-to-apples comparisons. Private sector statistics are based on non-veteran patients who, on average, are younger and have fewer medical and mental health conditions than do veterans.^{17 18}
- Metrics can confuse mathematical differences with meaningful clinical differences. A difference between a 14-day and a 16-day wait may not be justification for more expensive private care.
- Increases costs and decreases productivity.
 - Reduces VA's ability to control costs if veterans have the prerogative to opt for private sector care even when the local VA is able to provide treatment that is less expensive, clinically superior, quicker and/or closer.

¹⁵Fenton, J.J., Jerant, A.F., Bertakis, K.D., & Franks, P. (2012). The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of Internal Medicine*, 172(5), 405–411. <https://doi.org/10.1001/archinternmed.2011.1662>

¹⁶Brookes, L. (Interviewer) & Fenton, J. J. (Interviewee). (2014). *Patient Satisfaction and Quality of Care: Are They Linked* [Interview Transcript]. Retrieved from Medscape News and Perspectives site: http://www.medscape.com/viewarticle/826280_5

¹⁷Klein, S. (2011, September). The Veterans Health Administration: Implementing patient-centered medical homes in the Nation's largest integrated delivery system. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/-/media/files/publications/case-study/2011/sep/1537_klein_veterans_hlt_admin_case-study.pdf

¹⁸U.S. Department of Veteran Affairs. (2016). *Restoring trust in Veteran health care: Fiscal year 2016 annual report*. Retrieved from: https://www.va.gov/HEALTH/docs/VHA_AR16.pdf

- Requires VA providers to devote extra time mastering knowledge of private sector scores and going over those with patients. This decreases clinician productivity and increases wait times.
- Is more expensive overall than the current VA system.
- Incrementally removes option of the VA for veterans seeking VA as their home.
 - There will be a steady flow of funds out of the VA and into private sector care. If funds that could have been used to make improvements are diverted to pay for Choice, VA facilities that lag behind will never be able to catch up. Even high performing VA's will falter when funds diminish.
 - Dozens of VA service lines are already identified as falling below the metric, qualifying all of the clinic veterans to be automatically eligible for Choice.
- Fragments care.
 - Encourages the VA to provide foundational services and outsource other services to the private sector.
 - Bi-directional, interoperable sharing of VA and private sector electronic medical records does not exist.
- Expands provider network where needed.
 - Aims to develop high-performing networks that link the private sector to the VA over time, although they are not yet available.

ANALYSIS

Making significant, lasting improvements in the VA's ability to provide high quality care without serious delays is unquestionably the right thing to do. It honors the sacred obligation we owe to veterans, to care for those who have borne the battle. In our analysis, idea #1 optimally achieves what Choice was intended to do—remedy wait time delays by outsourcing care when the VA doesn't have prompt or existing services—without collateral damage to the unique advantages, superior quality, cost-effectiveness and integration within the VA healthcare system. It observes the guiding principle for healthcare systems and doctors, “first, do no harm.”

In a fixed pot, every dollar spent on Choice would be subtracted from local VA budgets. Choice care is paid first and the VA makes do with what's left. Expansion of Choice inherent in ideas #2, 3 and 4 sets in motion a hollowing out, in which over time, local VAs will have less money, vacant positions won't be filled, medical services will be cut back and clinics closed. As the availability of VA's services diminish, more veterans will opt for or be placed into Choice, leading to more VA cuts in a vicious cycle. These models degrade the quality of options that already exist. They inexorably privatize veterans' healthcare, with the conversion occurring quickly in ideas #2 and 3, and gradually in idea #4. Idea #1 impedes privatization.

Idea #1 best supports the VA's integrated care model. The VA's one-stop approach facilitates the immediate identification and referral of a variety of problems, for example, when a veteran hints at feeling suicidal during an optometry appointment and is walked down the hall to a mental health clinician. It best supports the VA's holistic approach that incorporates the physical, psychological, social, and economic aspects of health and the impact these factors have on treatment compliance. Care provided in ideas #2 and 3, and to some degree in #4, is more fragmented, and limited to just the patient's chief complaint. Further, there is no ability at present to bi-directionally coordinate VA-community care via electronic medical records.

Idea #1 is the only one that assures continuity of the VA's 71-year-old statutory education mission. More than two-thirds of all U.S. doctors, not just VA doctors, receive their training at VA facilities. So do 40 other healthcare professions. Ideas #2, 3 and 4 lead to reductions in the number of VA attending supervisors, case volume, resident rotations and specialty training programs. A decline in VA training opportunities will be calamitous, given the shortages that already exist. There is no large-scale capacity in the private sector to train knowledge and skills of practitioners.

Idea #1 most effectively fosters groundbreaking research that has been the hallmark of the VA. More than 60% of VA researchers are clinicians, and their studies originate from daily interactions with veterans.¹⁹ The VA has the largest integrated electronic medical record system in the world, uniquely enabling research questions to be pursued. Studies aimed at better understanding and treating veterans' conditions will be nearly impossible if care is scattered across the community.

Although ideas #1 and #4 are similar in some respects, there are key differences between them.

- #1 grants Choice options on a case-by-case circumstance. #4 does this too, but also grants Choice to large groups of veterans in identified clinics.

¹⁹U.S. Department of Veteran Affairs. (2016). *Restoring trust in Veterans health care: Fiscal year 2016 annual report*. Retrieved from: https://www.va.gov/HEALTH/docs/VHA_AR16.pdf

- #1 upholds the VA as a system treating a full complement of conditions. In #4, the VA emphasizes the provision of foundational services.
- While there have been important concerns raised about the use of distance and wait times to determine Choice eligibility in #1, these criteria allow the VA to manage Choice utilization and costs. The substitute composite metric in #4 is still unformed and untested.

The best information to date shows that community care is likely more expensive than VA's.²⁰ To offset added systemic costs for Choice care in plans #2, 3 and 4, it's likely that some current or future veterans would no longer be served, and/or charged higher deductibles and out of pocket expenses. Cutting benefits to disabled unemployable veterans to pay for Choice expansion was proposed in the original FY 2018 VA budget, although policymakers scrapped that idea recently and are now searching for a substitute.²¹

There is a myth that the only way the VA will be motivated to excel is if it is forced to compete with the private sector for its customers. This in spite of the reams of studies that show the VA—without relying on market-based incentives—already delivers care that is equal or superior to that provided in the private sector. The sense of mission to serve veterans is what motivates VA employees, and with convincing effect.

Ideas #2, 3 and 4 contradict what veterans overwhelmingly want—that the VA's clinical care and breadth of services be fixed and strengthened, not dismantled.²² That's especially true for those veterans who use the VA.

We recommend other considerations for Choice redesign:

- Build VA capacity first.
 - Sustain budgets that assure all VA facilities have sufficient capability to provide comprehensive, high performing care. Such resources include staff, space and IT support. It would be a mistake to expand the Choice Program without first increasing the capacity for care at VA facilities where demand for services exceeds supply.
 - Enhance telehealth resources (in VA's FY 2018 budget request) so that veterans have expanded access to VA providers without needing to go outside the VA.
- Guarantee a high level of coordinated, integrated care.
 - Mandate that Choice providers/facilities be able to bi-directionally exchange electronic VA medical records before they are accepted into the Choice program.
 - Mandate that Choice providers engage in the same treatment recommendation process expected of VA providers, i.e. for them to understand what medical and mental health services are available at their local VAs and refer their veteran patients to the VA when the VA renders higher quality care.
- Strengthen the VA brand.
 - Include only high quality providers in the network. Choice should not mean that VA relies on partners simply because they are willing to accept payment, without adhering to the same high quality standards. Stipulate in Choice contracts that providers meet VA's elevated standards, use evidence-based treatments, have knowledge of military culture and competence in veteran-specific problems, engage in ongoing measurement of progress, and perform screenings, such as for PTSD, Military Sexual Trauma and Suicide Prevention.
 - Expand opportunities for the VA to publicize and advertise what it does well. The public remains grossly uninformed about its successes, innovations and overall superior quality.

²⁰ Congressional Budget Office. (2014, December). Comparing the costs of Veterans' health care system with private-sector costs. Retrieved from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf

²¹ <https://www.stripes.com/news/va-backs-off-budget-proposal-to-cut-benefits-for-disabled-unemployable-vets-1.473551#.WUKEHnXysdV>

²² VFW. (2017). *Our Care 2017: A report evaluating Veterans health care*. Washington D.C.: VFW. Retrieved June 7, 2017, from <https://www.vfw.org/news-and-publications/press-room/archives/2017/3/vfw-survey-veterans-want-va-fixed-not-dismantled>

PREPARED STATEMENT OF LAUREN AUGUSTINE, DIRECTOR OF GOVERNMENT
RELATIONS, GOT YOUR 6



Statement for the Record

By

Lauren Augustine

Director of Government Relations

of

Got Your 6

before the

Senate Veterans Affairs Committee

hearing on

Pending Health Care Legislation

July 11, 2017

Chairman Isakson, Ranking Member Tester, 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 on the future of care in the community and appreciate this Committee's commitment to this topic and others in order to improve the health care our nation's veterans receive.

Got Your 6 -- through our 34 direct-impact, non-profit partners who collectively represent three million veterans and their families -- has a mission 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.

The Got Your 6 policy framework includes advocating for legislation that:

1. Supports efforts to change the current narrative of veterans as only "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.

Since passage of the Veterans Access, Choice, and Accountability Act in 2014, there have been ongoing conversations regarding the future of care in the community among the veteran community, within the VA, and in Congress. Given the impending funding shortfall of the existing Choice program there is a well-founded sense of urgency to legislate a long-term solution that respects the increased demand for community care while resolving some of the known shortfalls of current programs. Got Your 6 encourages the Committee to ensure any future care in the community program takes into account the



ease of use for all parties, the consolidation of community care programs into a singular program, the quick resolution of provider payments, and the exploration of expanding public-private partnerships.

Ease of Use

The need for any future care in the community program to be easy to use for all relevant parties to include VA employees, veterans, providers, and advocates, cannot be understated. If such a program is complicated for any end users, it will only exacerbate many of the issues related to access and accountability that have plagued veteran health care in recent years. The ease of use must take into account all facets of the program with particular attention to how determinations are made to send a veteran into the community, how a veteran schedules an appointment or resolves any concern with the program, and how a provider submits for reimbursement.

Ensuring ease of use must start with a clearly defined scope for when and by whom care in the community should be utilized. Got Your 6 is pleased to see the legislative options presented today remove arbitrary requirements for the availability of non-VA care, and we are encouraged by the idea of care in the community being based on the clinical need of a veteran, a reduction in the burden on the veteran seeking care, and a logical determination based on economics. However, we strongly caution against unfettered access to non-VA care before a detailed audit and analysis of the current Choice program demonstrates why a funding shortfall currently exists, how the continued increase in demand for non-VA care impacts the VA's ability to manage and provide such care, and how non-VA care impacts the overall VA budget and its ability to maintain a strong internal system.

Additionally, overall accountability for establishing and maintaining the easy usage of the program requires the VA to have a central role in the management of the system. Such a program should not be dependent on management by third-party contractors, which limits the ability for oversight and creates more opportunities for veterans to fall through the cracks. We should empower and strengthen the VA to manage all aspects of veteran care and provide any tools or regulatory changes necessary to ensure VA's success in this regard.

Based on the legislative options presented today, it is evident the Committee has the same goal in mind, but details matter. How the many provisions within each legislative option are implemented will be critical to the success of the program. Got Your 6 encourages Congress to work closely with the VA and private sector experts to ensure the intent of the program is successfully established and all aspects of the program aim to mitigate any issues limiting access to timely health care options or provider reimbursements. In an age of advanced technology-based solutions, developing a system that allows veterans to easily access non-VA care, empowers VA employees to easily navigate and manage such a system, and respects the need for timely reimbursements must be a reality achieved through Congress' thoughtful legislation and VA's careful implementation.



Consolidation of Community Care Programs

Historically, programs to establish care in the community options at the VA have emerged in response to specific needs or significant events, such as the development of the current Choice program in response to the events in Phoenix in the spring of 2014. 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. As this Committee considers long-term solutions to non-VA care, Got Your 6 strongly supports consolidation of all such programs into one, easy-to-use program that takes into account the need for flexibility to address future regional or issue-based concerns.

Quick Resolution of Payments

Complex relationships through third-party contractors 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. Based on the legislation under consideration today, the quick resolution of provider payments is clearly a priority of the Committee as well and Got Your 6 supports strict requirements on how providers must submit for reimbursement and how quickly the VA must provide reimbursement. Clearly defined responsibilities for all parties will better ensure a system that is fair and respectful of better business practices. Government should serve as the example of sound business practices, such as timely and efficient payment for services, and it is imperative any future care in the community programs respect that goal.

Greater Use of Public-Private Partnerships

Secretary David Shulkin made clear in his testimony to this Committee on February 1, and has since repeated, the VA must explore expansion of the use of public-private partnerships to both address the increase in demand for access to healthcare and its limited ability to continuously build new infrastructure. Got Your 6 strongly agrees that more can be done to foster public-private partnerships to best meet the needs of veterans and encourages the Committee to consider innovative ways to utilize public-private partnerships as it relates to the future of care in the community.

Specifically, Got Your 6 is impressed by the depth and ingenuity of care and research currently being provided by the philanthropic community through networks such as the Cohen Veterans Network and the Marcus Institute for Brain Health. These philanthropic foundations discovered a need for evidence-based services specific to the signature wounds of the current conflicts, such as traumatic brain injury (TBI) and psychological health concerns. Located across the country, these networks have established extensive mental health care options for veterans and their families that recognize the importance of military competencies, evidence-based research, and reliable service.

These networks have also committed themselves to providing products highly sought after in both the



veteran and larger health care communities: data and knowledge. In addition to providing comprehensive care, these networks have included the exportation of knowledge as part of their mission. Leveraging more data, knowledge, and evidence will only strengthen the treatment options available and will foster more innovative treatment options as we all better understand the complexities of specialized care, particularly as it relates to the ever-evolving understanding of psychological health.

The work of such networks illustrates the need to explore the expansion of public-private partnerships as a way to best meet the needs of veterans. We encourage the Committee to better understand what the larger community is doing independent of VA to address the needs of veterans, explore ways to expand the use of public-private partnerships, and integrate the potential care provided by public-private partnerships into the future of care in the community.

Current Choice Funding Crisis

We applaud the Committee's determination to substantively discuss and legislate the future of non-VA care, but we also urge a quick resolution to the impending shortfall of funding for the Choice program.

As many leaders from the VA have made clear, failure to address the immediate funding shortfall could result in longer wait times, disruption in care, and layoffs at call centers - the exact issues Choice was created to address. To prevent these issues from coming to fruition, the VA has begun to shift carryover funds for Medical Services to the Choice account. However, this is not a sustainable solution and it grievously threatens the future stability of VA Medical Services at-large. Because of this, it is critical Congress find a means to sufficiently fund the Choice program at its increased demand load as soon as possible; and if a reasonable and responsible payfor can be found, Got Your 6 encourages the Committee to consider such offsets.

In addition to quickly securing necessary funding to ensure seamless access to adequate health care options for veterans, we also urge you to consider an in-depth audit of the management of the current Choice program. This audit should not be used or seen as a tool to diminish the work of the VA, but should aim to determine what practices or mechanisms led to this funding shortfall and what information the VA could be better equipped with to prevent funding shortfalls in the future.

In conclusion, Got Your 6 -- through our 34 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 when they return home -- is 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 status quo.

The veteran empowerment movement also strives to remember and advocate for the majority of veterans who do not use the VA. To that end, Got Your 6 continues to encourage this Committee to



consider holding a topical hearing on community programs and veteran organizations currently meeting the needs of and empowering veterans outside the walls of VA facilities.

We would like to thank this Committee for its leadership on veterans' issues and look forward to working together to empower all veterans.

PREPARED STATEMENT OF TOM PORTER, LEGISLATIVE DIRECTOR, IRAQ AND
AFGHANISTAN VETERANS OF AMERICA



Testimony by Tom Porter
before the
Senate Committee on Veterans' Affairs
July 11, 2017

Statement of Tom Porter
Legislative Director
of
Iraq and Afghanistan Veterans of America
before the
Senate Veterans Affairs Committee
hearing on
Pending Legislation

July 11, 2017

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

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, thank you for the opportunity to share our views on the legislation under consideration today. For thirteen years, IAVA has been the preferred empowerment organization for Post-9/11 veterans. IAVA's "Big 4" Policy Priorities for the 115th Congress are to Fully Recognize and Improve Services for Women Veterans, Defend Veterans Education Benefits—particularly the Post-9/11 GI Bill, reducing Military/Veteran Suicide, and reforming the VA.

This year, we have tackled women veterans issues head on by launching our **She Who Borne The Battle** campaign, a critical component of which is the *Deborah Sampson Act* (S. 681), by Sens. Tester and Boozman, to improve recognition and services for women veterans. We would also like to thank you for taking action to recently enact of the *VA Accountability and Whistleblower Protection Act* (P.L. No: 115-41) to provide strong tools to for Secretary Shulkin to bring accountability to his Department.

There are few issues more important to the healthy transition home for our generation of veterans than ensuring a veteran-centric, exceptional, and sustainable VA. Since passage of the *Veterans Access, Choice, and Accountability Act* in 2014 after the Phoenix VA scandal exposed similar problems with VA medical centers around the country, IAVA has worked with our VSO partners, the VA, and Congress to ensure that veterans have access to the timely and quality healthcare they deserve. We would like to thank Committee leaders, Sen. Crapo, and the VA for putting forth various proposals to get at the heart of this matter. Although they differ significantly in some respects, no one can doubt your sincerity and strong desire to make improvements in the lives of



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those who have served in uniform.

According to the VA, over 60% of post-9/11 veterans use VA health care. This is consistent with what we have seen from IAVA's most recent member survey, which informed us that 28% use VA exclusively, while another 38% use the VA in combination with another health care plan.

IAVA is also concerned about the massive investment in VA's still unproven Choice program. IAVA members have given Choice very mixed reviews in our annual survey. The President's budget calls for a \$28 billion increase to the VA Choice program over the next decade –15% of the funding overall. Yet only 20% of IAVA member survey respondents have actually used the program. Of those, only 37% rated the Choice program as above average/excellent, while 34% rated it as average and a concerning 28% rated it as below average/poor.

As more veterans return and as we face the challenges of physical and mental injuries, we need to know that the VA will deliver for us.

IAVA has testified previously that our members hope to see the VA offer an integrated network of care that provides timely access to high-quality, comprehensive, and veteran-centric care, that includes community providers led by 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 40-mile and 30-day standards are arbitrary access standards; Decisions about when and where vets can receive medical treatment should be clinical - between the veteran and his or her doctor.

VA provides a unique model of care, one that treats the physical, psychological, social and economic aspects of health; it can benefit from private sector support and the private sector can benefit from its unique model of care.

Because the Committee's discussion drafts have only been available for a very short time, IAVA strongly encourages SVAC to provide for a thorough and public review, through hearings and roundtable discussions of the various proposals,



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with participation by our VSO colleagues and VA leaders. Too much is at stake to rush consideration of these proposals and we must get this right.

Among the remaining legislation, I testified before this same Committee last Congress in support of Sen. Tester's *Grow Our Own Directive* and am pleased to once again. Currently, veterans who served in the medical field have the opportunity to work at the VA through the Intermediate Care Technicians Pilot Program, but they do not receive the additional training they need to advance their careers at the VA. S. 426 establishes a five-year pilot project to provide veterans with military medical specialties with the opportunity to attain the education and training needed to become a Physician Assistant at the VA.

Through passage of the *Grow Our Own Directive*, the VA will empower former military medical professionals to launch civilian careers as physicians assistants and increase the number of medical specialists at the VA.

IAVA has been active in calling for the scourge of military sexual assault to be eliminated, and we have also been strongly supportive of efforts to prohibit the sharing intimate images of others online without their consent. Currently, consistent with these challenges, IAVA supports the *Servicemembers and Veterans Empowerment and Support Act* (S. 833) to allow veterans and servicemembers who have been sexually harassed online to access VA counseling and benefits. Cyber sexual harassment victims are not currently eligible for these services. It is unfortunate that we have to have these discussions, but until we change the culture of how many in our military treat each other both online and in person, we will need to adjust our priorities to appropriately punish offenders and assist victims.

IAVA is also pleased to support for the *Veterans Treatment Court Improvement Act* (S. 946) to require the VA to hire additional Veterans Justice Outreach (VJO) specialists in order to ensure veterans have improved access to Veteran Courts and effective treatment. Veterans Courts provide enormous benefits both to veterans and the community. Those convicted through a Veterans Court are put through a rehabilitative program that often includes mental health support, and they avoid criminal sentences if they meet the requirements of the program. This provides veterans with a second chance, but also lowers recidivism rates and saves taxpayers money. Although the program has demonstrated success, the VA does not have enough VJOs to serve the needs of justice-involved veterans. Importantly, S. 946 helps to close this gap in capacity and IAVA encourages the bill's swift passage.

For the remaining bills being considered today, IAVA thanks the sponsors for their desire to address these matters and gaps in care, and we are looking



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forward to hearing the testimony by the VA and other witnesses on the need for these policy changes.

Finally, I would like to call attention to our soldiers, sailors, airmen, Marines, and Coast Guardsmen serving around the world, many in harm's way. Although America knows that our footprint in Iraq and Afghanistan has been significantly reduced, we are still in combat there and in new locations. Our post-9/11 conflicts may be in the rearview mirror to many, but they continue to be very up close and personal to those at the tip of the spear. THANK YOU to our servicemembers and military families for standing the watch. You can always know that we've got your back!

Thank you for your time and attention. IAVA is happy to answer any questions you may have.

PREPARED STATEMENT OF MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, 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 is grateful to the committee for holding this important hearing and for your tireless commitment to supporting our nation's servicemembers and veterans and their families.

This is a critical time for Secretary Shulkin as he leads the Department of Veterans Affairs (VA) in a massive effort to transform the agency for the 21st Century during a fiscally challenging time. MOAA believes many of the bills under consideration today will provide the secretary additional tools and resources he needs to further transform the agency's health and benefits systems and thus improve the health and well-being of our veterans and their families. MOAA looks forward to working with the members and staff to strengthen and improve the legislation before the committee to ensure laws can be enacted this year.

MOAA fully supports the following select bills:

- ***S. 115, Veterans Transplant Coverage Act***—would authorize the secretary to provide expanded donor care and services for veterans in need of a transplant procedure, before and after conducting the transplant procedure, to live donors not eligible for VA health care, in either a VA or non-VA medical facility
- ***S. 426, Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017***—would increase educational assistance provided by the VA for education and training, establish pay grades, and require competitive pay for physician assistants of the department
- ***S. 683, Keeping Our Commitment to Disabled Veterans Act of 2017***—would extend the requirement to provide nursing home care to certain veterans who have a service connected disability rated at 70 percent or greater or need nursing home care for their service-connected conditions, reauthorizing the current law which will expire on December 31, 2017
- ***S. 833, Servicemembers and Veterans Empowerment and Support Act of 2017***—would expand health care and benefits for victims of military sexual trauma and require the secretary to accept the diagnosis by a mental health professional with satisfactory lay or other evidence of such trauma as sufficient proof of service-connection
- ***S. 946, Veterans Treatment Court Improvement Act***—would require the secretary to hire additional veterans justice outreach specialists to provide treatment court services to veterans involved in the justice system

- *S. 1261, Veterans Emergency Room Relief Act*—would require the secretary to pay the reasonable costs of urgent care provided to certain veterans and would establish cost-sharing amounts for veterans receiving care at an emergency room of the VA

Discussion Draft Bills

Due to the urgency in replacing and reforming the Veterans Choice and VA community care programs, MOAA focuses our comments today on two discussion draft bills, the *Veterans Choice Act of 2017* and *Improving Veterans Access to Community Care Act of 2017*, as these are paramount issues requiring immediate attention by Congress this fiscal year.

MOAA thanks the chairman and ranking member for their leadership and tireless efforts over the last three years to improve access and quality of medical care and services in the VA Health Administration (VHA) through ongoing hearings, roundtables, and collaboration with Veteran Service Organizations (VSOs) like MOAA, and the department to ensure the long term viability of the system so veterans get the best care possible.

While MOAA supports both bills in principle, we offer the following comments and recommendations to build upon the significant work put forth in this legislation as well as what has been learned from the work of VA Commission on Care and the lessons learned from implementing Choice, and the earlier PC3 (Patient-Centered Community Care) and pilot Project ARCH (Access Received Closer to Home) non-VA or private provider programs.

General Comments

- **Veterans Choice Act of 2017**—would permit all veterans enrolled in the VA health system to receive health care from non-department health care providers
 - **Attributes**
 - Expands access to care in the community and establishes an integrated network of care, combining VA and non-VA resources
 - Allows veterans the choice whether to receive care in VA or in the community
 - Requires VA to assign a dedicated primary care provider to each veteran, but veterans have the option to choose a provider
 - Seeks to expedite establishing a more robust community care program, recognizing Choice and existing community care programs are insufficient to meet current and future health care demand
 - Expands the VA provider network to include participating providers in the Medicare program, Department of Defense (DoD), Indian Health Service, and other federally-qualified health professionals
 - Permits VA to pay the same rates for care under the Medicare program to contract providers and adjust rates for veterans residing in highly rural areas
 - Directs VA to be the primary payer for non-VA care and restricts providers from seeking payment from veterans receiving care
 - Establishes requirements for prompt payment to providers and timelines for claims processing and reimbursements
 - Allows VA to enter into agreements with State homes to provide nursing home care, removing current restrictive federal contracting requirements

- Requires the VA to establish and update annually a strategic plan that will forecast health care capacity, capabilities and demand across the system
 - Establishes requirements for procurement of an off-the-shelf electronic health record (EHR) platform that conforms to standards of interoperability with the DoD's EHR and is accessible by multiple providers
 - **Concerns**
 - Significant costs associated with permitting all enrolled veterans to receive health care from non-VA providers
 - Must ensure contracted health care organizations or third-party administrators do not assume critical core responsibilities which may erode VA's ability to oversee and effectively manage customer service and coordination of veterans care
 - Quality of care not listed as a reporting requirement for monitoring care furnished through provider networks
 - Provisions are numerous and highly complex requiring VA to have the necessary funding, resources, and flexibility to successfully implement
 - Reporting requirements may be burdensome and/or impractical in some cases for VA to meet some deadlines (e.g., "Not later than 120 days after the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a strategic plan that specifies a 5-year forecast..."[Page 40, (3)(b)(1)])
- **Improving Veterans Access to Community Care Act of 2017**—would establish the Veterans Community Care Program in the VA to improve health care provided to veterans by the department
 - **Attributes**
 - Expands access to care in the community and establishes an integrated network of care, combining VA and non-VA care
 - Allows veterans the choice whether to receive care in VA or in the community
 - Requires VA to coordinate non-VA care
 - Establishes clinical necessity as one of several factors, including wait time, driving distance, unusual or excessive burden for accessing care, availability of care, and other conditions for determining eligibility
 - Establishes an appeals process for disagreements between the veteran and the VA provider
 - Expands the VA provider network to include participating providers in the Medicare program, DoD, Indian Health Service, and other federally-qualified health professionals
 - Permits VA to negotiate rates for furnishing care as well as to pay the same rates under the Medicare program, to incorporate value-based reimbursement models to promote high quality care, and to adjust rates for veterans residing in highly rural areas
 - Requires VA to provide information to a veteran about availability of care and services at the time of enrollment and at the time eligible, or when the veteran may be eligible for hospital or medical care
 - Establishes requirements for prompt payment to providers, timelines and accuracy goals for claims processing and reimbursements

- Seeks to consolidate all VA community care programs, including Choice into a single, consolidated program funded through discretionary medical services funding rather than funding through a combination of mandatory and discretionary accounts as is currently the case
- Requires VA to conduct an analysis of commercially available technology and submit a report to Congress before procuring, designing, or building an electronic interface system for claims processing and reimbursement
- Provides protections for veterans if disability or death resulted from care furnished by a VA network provider
- Directs VA to be the primary payer for non-VA care and restricts providers from seeking payment from veterans receiving care
- Requires VA to establish a system or systems for monitoring quality of care and services furnished by eligible providers in the network
- Allows VA to enter into agreements with State homes to provide nursing home care, removing current restrictive federal contracting requirements
- **Concerns**
 - Significant costs associated with expanding VA network and access to community providers
 - Provisions are numerous and highly complex requiring VA to have the necessary funding, resources, and flexibility to successfully implement
 - Allowing VA to consider multiple factors for determining veteran eligibility for accessing community care (clinical necessity, wait time, driving distance, unusual or excessive burden, availability of care, etc.) adds more complexity in administration and execution, and will likely result in creating more confusion for providers, veterans and VA employees than the current Choice program

Recommendations

Both the *Veterans Choice Act of 2017* and *Improving Veterans Access to Community Care Act of 2017* draft bills have a significant number of provisions which would result in positive improvements to the current health system. However, without the requisite funding, resources and commitment from Congress to support this legislation and/or any reform efforts, including VA's Veterans CARE (Coordinated, Access and Rewarding Experiences) plan will only place additional pressures on an already fiscally constrained system, resulting in further fragmentation of the system, and ultimately limiting veterans' access to care—outcomes opposite from what Congress and VA intends to achieve.

MOAA, like many of our VSO and military service organization colleagues have been working closely with VA, the Commission on Care and Congress to transform VHA and develop a plan to replace Choice and reform and consolidate VA community care programs.

A tremendous amount of progress has been made by the Secretary and his team, and a great deal of recommendations have come out of the hard work of the Commission on Care and the important and thoughtful work of our Independent Budget (IB) partners (Disabled American Veterans, Paralyzed Veterans of America and the Veterans of Foreign Wars) in producing *A Framework for Veterans Health Care Reform* which parallels much of the work the VA has undertaken.

VA is close to submitting its Veterans CARE plan to Congress. MOAA believes VA's plan supports many of the provisions outlined in the two draft discussion bills and includes many other provisions Congress should also consider as part of its deliberations on VA community care and VHA health reform.

Regardless of what legislation is passed or what the system of care will look like in the future, MOAA believe the key elements of a health system veterans and their families and caregivers value most include high quality, accessible, comprehensive, integrated, and veteran-centric—a system that is simple, easy to both understand and navigate, and is seamless, whether care is delivered in-house or in the community.

In a June 28, 2017 letter to the Senate and House Veterans' Affairs Committees, MOAA, along with eight other VSOs urged Congress to not only address the current Choice and community care funding crisis through emergency funding and authorization but to also remain focused on moving beyond the flawed Choice program as soon as practical.

Specifically, MOAA and VSOs recommend Congress:

- *Work with VSOs, the Secretary and other critical stakeholders to design and implement a new paradigm for veterans' health care built around an integrated network, with a modernized VA serving as the coordinator and primary provider of care, and community providers addressing the remaining gaps in access and services.*
- *Consolidate all community care programs through a single unified discretionary funding source that includes flexibility and accountability to assure VA can deliver the highest quality of care in the most appropriate clinical settings within the network.*

Further, MOAA recommends Congress:

- *Preserve VHA's critical missions of care which include clinical, training, research and emergency response, all essential pillars to delivering high quality health care to veterans.*
- *VA must retain existing special-emphasis resources and specialty care expertise such as spinal cord injury, blind rehabilitation, mental health, prosthetics, etc.*

MOAA thanks the committee for considering this important legislation and for your continued support of our veterans and their families.

PREPARED STATEMENT OF MAX STIER, PRESIDENT AND CEO,
PARTNERSHIP FOR PUBLIC SERVICE



Chairman Isakson, Ranking Member Tester, members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to submit a statement for the record on the critical healthcare legislation pending before this Committee today. I am Max Stier, President and CEO of the Partnership for Public Service, a nonpartisan, nonprofit organization dedicated to making government more effective for the American people. I am pleased to express my organization's strong support for S. 1325, the *Better Workforce for Veterans Act*, which will improve the authorities of the Department of Veterans Affairs (VA) to hire, recruit, train, and retain the mission-critical talent necessary to meet the healthcare needs of veterans, and thank Ranking Member Tester for his commitment to strengthening the VA's workforce.

The persistent challenges VA faces in filling mission-critical vacancies require strong congressional engagement, and so this Committee deserves credit for the focus it has given to the talent needs of the Department. Despite efforts on the part of VA to fill vacant positions, it remains significantly understaffed. Earlier this year, Secretary Shulkin reported that the Department had 49,300 vacancies, with 45,000 in clinical positions.¹ These vacancies have a real impact at the facility level where veterans receive care. In the Central Arkansas Veterans Affairs Healthcare System, for example, 140 unfilled nursing positions lead to longer hours and more work for nurses on staff and greater difficulty in providing high-quality care to patients.² The employees of the VA seem to agree that the Department is struggling to recruit and hire effectively: less than half agree that their work unit can recruit people with the right skills, while only about fifty-two percent believe that the skill level in their work unit has improved over the past year.³ According to the Partnership's 2016 *Best Places to Work in the Federal Government Rankings*[®], VA was ranked just twelfth out of 18 large agencies in the "Strategic Management" category, which measures whether management is successful at hiring new employees with the necessary skills to help the organization.⁴ Getting good talent and holding employees accountable for results is the key to organizational and mission success. The *Better Workforce for Veterans Act* represents an important step towards reducing staffing shortages and ensuring that the Department has the personnel authorities it needs to manage its talent effectively and achieve its mission.

In the Partnership's view, the challenges VA faces in recruiting, hiring and retaining talent are the result of the complex, burdensome, and outdated federal civil service system under which it operates. The current civilian personnel system dates back to 1949 and largely disconnects the federal workforce from the larger talent market for knowledge-based professional jobs, a problem very apparent at VA. In 2014, the Partnership issued a report that identified many of the challenges created by the government's personnel system and recommended significant, wide-ranging reforms that would empower both agencies and employees to meet their missions.⁵ The Commission on Care similarly found that the federal civil service system was to blame for VHA's staffing shortages.⁶ The government's personnel rules should not

¹ Ogrysko, Nicole. "Shulkin to Release 'State of VA' Report Amid Reorganization Efforts." *Federal News Radio*, 3 May 2017, <https://federalnewsradio.com/veterans-affairs/2017/05/shulkin-to-release-state-of-va-report-amid-reorganization-efforts/>.

² Wentling, Nikki. "Staffing Shortages in Arkansas a 'Snapshot' of VA Hiring Problems." *Stars and Stripes*, 30 June 2017, <https://www.stripes.com/news/veterans/staffing-shortages-in-arkansas-a-snapshot-of-va-hiring-problems-1.476135#.WWPUgljyuUk>.

³ "2016 Federal Employee Viewpoint Survey." *U.S. Office of Personnel Management*, 2016, <https://www.fedview.opm.gov/>.

⁴ Partnership for Public Service. "Strategic Management." *Best Places to Work*, 2017, http://bestplacestowork.org/BPTW/rankings/categories/large/management_16.

⁵ "Building Enterprise: A New Civil Service Framework." *Partnership for Public Service* with Booz Allen Hamilton, April 2014, <http://ourpublicservice.org/publications/viewcontentdetails.php?id=18>.

⁶ "Commission on Care Final Report." *Commission on Care*, 30 June 2016, p. 139.

stand in the way of the ability of agencies like VA to get the talent they need, but rather help the organization do so. Though government-wide reform is outside of the Committee's jurisdiction, many of the past reforms authored by this Committee have become templates for changes proposed elsewhere in government. I would, therefore, encourage you to think about these ideas both in the context of the Department of Veterans Affairs and in terms of the broader influence they might have on future reforms across the federal enterprise.

S.1325 Gives VA More Flexibility to Manage Talent, Improves the Quality of Personnel Data for Decision-Making, and Holds Leaders Accountable for Effective Workforce Management

The *Better Workforce for Veterans Act* would help to address VA's talent challenges in three key ways: the bill gives the Department more flexibility to manage its talent, requires that it collect better workforce data to enhance decision-making, and holds leaders accountable for recruiting, hiring, training, engaging, and retaining mission-critical employees.

Authority to flexibly manage the workforce and hire mission-critical talent when and where it is needed is essential for the VA to meet its obligation to veterans. The legislation the Committee is discussing today would provide this flexibility in several ways. The *Better Workforce for Veterans Act* would make it easier for the Department to rehire qualified former federal employees who may have gained additional valuable experience during their time away from VA and require it to accept resumes in the initial stages of the hiring process for senior executives. The bill would also make it easier for the VA to make use of government-wide direct hire authority and allow the Department to directly appoint highly qualified recent graduates and post-secondary students, groups that are typically disadvantaged by the traditional hiring process, to positions within the Department. Given that under six percent of the VA workforce is below the age of 30, this is a badly-needed reform that will help the Department build a pipeline of talent for the future.⁷ S.1325 would also allow VA to offer market-sensitive pay to Veterans Integrated Service Network (VISN) and medical center directors, giving the Department more flexibility in efforts to recruit senior leaders who play a key role in ensuring that VA manages facilities efficiently and effectively. Should this legislation be enacted into law, it will be critical for the Committee to conduct continued oversight of the Department's implementation of these authorities to ensure that they are effectively used to reduce staffing shortages and recruit mission-critical talent.

The *Better Workforce for Veterans Act* would also require the VA to collect and report more information about the state of its workforce. It is a well-known axiom of good management that an organization cannot manage what it does not measure, and this is just as true at the Department of Veterans Affairs as it is elsewhere. GAO and others have found that the decentralized nature of the Department's HR structure and long-standing IT challenges have hindered its ability to effectively measure, collect, and report key people metrics needed to address both facility-level and organization-wide talent issues.⁸ The Department's HR systems simply are not built to centralize information, with personnel databases scattered across facilities in sometimes incompatible formats. S.1325 will push VA to gather more data and put it to better use by requiring the collection of agency-wide data on hiring effectiveness. It will also allow the broad reporting of exit survey data, which gives medical center and VISN leaders greater

https://www.stripes.com/polopoly_fs/1.417785.1467828140!/menu/standard/file/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

⁷ U.S. Office of Personnel Management. FedScope: Federal Human Resources Data, 2017, <https://www.fedscope.opm.gov/>.

⁸ Government Accountability Office. "Veterans Health Administration: Management Attention is needed to Address Systemic, Long-Standing Human Capital Challenges." GAO Publication No. 17-30, December 2016, p. 29, <https://www.gao.gov/assets/690/681805.pdf>.

visibility into the state of their workforces and insight into how they can address persistent talent issues. The VA's Directive 5006, issued in 2003, required the Department to conduct exit surveys of separating employees, but it is unclear to what extent facilities are consistently collecting this data or how the organization shares it with leaders at the individual facility level, making the requirement for mandatory exit surveys all the more important. The bill also requires the Department to develop a plan to modernize its IT systems for employee performance management and to report on vacancies in mission-critical fields, like nursing. Though there will be a cost associated with setting up systems capable of gathering and reporting this information, it should be considered an investment in strengthening the VA workforce and providing improved services to veterans. This information, taken together, should provide the VA, Congress, and veterans with a complete picture of the areas in which the Department is struggling and how it can improve, as well as where to direct future reform efforts.

Finally, S.1325 will hold leaders in the VA, especially human resources leaders, accountable for effective workforce management. The fact that VA has managed to fill many positions and, in particular, to greatly reduce the number of vacancies at the medical center and VISN leadership level, illustrates the commitment of the organization to addressing workforce gaps. However, persistent vacancies demonstrate that VA can and should do more. VA's leaders need to be empowered to get results and then held accountable for achieving them. I believe this legislation will do so by clarifying lines of authority in the Department's human resources management, where day-to-day program and policy implementation happens at the facility and VISN level, rather than at the central office. Though this model provides flexibility, it also makes it harder to get things done. Media stories have noted how even policies pushed directly by the Secretary "at times have taken months to be enacted – if they even get implemented at all."⁹ Empowering the leaders with visibility over the entire VA and VHA human resources enterprise, like the Assistant Secretary for Human Resources and Administration and Deputy Under Secretary for Health for Workforce Services, to hold medical center HR leaders accountable for results and drive change can help improve the way the organization's HR function does its work. The bill also requires the organization to provide training and assess the competency of HR specialists on available recruitment, hiring, and personnel authorities, and certify that employees have met the training requirements and understand the material. While VA does have robust training resources available, GAO recently noted that many of VA's HR specialists do not feel that they have the time or bandwidth to take advantage of them.¹⁰ In implementing this legislation, the Department must work to ensure that employees can invest in training, whether that is by prioritizing filling vacant HR positions or reprioritizing current training requirements. S. 1325 further improves accountability by requiring the Department to reorder how it implements future reductions-in-force by raising the priority of performance while still respecting employee tenure and veterans preference. This reform will help recognize high performers in the unfortunate event that a reduction-in-force occurs and follows a similar effort by the Senate Committee on Armed Services and the Department of Defense last year. With these new requirements and authorities in place, the Committee should expect and demand real improvements in the way the Department's HR function operates.

Conclusion

Chairman Isakson, Ranking Member Tester, and members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to express our strong support for S.1325, the *Better Workforce for Veterans Act*. The ability of the Department of Veterans Affairs to meet its solemn obligation to those who have served our country requires a highly-trained, highly-engaged workforce and an organization that can recruit, hire and retain the best and brightest. In the Partnership's view, that is what this legislation will help the Department do. Thank you for your efforts on the part of the Department, its employees, and veterans. I urge the Committee to report the bill to the full Senate and encourage Congress to pass it quickly.

⁹ Slack, Donovan. "VA Still in Critical Condition, Secretary David Shulkin Says." *USA Today*, 1 June 2017, <https://www.usatoday.com/story/news/politics/2017/05/31/veterans-affairs-secretary-david-shulkin-state-of-va/102333422/>.

¹⁰ Government Accountability Office. "Veterans Health Administration: Management Attention is needed to Address Systemic, Long-Standing Human Capital Challenges." GAO Publication No. 17-30, December 2016, p. 26, <https://www.gao.gov/assets/690/681805.pdf>.

PREPARED STATEMENT OF URGENT CARE ASSOCIATION OF AMERICA

**Urgent Care Association of America**

Statement Submitted to the United States Senate Committee on Veterans' Affairs
 Hearing on Pending Health Care Legislation
 July 11, 2017

The Urgent Care Association of America (UCAOA) and its members applaud Senator Bill Cassidy's introduction of the Veterans Emergency Room Relief Act of 2017 (S. 1261) and appreciate the consideration of this legislation by the U.S. Senate Committee on Veterans' Affairs. If enacted, this legislation will provide relief to the Department of Veterans Affairs' (VA) overburdened health care system and establish urgent care centers as an important health care access point for our nation's veterans.

The UCAOA represents an industry of nearly 7,400 urgent care centers throughout the United States. Urgent care centers play a dominant and important integrative role in health care communities across the country and are uniquely positioned to help address the significant health care access issues facing our nation's veterans.

Urgent care centers have the capacity to care for veterans in the communities where they live. Veterans in need of urgent care are oftentimes unable to access a primary care physician or VA facility in a timely manner and are seeking care in hospital emergency departments, oftentimes unexpectedly finding themselves responsible for the cost of that care.

This legislation would provide veterans access to urgent care centers for non-emergent health care needs, such as lacerations and broken bones that need immediate attention, as well as other common illnesses and injuries that can worsen if left untreated or are not addressed in a timely manner.

The VA has highlighted the essential need to partner with providers in communities across the country to meet the steep increase in demand for care for veterans. Not only will the Veterans Emergency Room Relief Act serve to help meet the health care needs of veterans, but it has the potential to reduce health care costs to the VA system.

UCAOA believes it is important for all veterans to have a regular source of health care. Access to urgent care in the community should be used as appropriate and not as a substitute for a patient's medical home. Co-management with the patient's dedicated primary care provider is a central tenet of urgent care delivery. UCAOA's member surveys have shown that urgent care centers serve a crucial nexus for the American health care system, ensuring patients are referred to a necessary source of primary and preventive care.

The Veterans Emergency Room Relief Act of 2017 is an important step toward ensuring that our nation's veterans receive the highest level of quality, timely health care. UCAOA members thank the members of the U.S. Senate Committee on Veterans' Affairs for their consideration of this important legislation.

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PREPARED STATEMENT OF RUBINA DASILVA, MBA, PA-C, PRESIDENT, VETERANS
 AFFAIRS PHYSICIAN ASSISTANT ASSOCIATION

CHAIRMAN ISAKSON, RANKING MEMBER; SENATOR TESTER AND OTHER MEMBERS OF THE SENATE VETERANS' AFFAIRS COMMITTEE, On behalf of the entire membership of the Veterans Affairs Physician Assistant Association (VAPAA) we appreciate the invitation to submit this testimony for the record. We thank bipartisan Members of this Committee for critical legislation for Physician Assistant (PA) Workforce issues

before you today in the VA System with sponsoring “Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017.” (S. 426) and we thank Senator Tester for his leadership on this bill.

The Physician Assistant (PA) profession has a special unique relationship with veterans. The very first classes of physician assistants to graduate from PA educational programs were all former Navy corpsmen and Army medics who served in the Vietnam War and wanted to apply their knowledge and experience in a civilian role in 1967. Today, there are approximately 2,178 PAs employed by the Department of Veterans Affairs (VA), making the VA the largest single Federal employer of PAs. These PAs provide high quality, cost effective quality health care working in hundreds of VA medical centers and outpatient clinics, providing medical care to thousands of veterans each year in their clinics. Physician Assistants work in Primary Care and Lead PACT teams of nursing, pharmacist, social workers, dieticians, and rehabilitation services.

The Veterans Affairs Physician Assistant Association (VAPAA) maintains that Physician Assistants are a critical component of improving VA health-care delivery, and have consistently recommended that VHA include them in all health-care national strategy staffing policy plans. PAs have remained on the OIG Top Ten critical occupation 2015 and 2016 tied at number 3 and have remained a top ten critical occupation on the Workforce Succession Planning from 2010 –2016. The occupation 0603 Physician Assistant—there were 640 vacancies, representing a 23% vacancy rate.

In 1990, VA turnover for registered nurses was 20%, because of continued problems, Congress enacted the Nurse Pay Act of 1990 (Public Law 101–366) requiring VA to establish a locality pay system for nurse. The acts primary intent was to make VA salary rate competitive with those in the private sector health care facilities in the same communities. VA implemented the locality pay system on April 7, 1991, about 8 months later after the passage of the act.

Workforce Management Consultant (WMC) in 2016 stated that Converting Physician Assistant (PA) pay structure to the Nurse Locality Pay System (LPS): “it is unknown if converting Physician Assistants to the Nurse Locality Pay System will improve recruitment and retention at those facilities.” This, despite acknowledging that Congress and VA enacted the Nurse Pay Act of 1990 (Public Law 101–366) for a vacancy rate of 20% for nurses.

VA WMC acknowledge the recommendation to convert PAs to the nurse Locality Pay System (LPS) was incorporated in VHA’s 2015 Strategic Workforce Plan and that the Secretary has the authority to place PAs on the LPS—but USH and Secretary have not done so, thus continuing the problems with recruitment and retention of PAs which directly impacts access to veteran care.

On April 20, 2016, Dr. McCarthy Assistant Deputy under Secretary for Health for Patient Care Services Veterans Health Administration testified:

The PA occupation has been a difficult to recruit and retain occupation for several years. A major barrier to recruitment and retention of physician assistants is the significant pay disparity between private sector market pay and VA pay schedules for PAs. Although Special Pay rate authority exists at the medical center level to address these disparities, **it is antiquated and vastly underutilized.** Salary surveys performed during FY 2015 by several VA medical facilities has resulted in establishment or adjustment in local special salary rates for the PA occupation resulting in significant increases in salaries. This is an indication of the existing salary disparity overall. Including the PA occupation as a covered occupation under the Locality Pay System in VA would be an important element in addressing recruitment and retention difficulties.

Not including PAs in the LPS is an unsuccessful business and medical model for the VA as is it eliminating one third of its applicant pool that can provide care to veterans; it is creating an artificial and sustaining staffing shortage which is limiting Veteran access to care.

Costs such as recruitment, retention, relocation, bonuses, scholarships, employing locum tenens, and locality pay are substantially increased with higher overhead for two profession vs three self-sustaining professions—Physicians, PAs and NPs.

WMC (Workforce Management) rebuts that giving nurse locality to PAs, then VA is obligated to give LPS to every profession. If Congress or VA gives podiatry locality it only helps the recruitment of podiatrist. If locality is given to PA’s it will improve recruitment and retention of PA while increasing access to veterans in all VHA facilities and CBOCs within VHA as PAs carry their own veteran panels and practice in all areas of medicine. They work in both ambulatory care clinics, emergency medicine, CBOC’s in rural health, and in a wide variety of other medical and surgical

subspecialties including mental health, Women's Health, Compensation and Pension, Rehabilitation Services, Medical Home, Cardiology, Gastroenterology, Orthopedics, Dermatology, Rheumatology, Endocrinology, Emergency Services, Hospitalists, Intensivist, ENT, Radiology, Nuclear Medicine, Urology, Occupational Medicine, Renal, General Surgery, Cardiothoracic Surgery, Home Based Primary Care (HBPC), Community Living Centers, VHA Nursing Home

In the VA system about a quarter of all primary care patients treated are seen by a PA1. Approximately 33% of PAs today employed by VHA are veterans, retired military, or currently serving in the National Guard and Reserves.

Not one profession; Physician, PA or NP can sustain a local workforce as the VHA must compete with the private sector as the local demand recruits each profession which creates a delay in veteran access.

It is only within the VA that you see the disparity of VHA PA pay and the private sector pay. Large health care systems such as Kaiser Permanente, Mayo, and Cleveland clinic have competitive salary.

The 2015 Workforce Succession Planning Report showed that 12 out of the 22 VISN (85 main facilities not including respective CBOCs) stated that the reason they could not hire PAs was because they could not compete with the private sector. These VISNs had in their plan to conduct salary surveys to seek parity with private sector. However, upon recent review from 1/2014–2/2015 of submissions for PA special salary rates to VA Compensation Office, less than 8% submitted such requests.

July 2017 review of facilities submitting Special Salary Adjustments (SSA) have shown that the pay disparity between VHA PA pay was an average of 18% below local market pay with the highest being 34%. The data further supported facilities that sought out special pay rates were then able to immediately fill all positions which resolved the difficulty recruiting PAs. This demonstrates the strong correlation between seeking parity with the private sector and hiring hard to recruit PA positions within VHA.

The PA workforce has grown far less than other medical provider positions within the VHA, very little is being done about it; therefore, what should be a warning signal of serious retention and recruiting problems is being left to local VAMCs to manage. Despite increasing discrepancy in salary levels, benefits, and education debt reduction programs between the civilian sector and the VAMCs often tells our members there is no problem. Inclusion of Physician Assistants into the Nurse LPS within Grow Our Own Directive S. 426 will allow for salary adjustments so that the VHA can be competitive.

VAPAA is also concerned that the use of recruitment incentives within the VA is at the discretion of the hiring facility and is not standardized across the VA system. During 2012–2013 only 44 Physician Assistants have received \$319,074 in funding to further their education in comparison to Seven hundred five registered nurses seeking to become Nurse Practitioners receiving scholarship awards totaling over \$11,842,919 in support of NPs and NP programs. VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program by including PA as a hard to recruit occupation at the facility level to reflect WSP and OIG findings. Include Employee Debt Reduction Program funding to include PAs and make it available to all advertised PA vacancy announcements as EDRP cannot be issued unless it is advertised in the initial vacancy announcement. VISN and VA medical center directors must be held accountable for the failure to utilize these recruiting tools.

S. 426 also provides another solution for meeting the healthcare workforce challenges while providing support to unemployed Post-9/11 combat veterans and a career path for returning veterans who had served as medics and corpsmen with combat medical skills; like those of returning Vietnam War veterans with these skills. This legislation takes veterans with medical and military experience and provides them with educational assistance to become certified PAs for employment at the VA, where they can continue to serve their fellow veterans.

By serving where the VA needs are the greatest, the veteran PAs can increase access to care by serving in rural and underserved areas.

Recommendations: We ask that the Committee recognize the advantages to the Recruitment and Retention of Physician Assistant (PA) Workforce in the VA System by supporting enactment and supported by the veteran service organizations at the November 18, 2015 hearing on S. 2134 and call attention the VHA witness Dr. Carolyn McCarthy testified in favor of this legislation "Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015." (S. 2134) and (H.R. 3974).

A. Restructure VHA Handbook 1020—*Employee Incentive Scholarship Program (EISP)*.

B. Include PAs at all facility level to reflect Workforce Succession Planning and the OIG Top 5 as a hard to recruit occupation as this is the qualifying factor for EISP funding.

C. Include Education Debt Reduction Plan in all PA job postings.

D. Include targeted scholarships for the ICT program OIF OEF Grow Our Own returning veterans, and mandate VHA shall appoint PA ICT National director to coordinate the educational assistance necessary and be liaison with PA university programs.

E. S. 426 would direct new Physician Assistant director position to work within the National Healthcare Recruiter, Workforce Management & Consulting VHA Healthcare Recruitment & Marketing Office.

a. This position then can develop targeted recruiting plans with 187 PA programs, working in a way that the local Human Resource Officer (HRO) often will not; due to lack of staffing.

F. The VA employed PA national Healthcare Recruiter would develop improvements in finding qualified candidate in a matter of days not months.

G. VHA must incorporate new PA consultant manager into this National Healthcare Workforce program office.

H. *Health Professional Scholarship Program.*—The Health Professional Scholarship Program (HPSP) provides scholarships to students receiving education or training in a direct or indirect health care services discipline. Awards are offered on a competitive basis and are exempt from Federal taxation. In exchange for the award, scholarship program participants agree to a service obligation in a VA health care facility. The Committee believes strongly that ample resources exist within the Department to ensure that hard to fill Top 5 OIG occupations are not excluded from participation.

I. *Establish PA Pay Grades I-V*, to continue be competitive with the civilian job market

CONCLUSION

Chairman Isakson and Ranking Member Senator Tester, and other Members of SVAC, as you strive to ensure that all veterans receive timely access to quality healthcare and as you build increased capacity for delivery of accessible high-quality health care, and demand more accountability into the VA health care system, I strongly urge the full Committee to review the important critical role of the PA profession and ensure legislatively that VHA takes immediate steps to address these longstanding problems and continue to work with VAPAA in supporting our Nation's veterans.

PREPARED STATEMENT OF CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

CHAIRMAN ISAKSON, RANKING MEMBER TESTER 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, I would like to thank you for the opportunity to testify on today's pending legislation.

S. 115, VETERANS TRANSPLANT COVERAGE ACT

This legislation would authorize the Department of Veterans Affairs (VA) to provide live donor transplants to veterans eligible for VA health care regardless of the live donor's eligibility for care at VA. Currently, VA provides care to non-veterans who fall under one or more of the eight categories in which they are authorized to provide medical coverage. These categories range from survivors and dependents of certain veterans, newborn children of women veterans and in cases of humanitarian care.

By authorizing VA to perform medical care on non-veteran live donors in situations of medically necessary transplants for veterans, more veterans will be able to obtain lifesaving surgery in a timelier manner. The VFW strongly supports this legislation.

S. 426, GROW OUR OWN DIRECTIVE: PHYSICIAN ASSISTANT EMPLOYMENT AND EDUCATION ACT OF 2017

This legislation would build on the success of the Intermediate Care Technician (ICT) pilot program. Launched in December 2012, the ICT pilot program recruited transitioning veterans who served as medics or corpsmen in the military to work in VA emergency departments as intermediate care technicians. The ICT program

offered transitioning medics and corpsmen, who have extensive combat medicine experience and training, the opportunity to provide clinical support for VA health care providers without requiring them to undergo additional academic preparation.

This legislation would go a step further by affording transitioning medics and corpsmen the opportunity to become physician assistants. With the continued draw-down of military personnel, more medics and corpsmen will be leaving military service and transitioning into the civilian workforce. The VFW strongly supports efforts to leverage their medical knowledge and experience to meet the health care needs of our Nation's veterans.

S. 683, KEEPING OUR COMMITMENT TO DISABLED VETERANS ACT OF 2017

This legislation would extend, for one year, the requirement for VA to provide nursing home care to certain veterans with service-connected disabilities.

As the veteran population continues to age, the need for nursing home care continues to rise. Nursing home care within VA is considered the "safety net" for their outpatient services such as residential care, respite care, hospital-based home care, adult day health care, homemaker/home health aide services and other extended care programs. Yet the eligibility requirements for nursing home care and inpatient hospital care are inconsistent with standard medical practice and do not support continuity of care for veterans.

The VFW supports the intent of this legislation, but believes a standard for VA nursing home entitlement must be established for all veterans—not just veterans with a disability rating of 70 percent or higher.

S. 833, SERVICEMEMBERS AND VETERANS EMPOWERMENT AND SUPPORT ACT OF 2017

This legislation would expand health care and benefits from VA for veteran survivors of sexual trauma. While the VFW agrees with the intent of this legislation, there are concerns as well. The VFW strongly supports the expansion of coverage to include survivors of cyber harassment. As technological capabilities have continued expanding and becoming more accessible, many have fallen victim to sexual harassment and assaults of a sexual nature on the Internet and by other technological means. Survivors of cyber harassment should not fall victim again by being pushed to the wayside due to legal definitions not being inclusive of them. Regardless if an individual is sexually harassed or assaulted in a physical nature, or by means of technology, they deserve the right to seek counseling and treatment.

Section 2 would also expand the population who can use VA for counseling and treatment beyond the current restriction of only those who were assaulted while serving on active duty. It is the duty of Congress and VA to take care of every veteran who served, regardless of their duty status.

The VFW supports codifying the standard of proof for sexual trauma, as current law only regulates combat veterans. Yet, there are concerns with some portions of this section. Some inconsistencies can be found throughout section 3, which begins by saying it is covering all veterans making a claim of "a covered mental health condition" either due to, or aggravated by, military sexual trauma (MST). While this term is later defined, further into section 3 there are inconsistencies where only Post Traumatic Stress Disorder is referenced for the nonmilitary sources of evidence, as well as under the notice and opportunity to supply evidence portion.

The VFW has long advocated for nonmilitary sources of evidence to be able to be used by veterans filing disability claims with VA. Particularly for MST claims, as survivors may not have felt comfortable talking with military law enforcement, medical personnel or their commands. By expanding what veterans can submit as evidence for MST claims, to include records for non-military law enforcement, rape crisis centers, physicians and statements from others, this would greatly reduce the barriers of proof for survivors seeking treatment through VA. Yet, the VFW is concerned that by saying the Secretary shall accept nonmilitary evidence, but also saying the Secretary may seek a credible opinion during the review of evidence, will contradict and further complicate the benefits of allowing outside evidence.

This legislation would also expand notifications of opportunity to supply evidence for disability claims. The VFW is concerned that by providing veterans submitting MST claims the opportunity to submit more evidence after a claim is submitted, and before the Secretary is able to deny the claim, will create a double standard. While the VFW supports improving the disability claims process for veterans claiming MST, providing them a benefit others do not have in their claims process would be unfair to other veterans. There should be equity for all veterans in not just health care, but in benefits and applications as well.

This legislation would also require reports on claims for disabilities incurred or aggravated by military sexual trauma. One of the reporting requirements would be

a description of training that the Secretary provides to employees of the Veterans Benefits Administration. The VFW believes this reporting requirement should not be limited to strictly employees, but should also include contractors and affiliates of the Veterans Benefits Administration. This would include contract physicians' compensation and pension exams, as well as Veteran Service Organizations assisting in benefit claims.

The VFW supports section 4, which would ensure Sexual Assault Response Coordinators (SARCs) from the Department of Defense advise members of the Armed Forces reporting instances of sexual assault or harassment that they are eligible for services at Vet Centers. The VFW would like to see this section expand to ensure this information is provided during sexual assault awareness training as well as incorporated into training for the Sexual Assault Prevention Response Office.

S. 946, VETERANS TREATMENT COURT IMPROVEMENT ACT OF 2017

The VFW supports this legislation, which would require VA to hire 50 additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved veterans. These specialists serve as an invaluable asset in ensuring the VJO program helps veterans avoid unnecessary criminalization of mental illness and receive treatment in lieu of incarceration.

Outreach specialists for VJO make sure veterans within the program have access to VA services, provide outreach, and handle case management for justice-involved veterans. By requiring VA to not allow their number of employed VJO Specialists to go lower than the number currently within the system the day this legislation would go into effect, as well as increasing that number by 50, more veterans in need of assistance and guidance through this unique and live-saving program will have access to Veteran Treatment Courts.

S. 1153, VETERANS ACCESS ACT

This legislation would suspend or prohibit certain non-VA providers from providing community care health services to veterans. The VFW supports the intent of this legislation, but has concerns that must be addressed before passing.

The Veterans ACCESS Act has four factors which would result in the denial or revocation of eligibility of a health care provider to provide non-VA health care services to veterans. One of those factors categorized under section 2 of this legislation would authorize the Secretary to revoke eligibility of a medical provider who violated a law for which a term of imprisonment of more than one year may be imposed. This particular part of the legislation has nothing specifically to do with medical licensing and is incredibly vague. The VFW agrees if a crime results in a medical provider losing their license that they should not be able to practice medicine, but that is already covered in this legislation.

The VFW also has concerns with language stating that the Secretary may deny, revoke, or suspend the eligibility of health care providers under investigation by the medical licensing board of a state in which the provider is licensed or practices. This denies the providers their right to due process, as they are only under investigation and no verdict has been reached.

Last, this legislation provides no means for health care providers who may have their eligibility revoked, but want to come back as a community care provider for VA patients. Particularly in rural areas, these community providers are crucial in allowing veterans timely access to care. If health care providers are not able to provide care to veterans using VA, the department should be required to explain to them how long they are revoked or suspended. In instances where providers are revoked, they must be informed of what they may do to provide community care again, as well as when they may reapply.

S. 1261, VETERANS EMERGENCY ROOM RELIEF ACT

The VFW strongly supports expansion of emergency treatment and urgent care in the community. However, we oppose the requirement to have VA establish copayments for community urgent and emergent care that is different from copayments charged for VA care. This proposal also makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. Veterans currently exempted from co-payments should not be required to bear a cost-share for emergency and urgent care services.

As an alternative, VA should consider establishing a national nurse advice line to help reduce overreliance on emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call

the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance on emergency room care without having to increase cost-shares for veterans.

S. 1279, VETERANS HEALTH ADMINISTRATION REFORM ACT OF 2017

This legislation would, among other things, consolidate VA's community care authorities, expand VA's authority to provide emergency room and urgent care, and improve VA community care. The VFW supports this legislation and would like to offer suggestions to strengthen it.

The VFW strongly believes that veterans have earned and deserve timely access to high quality, comprehensive, and veteran-centric health care. In most instances, VA care is the best and preferred option, but we acknowledge that VA cannot provide timely access to all services to all veterans in all locations at all times; that is why VA must leverage private sector providers and other public health care systems to expand viable health care options for veterans.

The VFW supports section 2, but would like to offer recommendations to strengthen it. This section would build on lessons learned from the Veterans Choice Program to reform the way veterans access community care. When the Choice Program was first implemented, the VA wait time standard required a veteran to wait at least 30 days beyond the date a veteran's provider deemed clinically necessary—the clinically indicated date—before being considered eligible for the Choice Program. This meant that a veteran who was told by a VA doctor that he or she needs to be seen within 60 days was only eligible for the Choice Program if he or she was scheduled for an appointment that was more than 90 days out, or more than 30 days after the doctor's recommendation.

After the VFW expressed concern that veterans' health may be at risk if they are not offered the ability to receive care within the timeframe their doctors deem necessary, Congress amended Public Law (PL) 113-146, the Veterans Access, Choice, and Accountability Act of 2014, to require VA to offer veterans the option to receive care through the Choice Program if VA is unable to provide an appointment before the clinically indicated date.

The VFW strongly believes that when and where veterans receive their health care is a clinical decision made by veterans and their doctors. This bill would rightfully base eligibility for the proposed Care in the Community Program on whether receiving care through community providers is in the clinical best interest of the veteran.

Another lesson learned from the Choice Program is that geographic accessibility is difficult to define because it means different things in different locations and changes depending on the health care needs of the veteran concerned. That is why the VFW supports basing access to community care on whether a veteran would experience an undue burden if the veteran seeks care from VA. However, the VFW believes it necessary to authorize VA and veterans to work together to define what is considered an undue burden instead of establishing systemwide definitions that do not account for local variances.

This bill would also require VA to place veterans on an electronic waiting list. Instead of placing veterans on electronic waiting lists, the VFW recommends VA provide veterans an appointment that is beyond the wait time standards of the department and offer veterans the opportunity to receive community care. When veterans accept an appointment in the community, their VA appointments must be canceled to prevent no-shows. However, this would require VA to track community care appointments better than they have with the Choice Program.

This bill would charge VA with scheduling and coordination of community care appointments and management of the community care networks. In so doing, it would also limit VA's ability to use a third party administrator for the proposed Care in the Community Program. The Choice Program has experienced many issues because VA elected to simply contract virtually every aspect of the community care process. However, not every issue that the Choice Program has faced is the fault of the third party administrators, and there is no guarantee that VA would not have experienced the same issues without a third party administrator. What is clear from the VFW's continued evaluation of the Choice Program is that the third party administrators have the capability to accomplish certain tasks more efficiently than VA. For example, the VFW does not believe VA has the capability to manage a network of hundreds of thousands of private sector health care providers.

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 hire enough staff to keep pace with the expanded use of community care or downsize after surges have passed. 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 community 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.

The VFW supports section 3, which would establish a VA provider agreement authority. 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.

However, the VFW urges the Committee to amend section 3 of the bill to make it clear that provider agreements may only be used if VA is unable to schedule an appointment at its medical facilities or through the Care in the Community Program. Authorizing local medical facilities to enter into provider agreements with providers who are in or are being perused to join the community care network would erode the networks, and could result in such networks failing to meet needed coverage and size requirements.

The VFW supports section 4, which would reform VA emergency and urgent care options for veterans. The VFW continues to hear from veterans that VA refuses to pay the cost of their emergency room visits, which may have saved their lives or was their only option for receiving the urgent care they needed. That is why the VFW supports this legislation's expansion of emergency and urgent community care. Specifically, the VFW is pleased to see that this legislation would ensure copayments associated with emergency and urgent community care would be equal to the copayments paid by veterans at VA medical facilities. This would ensure veterans are not punished for using community care.

However, this legislation would require veterans to have received VA care with the past 24-months in order to be eligible to receive reimbursement for the cost of community emergency and urgent care, which is similar to the eligibility requirements under VA's current emergency care reimbursement program. This barrier to access has caused undue hardship on veterans who enroll in VA health care, but have been denied access due to wait times, and subsequently require emergency services. VA is aware of this problem and has requested the authority to make an exemption to the 24-month requirement for veterans who find themselves in this situation. The VFW recommends that the Committee amend this legislation to ensure veterans who face long appointment wait times are not precluded from seeking the emergent and urgent care they need.

The VFW strongly supports section 5, which would require VA and the Centers for Medicare and Medicaid (CMS) to enter into a memorandum of understanding. The VFW has long supported Medicare subvention, because our members see no logical reason VA lacks the ability to bill their Medicare plans for the cost of providing non-service-connected care. This section would require VA and CMS to do the next best thing—coordinate referrals. By requiring Medicare providers to accept referrals from VA doctors, this section would enable veterans who want to use private sector doctors but maintain all their records and health care management at VA the ability to do so.

The VFW support sections 6 and 7, which would establish education programs to teach veterans, community care providers and VA employees about VA's community care programs. The VFW believes that community care providers must also have the opportunity to obtain military competency training and continuing medical education (CME) on how to provide veteran-centric care. That is why we recommend the Committee expand section 7 by requiring VA to also provide CME on veteran-specific health care and military competency training.

S. 1325, BETTER WORKFORCE FOR VETERANS ACT OF 2017

The VFW strongly supports this bill and thanks the Committee for including it in the agenda. If enacted, this bill would significantly improve VA recruitment and retention authorities. When the VFW asked veterans how they would improve the VA health care system in our latest survey of VA health care entitled "Our Care 2017," the most common suggestion was to hire more health care staff to reduce wait times.

The VFW thanks the Committee for recognizing that VA's ability to hire and retain high quality employees is important. Considering that more than 30 percent of VA employees will be eligible for retirement by 2020, it is vital that Congress focuses on ways to improve VA's hiring and retention authorities to ensure veterans have timely access to the care they have earned.

Title I of this important bill would improve VA recruitment and hiring practices. It would improve authorities for quickly hiring students who complete their residency or internships at VA. With more than 70 percent of America's health care workforce receiving some or all of its training at VA, it should be easy for VA to develop a pipeline of students who become employees. However, VA's cumbersome human resources (HR) requirements limit its ability to recruit the students it trains. The VFW supports eliminating such H.R. barriers to ensure VA is able to quickly hire the high quality health care professionals it trains.

The VFW is also pleased this bill takes steps toward improving veterans preference to ensure veterans who served in the National Guard and Reserve are afforded the same hiring preferences as their active duty counterparts. Currently, veterans who served after September 11, 2001, are required to have served at least 180 consecutive days on active duty. Due to our all-volunteer military and the nature of the wars in Iraq and Afghanistan, the Guard and Reserve have been utilized much more than they have during past conflicts.

However, not all Guard and Reserve servicemembers receive active duty orders for more than 180 days. Thus, many veterans that deployed into harm's way in support of the wars in Iraq and Afghanistan are not eligible for veterans hiring preferences. Changing the eligibility for veterans preference from "180 consecutive days" to "for a total of more than 180 days," ensures Guardsmen and Reservists are afforded the same opportunity to obtain meaningful civilian employment after military service as their active duty brothers and sisters.

This important bill also makes several administrative changes to VA's H.R. processes. The VFW strongly supports amending VA's reduction in force procedures to make certain VA ranks its employees based on performance instead of tenure. Doing so would ensure the highest quality employees would remain to care for our Nation's veterans if VA is required to implement a reduction in force.

DISCUSSION DRAFT, THE VETERANS CHOICE ACT OF 2017

This legislation would expand the Choice Program, establish VA provider agreements authority, require VA to assign each veteran a primary care provider, and establish demand capacity analyses, among other things. The VFW supports sections 4, 5, 6, 9, 10 and 11; supports the intent of section 7; has serious concerns with section 3; and takes no position on sections 8 and 12.

The VFW has serious concerns with section 3 as written and would be forced to oppose the underlying bill if changes are not made to the bill before it is advanced by the Committee. While the Veterans Choice Program has made significant progress since it was implemented in November 2014, it has yet to achieve what Congress envisioned when it passed the Veterans Access, Choice, and Accountability Act of 2014. The purpose for this landmark program was to address the national access crisis that has plagued the VA health care system, where veterans wait too long or travel too far for the care they need. The VFW has made a concerted effort to ensure the program works as intended by evaluating what aspects of the program are working and identifying common sense solutions to aspects that are not working well. We have done this because we agree that VA must leverage its community care partners in order to fulfil its obligation to our Nation's veterans. However, we firmly believe that community care must complement, not supplant or compete with, the high quality, comprehensive and veteran-centric care veterans receive from their VA health care system.

Section 3 would make any veteran enrolled in VA health care eligible for the Choice Program. The VFW is seriously concerned that such a significant expansion of eligibility would result in veterans receiving disparate and uncoordinated care. Medical research has determined and the Commission on Care has reiterated that integrated and managed health care systems provide better health care outcomes than fee-for-service systems. That is why the majority of high performing health

care systems, including VA, have implemented the patient-centered medical home model of delivering health care, which ensures patients receive the care they need when they need it.

While the idea that veterans should be free to choose between VA and community care providers whenever they want and every time they seek care sounds enticing, it is unsustainable because of the cost, and the VFW would vehemently oppose any future efforts to pass that cost onto veterans. The Commission on Care estimated that the cost of a proposal very similar to Choice Program eligibility proposed by section 2 would have ranged from \$156 billion to \$237 billion once fully implemented. The VFW is not concerned that veterans will flee VA medical facilities for private sector doctors. To the contrary, VFW health care surveys show that nearly 60 percent of veterans who use VA health care prefer it, despite having other health care options. Yet, the increased reliance on VA health care due to such a generous benefit and VA's inability to keep pace with the increase in demand would require Congress to shift already strained and insufficient appropriations from direct care to community care. Such a shift of resources would further limit VA's ability to update its aging infrastructure, hire needed health care professionals, compete with the private sector, and would lead to the gradual erosion of the VA health care system.

The VFW is also concerned that a "choose your own adventure" approach to health care would lead to veterans receiving fragmented health care that the Commission on Care found would lower health care outcomes and endanger patient safety. Veterans deserve the highest quality health care possible, not fragmented care that fails to meet their health care needs. The VFW urges the Committee to amend this section by ensuring veterans who are unable to receive a VA appointment by a clinically indicated date, or within a distance an enrolled veteran and such veteran's health care provider agree is reasonable, are offered community care options.

The VFW supports provisions which authorize VA to enter into regional contracts to establish and manage networks of health care providers, schedule appointments, process claims and payments, and collect medical documentation. However, the VFW believes the specific processes that are completed by the contractor should be determined by VA in consultation with Veterans Service Organizations, the current third party administrators and entities interested in becoming a third party administrator.

VA has worked on this process for the past year, and has determined that it is best for VA community care staff to schedule Choice Program appointments when feasible, and to turn to the third party administrators when local facilities are unable to timely process appointments. While different parts of the country have experienced mixed results with the current third party administrators, the VFW does not believe it would be in the best interest of veterans for every aspect of the Choice Program to be managed by a third party administrator or VA. By evaluating issues the Choice Program has faced, and with increased communication and management of the current third party administrators, VA must strike the right balance between what is handled internally and what can be contracted out. The most important factor is that veterans must have a seamless transition from VA care to community care and vice versa.

This section would also prohibit VA from using tiered networks to direct veterans to specific providers. While the VFW agrees that veterans must not be forced to receive care from specific community care providers, VA must have the authority to recommend providers in higher tiers to incentivize network providers who show dedication to developing military competency and veteran-centric health care practices. The VFW recommends the Committee amend this section to prohibit VA from requiring veterans to obtain care from specific doctors, but still make recommendations based on a provider's tier level.

The VFW supports the provision to authorize VA to collect reasonable charges from a veteran's other health care plans. Doing so would ensure VA is able to offset some of the costs of providing community care to veterans. Specifically, the VFW is glad this bill would not impose a financial penalty on veterans who may not be aware that their other health care coverage has changed. We do, however, recommend that the Committee expand the definition of other health care coverage to include Medicare. VFW members who pay for Medicare coverage see no justifiable reason for VA to be treated differently than private sector providers when a Medicare-enrolled veteran receives non-service-connected care from a VA doctor. Doing so would further offset the cost of providing community care.

The VFW supports section 4, which would authorize VA to enter into provider agreements. Specifically, the VFW is glad this bill would require VA to provide care through its facilities or the Choice Program before considering provider agreements.

This would ensure provider agreements do not impact the integrity of the Choice networks or VA's ability to provide direct care.

Section 7 would require VA to assign each enrolled veteran a primary care provider. It would also authorize veterans to freely choose a community primary care provider when such veteran enrolls into the VA health care system. The VFW supports including community care options when veterans seek primary care and, to ensure continuation of care, veterans must be given the opportunity to receive all their primary care from their assigned community primary care provider. However, the VFW does not support giving veterans a list of providers and leaving them to fend for themselves to find a community primary care provider who is accepting new patients and is willing to see them. Instead, VA must work with every veteran who requests primary care to determine what option and doctors are best for each individual veteran.

Furthermore, the VFW recommends the Committee require community primary care providers give VA the right of first refusal when referring veterans to specialty care. Under the current Choice Program, community care providers do not have the ability to refer veterans back to VA for specialty care or follow-up care. Doing so would ensure proper utilization of VA resources and strengthen the relationship between VA and local community care providers.

The VFW strongly supports section 9, which would require VA to conduct demand capacity analyses. The VFW believes that community care networks and VA's footprint must be tailored to each health care market. There are some areas in this country where wait time for private sector care is much greater than VA. In other areas, VA is duplicating services that are readily available in the private sector or through other public health care systems. By conducting periodic demand/capacity analyses, VA would be able to determine when it should leverage the capabilities of its community care partners and when it must expand internal access. Doing so would ensure VA devotes its finite resources to capabilities the community lacks.

DISCUSSION DRAFT, IMPROVING VETERANS ACCESS TO COMMUNITY CARE ACT OF 2017

This legislation would consolidate VA's community care authorities and improve VA community care, among other things. The VFW supports sections 102, 103, 201, 202, 204 and 205; has concerns with section 101; and agrees with the intent of section 203.

The Choice Program has faced a number of challenges since it was implemented in November 2014. The VFW has made a concerted effort to evaluate what aspects of the program have worked and identify common sense solutions to aspects that have not worked as intended. That is why we are pleased to see that this legislation would incorporate many of the lessons learned from the implementation of the Choice Program and other community care programs, such as consolidating all of VA's community care authorities to ensure veterans, VA employees and private sector providers understand how to navigate VA's community care program.

Section 101 would reconstitute and make a number of improvements to the Choice Program, to include ensuring a veteran's continuation of care is not interrupted by bureaucratic rules. The VFW supports provisions to allow veterans who receive authorized care from a community care provider to continue to see their community care provider or another community care provider to complete an episode of care, or enter into follow-up treatment without the need to request additional authorization.

The VFW is glad to see that this legislation includes recent improvements to the eligibility criteria in the proposed Veterans Community Care Program, such as the Secretary's authority to determine that there is a compelling reason for a veteran to use community care in lieu of VA care. However, the VFW is concerned that the bill continues the flawed 40-mile and 30-day eligibility criteria to determine when veterans are afforded the opportunity to access community care. The VFW believes that the distance a veteran is required to travel or how long a veteran is required to wait for health care must be a clinical decision made by the veteran and his or her health care provider.

Another lesson learned from the Veterans Choice Program is that VA provides health specialties that do not have a Medicare rate, including obstetrics and gynecological care. While the VFW understands the need to set limits on the amount VA is authorized to reimburse community care providers, the VFW believes that a consolidated community care program should authorize VA to provide community care options for every health care specialty it delivers. That is why we are glad to see the legislation would authorize VA to establish a fee schedule for services it provides that do not have a Medicare rate. It would also authorize VA to negotiate rates, which the VFW supports.

This section would also authorize VA to establish tiered networks to operate the Veterans Community Care Program. The VFW supports establishing tiered networks to incentivize community care providers to develop military competency and veteran-centric health care practices. However, a veteran's choice of community care provider should not be limited by a specific tier. Each veteran should be given the opportunity to work with VA to determine what community care options are best suited to the veteran's clinical needs and preferences.

The VFW supports section 102 which would require VA to comply with prompt payment requirements. The VFW continues to hear from veterans that they have been billed for care that VA is responsible for paying simply because the community care provider VA sent them to was unable to collect payment from VA in a timely manner, so the provider elected to bill the veteran instead. Prompt payment is vitally important to ensuring VA's community care network is able to attract and maintain high quality private sector health care providers.

The VFW supports section 103, which would expand medical malpractice protections to veterans who use VA community care. Veterans who receive care at VA medical facilities are eligible for disability compensation and other benefits if they have been injured or negatively impacted by VA care. Veterans who use the Choice Program are not offered the same opportunity and are required to seek legal action in order to be compensated for malpractice.

The VFW agrees with the intent of section 203, which would authorize VA to transfer resources between its medical services and community care accounts. If veterans receive care from community care providers or VA, health care facilities must be determined at the local level by each veteran and his or her health care team, not by Congress or VA bureaucrats who favor one option over the other. That is why the VFW supports authorizing VA to transfer resources between its internal care and community care accounts based on demand. Instead of implementing this section, the VFW would recommend doing away with the community care appropriations account and simply require VA to report on the use and cost of community care, rather than continuing to fence off certain appropriations for community care.

The VFW supports section 204, which would authorize VA to obligate funds when care is approved, not when VA authorizes community care. If enacted, this provision would enable VA to better forecast community care expenditures and reduce the amount of resources it is required to deobligate, because it obligated more money than it was required to pay in an effort to prevent the department from violating anti-deficiency laws.

THE DEPARTMENT OF VETERANS AFFAIRS QUALITY EMPLOYMENT ACT OF 2017

The VFW strongly supports this legislation which would improve employment practices at VA. If VA is not able to quickly hire high quality employees, it will lack the staff needed to accomplish its mission. In its report, "Hurry Up and Wait," the VFW highlighted deficiencies in VA Human Resources practices. The VFW recommended Congress ease Federal hiring protocols for VA health care professionals to ensure VA can compete with private industry to hire and retain the best health care providers in a timely manner.

In their review of VA's scheduling system and software development as required by the Veterans Access, Choice and Accountability Act of 2014, the Northern Virginia Technology Council (NVTC) reinforced the VFW's concerns that VA's hiring process moves too slowly. NVTC suggested that for VA to be successful, it must aggressively redesign its human resources processes by prioritizing efforts to recruit, train, and retain clerical and support staff. This important bill would make many needed improvements to the way VA hires and retains high quality employees.

The VFW strongly supports the creation of an Executive Management Fellowship Program. This idea was advocated by a VFW-Student Veterans of America fellow. In his proposal, "Connecting America's Best to Serve America's Best," Karthik A. Venkatraj highlighted how a private-public partnership program such as the Executive Management Fellowship—where VA leaders are detailed to a private sector company and vice versa—can infuse private sector expertise and disciplines into VA governance and management. The proposed fellowship would also grant private, non-profit and academic institutions the ability to immerse its leadership in the highest levels of our Nation's public policy to better understand how the public and private sector can learn from each other and work together to improve the lives of America's veterans.

This bill includes other ideas the VFW has suggested and supported in the past, such as expedited hiring authority for students enrolled in a VA residency or internship program and recent graduates who are being poached by private sector health care systems, because VA's hiring process is too long and cumbersome. It also

includes a requirement for VA to conduct and use exit surveys to determine why its medical professionals are leaving. Doing so would ensure VA is able to address retention issues, which is one of the biggest reasons behind VA staff shortages.

PREPARED STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT,
VIETNAM VETERANS OF AMERICA

GOOD MORNING CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND OTHER EXEMPLARY MEMBERS OF THE SENATE VETERANS' AFFAIRS COMMITTEE. Vietnam Veterans of America is pleased to have the opportunity to present for your consideration our Statement for the Record on pending legislation before this Committee

S. 115, the Veterans Transplant Coverage Act, introduced by Senator Dean Heller (R-NV). This bill would authorize the Department 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.

According to the Health Resource Services Administration (HRSA), the demand for organs far outweighs the number of donors. Living donations offer another choice and extend the supply of organs. Of the 28,954 organ transplants performed in the U.S. in 2013, more than one-fifth (5,989) were living donor transplants.

While VVA has no objection to this 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. This would create a situation that will have to be addressed should S. 115 be enacted.

S. 426, the Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017, introduced by Senator Jon Tester (D-MT). This bill would increase assistance provided by the VA for education and training of physician assistants of the department, and establish pay grades and require competitive pay for physician assistants.

VVA supports this important bill. Access to safe, quality health care has always been critical to veterans. Physician Assistants (PAs) play a significant role in the Veterans Health Administration's model for delivering comprehensive health care. Yet in September 2016, the VA Inspector General reported that PAs ranked third among health professions experiencing troubling provider shortages (psychologists were tied with PAs in this ranking).

This bill would provide scholarships to veterans who have medical or military health experience. Upon completion of training and education, a new PA would be required to work for the VA in a medically underserved area and in a state with a per capita veteran population of more than 9 percent (according to the National Center for Veterans Analysis and Statistics and the US Census Bureau).

Importantly, the bill also establishes pay grades for PAs as well as competitive pay requirements, and mandates that the VA implement a national strategic plan for the retention and recruitment of physician assistants.

S. 683, the Keeping Our Commitment to Disabled Veterans Act of 2017, introduced by Senator Mazie Hirono (D-HI). This bill would extend the requirement for the VA to provide nursing home care to certain veterans with service-connected disabilities through December 31, 2018.

VVA fully supports this extension.

S. 833, the Servicemembers and Veterans Empowerment and Support Act of 2017, introduced by Senator Jon Tester (D-MT), would expand VA health care and benefits for Military Sexual Trauma.

VVA supports this legislation. It is no secret that incidents of cyber-harassment of a sexual nature are on the rise. Earlier this year, it was reported in the San Diego Tribune that a private Facebook forum called Marines United allowed postings of sexually suggestive or explicit photos of female servicemembers, often without their knowledge or consent. Members of the forum, both active-duty military and veterans, made lewd and offensive remarks. When some of the victims learned about this and complained, they were bullied and/or subjected to threats.

This bill seeks to expand the coverage of counseling and treatment for military sexual trauma to include cyber-harassment of a sexual nature and relax the standard of proof for service-connection of mental health conditions related to MST. The expanded coverage would include members serving on active duty, active duty for training, as well as inactive duty for training.

VVA understands that the devil is in the details and we extend to the Committee an offer to work with staff to refine and clarify this legislation.

S. 946, the Veterans Treatment Court Improvement Act, introduced by Senator Jeff Flake (R-AZ), would require the Secretary of Veterans Affairs to hire additional Veterans Justice Outreach specialists to provide Veterans Treatment Court services to justice-involved veterans.

Justice-involved veterans too often are forgotten by the Nation they once served. They did wrong; they do time. Yet the VA does not abandon these vets. Its Veterans Justice Outreach program specialists play a crucial role not only in assisting many to reintegrate into society but in helping others avoid incarceration. They are vital cogs in the workings of Veterans Treatment Courts.

Senator Flake's well-conceived bill recognizes the value of the work done by VJO specialists, and affirms the need to ensure that this program is available throughout the VA. And S. 946 is not an unfunded mandate: it would appropriate \$5,500,000 to support this program for each fiscal year through 2027. Hence, VVA endorses this bill without reservation.

S. 1153, the Veterans ACCESS Act, introduced by Senator Tammy Baldwin (D—WI), would prohibit or suspend certain health care providers from providing non-VA health care services to veterans.

VVA has no objection to this bill. Ensuring that health care providers are fully vetted before integrating them into the VA healthcare system is the standard VVA expects from the department. Too often, however, some less-than-honorable healthcare providers fly below the disciplinary radar before something in their past catches up to them.

This bill authorizes the Secretary to review the status of each non-VA clinician. The review would include the history of any employment with the department to determine if they have violated one of several criteria as laid out in the legislation.

S. 1261, the Veterans Emergency Room Relief Act, introduced by Senator Bill Cassidy (R-LA), would require the Secretary of Veterans Affairs to pay reasonable costs of urgent care provided to certain veterans, and establish cost-sharing payments for veterans receiving care at a VA emergency room.

VVA supports the inclusion of urgent care services as a choice for veterans to receive health care. Many urgent care clinics are conveniently located in communities where veterans live and seek treatment. This is generally consistent with what VA proposed as part of their community care program.

VVA has no objection to the establishment of cost-sharing for emergency room care at a VA facility. However, there is no floor or ceiling as to how much of the cost-sharing payment for which the veteran would be responsible, nor how this figure might be arrived at, although this is a detail perhaps best left to the regulation that would follow enactment of this bill.

The VA has struggled to implement emergency care services as established by the Millennium Act with regards to non-service-connected conditions. Eligibility of the veteran for what services, inappropriate denials of payment, and who should pay for what services are just a few of the problems reported by the GAO as recently as March 2014. GAO's report, "Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," was not flattering for the VA and demonstrated that, nearly 15 years after enactment, VA emergency care services are still in need of repair.

VVA urges the Committee to provide hardcore oversight of the VA on their emergency care services in general, with the goal of making it easier for both the employees and veterans understand the benefits offered at VA emergency rooms.

S. 1266, the Enhancing Veteran Care Act, introduced by Senator James Inhofe (R-OK). This bill would authorize the Secretary of Veterans Affairs to enter into contracts with nonprofit organizations to investigate VA medical centers.

VVA does not object to the concern behind this legislation. However, VA health care is far more transparent generally than health care in the private sector is. And we question just what circumstances would warrant an outside investigation as opposed to requesting the VA OIG to step in—or asking for firm yet fair oversight on the part of Congress.

S. 1279, the Veterans Health Administration Reform Act of 2017, introduced by Senator Mike Crapo (R-ID), would permit furnishing health care for eligible veterans by non-VA healthcare providers.

This legislation, which is similar to the trio of draft bills up for discussion, would establish a Care in the Community Program through contracts, care agreements, or other laws or practices administered by the VA. We feel compelled to point out that, while we appreciate the eligibility criteria outlined in this bill for such a program, VA medical centers have long engaged outside clinicians to engage in care that the VA cannot provide, and under the guidance by the current VA Secretary and under

the critical—and watchful—eye of you here in Congress, the VA is developing and implementing what we trust will be a vibrant community care program navigated by the VA, and one in which outside providers will be carefully vetted.

However, this legislation does not address the assignment of a primary care physician upon enrollment, which is essential to ensuring that care is coordinated through and navigated by the VA. Primary care, in our view, must remain in the VA.

We also must point out that, while “choice” has been the go-to word in Congress in recent years, patients don’t usually have “choice” available to them in the private sector; rather, they take the advice of their doctor, or the recommendation of a friend or relative or colleague. Such “choice” for VA patients, if ordered by law, has the very real possibility of causing considerable consternation—on the part of veterans seeking to go to clinicians who do not or cannot provide the quality of care the VA would demand; on the part of the VA, which would have to tell a veteran that s/he cannot use a particular clinician with the VA footing the bill; which would only cause major headaches to Members of Congress when veterans complain about the VA having rejected the clinician they have “chosen.” Besides, ceding unfettered choice outside the VA was never a recommendation of the Commission on Care

VVA, though, is supportive of the provider agreement language in this bill, the authority for which the VA has asked for previously. Provider agreement authority is essential in any care in the community program.

S. 1325, Better Workforce for Veterans Act, introduced by Senator Tester, seeks to improve the authorities of the Secretary of Veterans Affairs to recruit, hire, train, and retain employees.

For years, the VA has struggled to recruit, then hire and retain employees, particularly the clinicians so essential to the provision of quality health care. VVA has no objection to the improvements of authorities and reporting requirements set forth in this legislation. We note that the VA has reported critical staffing shortages across the system, aggravating an already stressed access issue. The VA OIG reported in September 2016 on the top five occupational staffing shortages for VHA. In order ranked as most critical is Medical Officer, followed by Nurse, Psychologist and Physician Assistant (tied), and Physical Therapist and Medical Technologist (also tied).

Title II of this legislation addresses accountability, oversight, transparency, and personnel matters. VVA has a long history of advocating for stronger programs on all of these issues.

Section 204 would establish pay for medical center directors and VISN directors. The Secretary would be required to consult not fewer than two national surveys on pay for similar positions to determine market pay. Additionally, the Secretary would be required to set forth a department-wide minimum and maximum for total annual pay once every two years. Pay inequity is one of the biggest barriers to recruiting and retaining high-quality employees to oversee the health care facilities where veterans receive care. VVA believes this reform is long overdue.

Sections 205 and 208 address long-standing problematic issues. The VA has reported a critical shortage of trained Human Resources professionals, which only adds to the already glacial hiring practice that exists across the Federal bureaucracy.

Section 205 would establish a Human Resources Academy in VHA to provide annual training for and insights on how to best recruit and retain employees. While this is a solid approach to the problem, we offer this caveat: vigilant oversight by Congress and the VSOs of the establishment and implementation of this will be needed.

Section 208 requires the Secretary, via the Under Secretary for Health, to develop a comprehensive assessment tool to measure competency within the H.R. ranks, and to ensure that the knowledge gained by the training provided at the academy is effectively employed. Section 208 also requires the establishment and clarification of lines of authority within VHA to conduct proper oversight at all levels of the H.R. process. This is a critical piece in ensuring the responsible parties are held accountable for any failure to comply.

S. Discussion Draft: The Veterans Choice Act of 2017 (Isakson) would permit all veterans enrolled in the patient enrollment system of the Department of Veterans Affairs to receive health care from non-VA health care providers.

Section 3 of this draft establishes the Veterans Choice Program and goes on to delineate how that establishment would take place. Of note to VVA are a few issues we would like to bring to this Committee’s attention:

Chairman Isakson’s bill would authorize the Secretary to enter into consolidated, competitively bid regional contracts to establish networks of health care providers,

who would be responsible for everything with the exception of the maintenance of interoperable Electronic Health Records. This construct is very similar to the current third-party administrator model that has been a source of problems at every level. The Secretary has expressed his desire to keep in-house the scheduling of the appointments for veterans, which this section would not allow. It is not clear to us why the legislation prohibits VA from using a tiered network. As the Committee is well aware, development of a tiered network model is the basis for VA's care in the community vision going forward and was outlined in VA's care consolidation plan in October 2015. We do, however, appreciate the inclusion of language that would require a veteran to be assigned a primary care provider upon enrollment. This is of course necessary for effective and efficient care coordination.

The authorization for provider agreements is a welcome addition and would enhance the delivery of care to veterans, including those residing in state homes. This has been an ongoing legislative priority for VA moving forward with community care once the dollars remaining in the current Choice Program run out. Medicare and TRICARE use provider agreement authority to bypass Federal acquisition regulations. There is no reason why the VA cannot be afforded the same.

Section 9 would require the Secretary to assess the demand for health care services furnished by the department. The VA should already be doing this. It would help to inform their budget projections with real-time information. VVA supports this requirement.

Section 11 directs the Secretary to procure a COTS EHR platform for health care services that conforms to the standards of interoperability with DOD. Billions of dollars have been spent, and wasted, over the past decade to get the two agencies together on the interoperability issue. VVA supports this section as well.

S. Discussion Draft: Improving Veterans Access to Community Care Act of 2017 would establish the Veterans Community Care Program of the Department of Veterans Affairs to improve health care provided to veterans by the VA.

Similar to the previous draft, "The Veterans Choice Act of 2017," this draft legislation establishes the Veterans Community Care Program. This draft legislation, however, takes a decidedly different approach. It would require the VA's Non-VA Care Coordination Program to coordinate the care, which would embrace the scheduling of appointments for eligible veterans. Additionally, it does allow for the development of a tiered network construct, but prohibits the Secretary from prioritizing providers in one tier over providers in any other tier if it limits the veteran's choice of a clinician in a particular specialty.

VVA would note that the eligibility criteria outlined in this draft are complicated, somewhat arbitrary, and will pose a nightmare for both VA employees and veterans to figure out eligibility. The Secretary has expressed many times that he is attempting to shift away from an administrative system to one that is clinical in nature. The goal, as VVA understands it, is for a clinical decision be arrived at between the veteran and the doctor as to where the best care for that veteran resides. Which is as it should be.

Section 102 addresses payment of health care providers and compliance with the Prompt Payment Act. This is very similar to other legislative language included on the agenda today and for which VVA has no objection to this section.

VVA supports Section 103, which amends Section 1151 (a) by adding a new paragraph addressing benefits for persons disabled by treatment under the Veterans Community Program.

Section 201 authorizes Veterans Care Agreements. The language is similar to that in other pieces of legislation on today's agenda. VVA fully supports giving the VA the authority to enter into such agreements, including with state homes.

S. Discussion Draft: The Department of Veterans Affairs Quality Employment Act of 2017 seeks to improve the authority of the Secretary to hire and retain physicians and other employees.

This draft legislation sets forth a number of requirements to improve the quality and competency of VA employees. It also addresses recruiting, retention, and training of personnel through the establishment of recruiting databases for critical position vacancies and mental health vacancies. VVA has no objection to this draft legislation.

In conclusion, we note that there are many provisions in the bills and drafts that seek to accomplish the same goal, albeit not quite in the same way. We would encourage this Committee and your counterpart in the House to evaluate the different approaches, continue to work with all of the stakeholders, including the VA, and put a comprehensive package together that strengthens the Department of Veterans Affairs and improves health care delivery and services for veterans.

Thank you for the opportunity to submit VVA's views on these very important pieces of legislation.

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

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WOUNDED WARRIOR PROJECT
STATEMENT FOR THE RECORD
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JULY 11, 2017

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

Thank you for inviting Wounded Warrior Project ("WWP") to offer our views today on the legislation being considered by the Committee. WWP brings perspectives based on our first-hand experiences offering comprehensive programs and services to warriors who have sustained wounds, injuries, and illnesses in service since 9/11 and their families. While several bills on the Committee's agenda may have a meaningful impact on the community we serve, WWP would like to offer our perspective on one item in particular.

S. 946 – Veterans Treatment Court Improvement Act of 2017

On behalf of the veterans we serve and the generous members of the American public who help fund our mission to honor and empower wounded warriors, WWP is proud to support the *Veterans Treatment Court Improvement Act of 2017*, and we acknowledge and appreciate U.S. Sens. Jeff Flake (R-Ariz.), John McCain (R-Ariz.), as well as Ranking Member Tester (D-Mont.) for their leadership in introducing this legislation.

Having registered over 100,000 wounded warriors for our programs and services, WWP is acutely aware of the difficulties veterans face beyond the visible wounds of war. WWP has taken special care to acknowledge and generate awareness of the invisible wounds veterans endure such as TBI, PTSD, and other mental health challenges. These wounds manifest in many ways and sometimes lead veterans into court appearances as defendants.

Since 2008, when the first veterans treatment court (VTC) was established in Buffalo, New York to acknowledge and address the specific needs of justice-involved veterans, VTCs have emerged as an effective alternative to a traditional court system that may not consider both the sacrifices veterans have made and the unique challenges associated with conditions like PTSD and TBI. VTCs have launched in over 400 jurisdictions across the country and continue to reach new veterans and communities as their reach expands¹. These courts

¹ Flatley, B., Clark, S., Rosenthal, J., & Blue-Howells, J. (2017). Veterans Court Inventory 2016 Update: Characteristics of and VA involvement in Veterans Treatment Courts and other Veteran-focused court programs from the Veterans Justice Outreach Specialist Perspective. Washington, DC, US Department of Veterans Affairs, Veterans Health Administration, March 2017.

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have achieved remarkable success that can be quantified by measures like reduced jail time and recidivism, and improved mental health recovery and successful re-entry for veterans into the community.

Existing VTCs have a better understanding of the specific needs of justice-involved veterans and have leveraged resources such as drug and alcohol treatment, mental health therapy, and peer mentorship. Another pivotal resource has been the ability of these courts to connect veterans with education and counseling related to Department of Veterans Affairs (VA) programs and services – a process often facilitated by the participation of Veteran Justice Outreach (VJO) Specialists.

As VTCs have grown, so too has the demand for VJOs. Current resources are limiting VA’s ability to use the VJO program to reach all potentially eligible veterans, and as a result, fewer veterans are benefitting from their assistance and being connected to VA resources by those best-able to navigate the system. By laying the groundwork for VA to hire more VJOs, the *Veterans Treatment Court Improvement Act of 2017* will help improve the efficacy of existing VTCs and encourage expansion into new jurisdictions.

Over the past year and a half, WWP has served as an official observer to the Uniform Law Commission’s (ULC) Model Veterans Court Act Drafting Committee, offering our perspective and counsel as drafters built a template for states and court jurisdictions to follow when launching or improving VTCs in their communities. The ULC’s work reflects the success that existing courts are having and continuing interest to make more VTCs available to justice-involved veterans. As more VTCs are established, the need for a sufficient number of VJOs will only be enhanced.

For these reasons, WWP is proud to endorse the *Veterans Treatment Court Improvement Act of 2017* and looks forward to helping expand the impact of VTCs around the country and improve outcomes for justice-involved veterans. Thank you for the opportunity to offer our views on this legislation, and we look forward to working with you to move this bill and others through the legislative process.

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