H.R. 1133 H.R. 2123 H.R. 2601 H.R. 3642, and Draft Legislation

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Statement Of

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National Legislative Service

Veterans of Foreign Wars of the United States

Before the

Committee on Veterans' Affairs

United States House of Representatives

With Respect To

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"**H.R. 1133; H.R. 2123; H.R. 2601; H.R. 3642;**

And Draft Legislation

WASHINGTON, D.C.

Chairman Roe, Ranking Member Walz and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this committee.

H.R. 1133, Veterans Transplant Coverage Act of 2017

The VFW supports this legislation, which would authorize Department of Veterans Affairs (VA) to provide care and services to non-veterans for purposes of donating organs to VA-eligible veterans.

Currently, VA provides care to certain non-veterans, ranging from survivors and dependents to humanitarian care for emergency room visitors. Under the current Choice Program, veterans in need of using the program to receive a live organ donation are denied access when the donor is not eligible to receive VA care. The VFW urges this committee to ensure any future community care program is able to be used by veterans who need an organ

transplant from a live donor. But until then, veterans should not be forced to wait any longer to receive the organs they need. Individuals in need of an organ transplant are in life or death situations, and finding a matching organ donor is time consuming and often rare.

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

The VFW strongly supports this legislation, which would authorize qualified VA health care providers to practice telemedicine across state lines. This legislation would be especially helpful for veterans who do not live in the same state as the VA facility in which they are enrolled. With geographic distance remaining a significant barrier to care for many veterans, the use of telemedicine technology has emerged as a highly effective method of providing veterans with timely and convenient care.

A recently signed Executive Order authorizes doctors to perform many of the duties this legislation would authorize. The Executive Order was based on VA's belief that it has authority to conduct telehealth in such manner. However, some doctors have expressed an unwillingness to practice under the authority of an Executive Order. As such, legislation would provide VA doctors the assurance they need to practice telemedicine.

H.R. 2601, Veterans Increased Choice for Transplanted Organs and Recover Act of 2017

The VFW agrees with the intent of this legislation, which would ensure veterans in need of organ transplants do not have to travel long distances to receive care. Congress and VA have learned that placing arbitrary distance and timeline requirements to use VA community care programs leads to unintended consequences. For that reason, the VFW cannot support this legislation.

The legislation is an example of why VA has multiple community care programs with different eligibility criteria. The VFW supports consolidation of community care programs to ensure veterans can receive the care they need, where they need it, instead of creating exemptions or rules for specific circumstances. Doing so would provide VA the flexibility it needs without forcing veterans to wait longer than needed for life-saving care. It would also allow VA to make decisions in circumstances where the VA facility may be less than 100 miles away, when it is best for a veteran to receive an organ transplant in the community, closer to home.

H.R. 3642, Military Sexual Assault Victims Empowerment Act

The VFW opposes this legislation, though understands the intent of the bill. After conducting six health care surveys and hearing directly from more than 20,000 VFW members, the VFW understands that veterans often face barriers accessing needed care. However, we view this bill as an overcorrection which would diminish the care veterans receive from VA.

Ensuring sexual assault survivors receive the care they need is a top priority for the VFW. This became especially clear when VA released their veteran suicide data in July 2016. This study showed women veterans who have survived sexual trauma from their time in the

military are at an increased risk of death by suicide compared to those who did not experience sexual trauma. That is why the VFW believes we must continue providing VA with the resources and authorities it needs to hire mental health care providers who specialize in not just the traumas of war, but the traumas of sexual assault.

Health care for survivors of sexual trauma must also be more inclusive than strictly mental health care. Survivors may need to seek treatment for health issues such as sexual dysfunction or substance abuse. These survivors are also at increased risk for needing assistance with housing and employment. All of these are specialties of VA's continuum of care and holistic medical scope for veteran patients. To make accessing these benefits easier, VA also offers Military Sexual Trauma Coordinators at all VA medical centers –– yet another example of something VA does which is not available in the private sector.

The VFW strongly believes VA must be the coordinator of care for veterans and continue to guarantee the quality of care veterans receive regardless of where the care is provided. This legislation would limit VA's ability to coordinate care for a very vulnerable segment of the veteran population and would lead to such veterans receiving fragmented care, which health care experts believe endangers patient safety.

The VFW also believes there are unclear discrepancies between the survey and reporting requirements of this legislation. One example of this is the surveying of the private sector timeframe between when a veteran would be able to make an appointment and when they have their appointment. Currently VA is held accountable for not just the wait time between when a veteran makes an appointment and when they get in for their appointment, but also for the veteran's preferred date. When gathering data to compare VA to the private sector, it is imperative VA and the private sector be compared and judged on the same playing field. The VFW also believes surveying for all medications a veteran may have so VA can later report which ones are being taken for sexual assault-related illnesses or injuries is overbearing.

Draft legislation to modify authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans.

The VFW supports this legislation and has a recommendation to improve it. This legislation would improve VA's current authorities to enter into agreements with state veterans homes.

This legislation would also increase the number of graduate medical education (GME) residency positions within VA. While the VFW supports increasing GME opportunities within VA, we urge this committee to expand this legislation to include psychology residencies. A recent VA Office of Inspector General reported entitled "OIG Determination of VHA Occupational Staffing Shortages," listed psychologists as the third largest staffing shortage within VA. This committee must ensure VA is able to address all of its staffing shortages.

Draft legislation to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line.

The VFW understands the intent of this legislation, but opposes it as written. This legislation would direct VA to conduct a study on the Veterans Crisis Line (VCL), which would require VA to gather data which is does not currently collect, nor should it.

In 2007, the Veterans Health Administration (VHA) established a suicide hotline, which later became known as the VCL, to provide 24/7, suicide prevention and crisis intervention to veterans, service members and their families. This was necessary as a means of constant availability for individuals in need of crisis intervention. The VCL provides crisis intervention services to veterans in urgent need, and helps them begin a path toward improving their mental wellness. The VCL plays a critical role in VA's initiative of suicide prevention, and ongoing efforts to decrease the estimated 20 veterans who die by suicide each day. The VCL answers more than 2.5 million calls, responds to more than 62,000 text messages and initiates the dispatch of emergency services more than 66,000 times each year. Recently, the VCL has expanded to three call centers located in Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.

When veterans contact the VCL they are answered by professional staff with extensive background and expertise in social work and crisis prevention/intervention. These unseen heroes answer thousands of calls by veterans in their most vulnerable moments. No veteran in need should contact the VCL only to be asked for their personally identifiable information. Just as with Vet Centers, veterans must have the ability to seek care for the VCL anonymously.

The VFW understands that when VCL staff must dispatch emergency responders, or do a warm hand-off between the veteran and a VA suicide prevention specialist, that personally identifiable information will be collected. At that point, the VFW believes identifying and tracking the veteran's progress should begin. The purpose of the VCL is to provide crisis intervention and prevent veterans from dying or attempting suicide. Prevention is key here, and Congress must not implement measures which would deter veterans from utilizing the VCL.

Tracking the successes and possible downfalls of VCL is important to the VFW. But we believe the data already available shows the crisis line is successful. One reason for its success is that callers are only asked whether they are veterans, therefore veterans who may not be eligible for VA services are able to use the line. It is currently well known that of the 20 veterans who die by suicide each day, 14 of those veterans were not actively enrolled in VA. If Congress and VA sincerely want to eradicate veteran suicide, then we must dive deeper into data on the 14 veterans not using VA. What better outreach can be done? Are they eligible for VA and not using it? What can VA do to further assist in prevention and intervention for these veterans?

The VFW firmly believes the VCL has improved and will continue to improve. Such improvement will continue to be slow, frustrating and life-endangering if the VCL does not begin collaborating with others. Aside from working with patient advocacy offices to cut down on non-crisis calls and VHA Member Services to readjust the advisory board and increase clinicians, the VCL must also work more closely with the Office of Suicide Prevention (OSP).

Member Services has undoubtedly assisted the VCL in quantity control, but OSP can also assist the VCL in quality control. If the goal of the VCL is to intervene for veterans in need of immediate assistance while they are in the middle of a mental health crisis, the VCL should be working with the subject matter experts and leaders in suicide prevention and outreach for VA. If all three offices could collaborate together, with better guidelines, Member Services would be able to continue improving the VCL call center expertise and business, while OSP would make sure the VCL is up-to-date with the most current clinical expertise on suicide prevention and outreach.

Draft legislation to establish a permanent Veterans Choice Program & Draft legislation from the Department of Veterans Affairs, Veteran Coordinated Access and Rewarding Experiences Act (CARE Act)

In the past three years, the VFW has assisted hundreds of veterans who have faced delays receiving care through the Choice Program, and has surveyed more than 8,000 veterans specifically on their experiences using VA community care. Through this work, the VFW has identified a number of issues and has proposed more than 15 common sense recommendations on how to improve this important program. The VFW would like to thank this committee for its leadership in addressing many of the issues the VFW has identified, such as making VA the primary payer for Choice Program care, removing restrictions on when VA is able to share medical records with Choice providers and making clinical necessity the trigger for community care.

The VFW must also commend VA and the third party administers for their willingness to work with us to address issues veterans encounter when obtaining care through the Choice Program. VA has made more than 70 modifications to the Choice Program's contract to address many of the pitfalls that have plagued the program, such as allowing the contractors to conduct outbound calls when they have the proper authorization to begin the scheduling process. The VFW is also supportive and pleased to see VA's eagerness to establish a pilot program which would share health care resources with the Department of Defense at up to five locations.

However, the Choice Program continues to face several challenges that must be addressed. That is why the VFW is very concerned that VA's CARE Act does not request to make the Choice Program a permanent discretionary program. The VFW believes this program must be improved and consolidated with other VA community care programs, but we oppose continuing it as a mandatory program. VA's medical care accounts are under discretionary spending and subject to sequestration budget caps. Having the Choice Program as the only VA health care program not subject to spending caps could lead to a gradual erosion of the VA health care system. Also, in an effort to streamline and improve VA's community care programs, the VFW believes all programs must be consolidated –– to include dialysis.

The VFW and its Independent Budget partners (DAV and PVA) also oppose VA's and this committee's proposal to eliminate the copayment offsets for veterans who have other health insurance. The VFW strongly believes implementing this change would limit VA medical collections. VA recently shared outreach material that urges veterans to share and update their health care insurance information with VA. The outreach material rightfully incentivizes veterans to share their information with VA because their VA copayments would be offset by money VA collects from their health insurance and such monies also covers their annual deductibles. Removing this offset would remove the incentive for veterans to share their health insurance information with VA and may even remove the need for veterans to keep their health insurance.

The VFW also opposes section 503 of VA's draft CARE legislation, which would round down cost of living disability pay increases –– a proposal which the VFW has opposed in the past and continues to strongly oppose.

The Administration has also proposed a cap on the amount of tuition and fees that may be paid under the Post-9/11 GI Bill for programs of education in which a public institution of higher learning enters into an agreement with another entity to provide such education. Currently, third party training programs that contract with public schools are able to charge unlimited fees since public schools have no set dollar amount cap. A couple of years ago, it came to light that some contracted flight training programs were charging exorbitant fees, which far exceeded the cost of an average in-state education. The VFW supports the Administration's proposal to place a reasonable cap on these sorts of training programs.

The biggest issue the VFW hears from veterans who use the program is the breakdown of communication between VA, the third party administrators, Choice providers and veterans. This breakdown has a significant impact on the care veterans receive. The VFW has heard from too many veterans that they were sent to the wrong doctor because VA and the

contractor could not figure out how to make certain the veteran sees the specialist who can provide the care the veteran needs. For example, veterans who need to receive the recently developed cure for Hepatitis C have been sent to hepatologists who cannot provide them the life-saving medications they need.

The VFW has also heard from veterans that the breakdown in communication between VA, contractors and Choice providers often delays their care because their Choice doctors do not receive authorization to provide needed treatments. What is concerning is that veterans are left to piece together the entire story or else they do not receive the care they need; or they are left to pay for the care out of pocket because their Choice doctors performed treatments beyond the scope of the Choice authorization. This is why the VFW is pleased to see the committee's draft legislation provide VA with consolidated networks and contracts while easing the payment process to the community care providers. Although, the VFW would like to see the draft legislation amended to provide VA with authority to incorporate use of a value-based reimbursement model, instead of requiring VA to do so. This authority would be best utilized initially as a pilot program, similar to Centers for Medicare and Medicaid Services, to see if value-based payments lead to better outcomes or reduced costs.

The VFW strongly supports provisions in the committee's draft legislation which would ensure VA remains the coordinator and primary provider of care for veterans. This includes ensuring VA is maximizing its resources before turning to community care to fill demand, and continually evaluating whether care VA is purchasing from community care providers should be delivered in- house. However, the VFW urges the committee to amend the bill to ensure veterans who are assigned a community primary care provider receive assistance from VA in selecting the provider that best fits their needs, instead of simply giving them a list of network providers and leaving them on their own to find one willing to see them.

VA has taken a number of steps to address this breakdown in communication. It is in the process of implementing a new authorization management system to eliminate the confusion regarding which providers veterans need to see. It has also worked with TriWest

Healthcare Alliance and Health Net, Inc. to have contractors co-located with VA community care staff at VA medical facilities to address the issues in approving secondary authorizations or ensuring veterans are sent to the right doctors. The VFW has received good feedback from VA employees and veterans at facilities with co-located VA and contract staff.

However, the underlying issue that causes this breakdown in communication is the fact that TriWest and Health Net are required to maintain their own systems to track Choice casework. VA transmits information to them instead of granting the contactors access to VA systems or using the same systems, which would eliminate the need to transmit data and documents between VA and the third party administrators. To avoid having to go through a third party when scheduling Choice Program appointments, VA has proposed to have its community care staff resume responsibilities for all the scheduling, which they have done in the past and continue to do under other community care programs.

The VFW supports utilizing VA community care staff to schedule Choice Program appointments when possible, but it is unreasonable to expect VA to be able to staff up enough to keep pace with the expanded use of the Choice Program. For that reason, the VFW recommends VA build on its co-located staff model and rely on contracted staff to support VA's community care staff when demand for Choice Program care spikes. To ensure veterans are not negatively impacted when they are rolled over to contract staff, VA must ensure the contracted staff has access to the same systems as VA community care staff.

As the VFW has highlighted in our two Choice Program reports, which can be found on our VA health care watch website, www.vfw.org/vawatch, the eligibility criteria for the Choice Program must also be reformed. The VFW firmly believes that VA must reevaluate how it measures wait times. In the VFW's most recent VA health care report, only 67 percent of veterans indicated they had obtained a VA appointment within 30 days, which is significantly less than the 93 percent VA reported in its most recent access report. This is because the way VA measures wait times is not aligned with the realities of scheduling a

health care appointment.

VA uses a metric called the preferred date to measure the difference between when a veteran would like to be seen and when they are given an appointment. However, this completely ignores and fails to account for the full length of time a veteran waits for care. For example, when veterans call to schedule appointments, they are asked when they prefer to be seen. The first question they logically ask is, "When is the next available appointment?" If VA's scheduling system does not preclude them from doing so, schedulers have the ability to input the medical facility's next available appointment as the veteran's preferred date –– essentially zeroing out the wait time. VA must correct its wait time metric to more accurately reflect how long veterans wait for their care.

However, VA's wait time measurement must not be used as an eligibility criterion for the Choice Program. While the VFW agrees using a clinically indicated date to determine eligibility is the right approach, we do not believe Congress or VA should dictate how long veterans must wait before receiving care from community care providers. Arbitrary thresholds such as 30-days or 40-miles do not reflect the health care landscape of our country. Veterans may not need to be seen within 30 days for appointments such as routine checkups. Likewise, such arbitrary thresholds do not account for veterans with urgent medical needs for which they need to be seen before 30 days, or veterans who suffer from disabilities which prevent them from traveling 40 miles. That is why the VFW is happy to see both this committee's and VA's draft legislation improve community care eligibility to be a clinically based decision between a patient and their provider.

The VFW does suggest amending the draft legislations to ensure VA is able to provide care and services to non-veterans if needed when caring for a VA-eligible veteran. In particular, this has greatly affected both live donor organ transplant patients as well as veterans seeking in vitro fertilization (IVF). If a veteran who uses VA and is in need of an organ transplant is matched with a non-VA eligible individual, that donor is not eligible to receive the operation or care under the current Choice Program eligibility requirements. Also, if a

veteran is approved for IVF services through VA and his or her spouse is a non-veteran, the veteran is not able to use the Choice Program to receive IVF.

When scheduling veterans for medical appointments, whether it is with VA or a community care provider, VA must take into account veterans' clinical needs and personal preferences. If a veteran has an urgent care need that must be met within 48 hours, that veteran must be seen within 48 hours. Additionally, VA must take measures to meet veterans' preferences when seeking care. For example, a male veteran who was sexually assaulted by a male may want to seek care from a female provider. VA should not have to interrogate veterans every time a veteran needs care, but it must give veterans the opportunity to discuss their preferences.

This would also require VA care coordinators to be able to view the availability and characteristics of VA and community care providers. VA must invest in information technology systems that would allow it to compile appointment availability for community care and VA. Doing so would enable veterans to truly work with their care teams to determine what options are best for them.

In its draft CARE legislation, VA has requested authority to reimburse veterans for walk-in care they receive from clinics around the country to fill the gap between emergency care and traditional appointment-based outpatient care. Doing so would ensure veterans with acute medical conditions that require urgent attention, such as the flu, infections, or non-life threatening injuries, do not wait days or weeks for a primary care appointment. Enabling veterans to be reimbursed for walk-in care would also curb the reliance on emergency rooms for non-emergent conditions, which is more expensive for veterans and VA. The VFW urges Congress to consider and swiftly pass legislation authorizing VA to reimburse veterans for using community walk-in and urgent care clinics. The VFW does, however, oppose any attempt to bill veterans for the cost of providing service-connected care, regardless of when or where the care is delivered. Furthermore, the VFW believes that copayments for community care programs must be the same as if veterans received such

care at a VA medical facility. Veterans must not be penalized because the care they need is not readily accessible at a VA medical facility.

The VA health care system delivers high quality care and has consistently outperformed private sector health care systems in independent assessments. The VFW's numerous health care surveys have also validated that veterans who use VA health care are satisfied with the care they receive. In fact, our latest survey found that 77 percent of veterans report being at least somewhat satisfied with their VA health care experience. When asked why they turn to VA for their health care needs, veterans report that VA delivers high quality care which is tailored to their unique needs and because VA health care is an earned benefit.

VA has made significant strides since the access crisis erupted in 2014 when whistleblowers across the county exposed how long veterans were waiting for the care they have earned and deserve. However, VA still has a lot of work to do to ensure all veterans have timely access to high quality and veteran-centric care. Veterans deserve reduced wait times and shorter commutes to their medical appointments. This means turning to community care when needed, but also means improving VA's ability to provide direct care. In this committee's draft legislation, the VFW believes the annual capacity and commercial market assessment must include a requirement to identify how building internal capacity either through construction or hiring would improve access, as well as identify barriers preventing VA from doing so. This would ensure Congress and VA know what improvements are needed within VA.

The VFW thanks Congress for its commitment to improving VA's community care authorities and programs. VA also needs the resources and authorities to quickly recruit and properly compensate a high performing health care workforce, properly train its employees, hold wrongdoers accountable, and update its aging capital infrastructure. Community care must continue to supplement direct VA health care. This means VA and Congress must continue to invest in VA to ensure it remains a premier health care system. That is why the VFW supports sections 301, 303, 304, 305, 307, 308, 309, 321, 322, 323,

324 and 401 of VA's draft CARE legislation.

The VFW supports passage of provider agreement legislation. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not able to provide the care. To ensure VA's community care programs operate appropriately, the VFW believes that provider agreements must supplement, not supplant the community care networks. Additionally, providers should be incentivized to join the community care networks, instead of continuing to operate under a provider agreement.

Provider agreements are particularly important for VA's ability to provide long term care through community nursing homes. The majority of the homes who partner with VA do not have the staff, resources or expertise to navigate and comply with FAR requirements and have indicated they would end their partnerships with VA if required to bid for FAR contracts. In fact, VA's community nursing home program has lost 400 homes in the past two years and will continue to lose 200 homes per year without provider agreement authority. This means thousands of veterans are forced to leave the place they have called home for years simply because VA is not able to renew agreements with community nursing homes. Congress must end this injustice by quickly passing provider agreement legislation.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in Fiscal Year 2017, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.