CHOICE CONSOLIDATION: EVALUATING ELIGIBILITY REQUIREMENTS FOR CARE IN THE COMMUNITY

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Tuesday, February 2, 2016

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Bilirakis, Huelskamp, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, Kuster, and O'Rourke.

OPENING STATEMENT OF DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. Good morning. The Subcommittee will come to order.

Thank you all for joining us for today's Subcommittee hearing, Choice Consolidation: Evaluating Eligibility Requirements for Care in the Community.

Today's hearing is our first of the new year, our first during the second session of the 114th Congress, and most importantly our first in a series of hearings that we will be holding on different aspects of the Department of Veterans Affairs' plan to consolidate care in the community under the Choice Program.

The VA currently uses seven mechanisms to provide care to veteran patients in the community. Each of these seven mechanisms works differently using seven different eligibility criteria, seven different reimbursement rates, seven different administrative processes, and seven different sets of business rules.

Recognizing that using multiple means to achieve the same end was confusing and inefficient, Congress required the VA to develop a plan to consolidate all seven community care programs under a single umbrella, a new, improved Choice Program.

The VA provided the bare bones of that plan last year and over the next several weeks, we will examine it in depth beginning with today's conversation on eligibility. Determining who will be eligible for what and when under the new Choice Program is perhaps the most important of all the discussions we will be holding over the next few months.

Eligibility for care in the community now is determined largely by how long veteran patients have to wait for an appointment, how

far they have to drive to get to the nearest VA medical facility, and when they get there, whether the VA can provide the service that they need.

While these existing criterions are not perfect, VA's proposed plan does not change them significantly. The VA's plan does include several significant changes to eligibility criteria for emergent care, however, by authorizing veterans to seek care in urgent care centers and requiring cost sharing for emergency care services in non-VA centers in order to incentivize appropriate behavior.

I am cautiously supportive of the eligibility criteria that the VA has laid out in the consolidation plan, though I remain concerned about many of the lack of details that the plan includes.

Moving from seven disparate methods for referring veterans to community providers to one streamlined common-sense program is certainly necessarily, but changing the status quo is never easy. And as the saying goes, the devil is in the details, precious few of which the VA has provided so far.

That is why I am glad to be joined this morning by Dr. Baligh Yehia, the new Assistant Deputy Under Secretary for Health for Community Care, who is leading the VA's consolidation efforts. I am hopeful that Dr. Yehia will be able to provide us some of the concrete details about how the VA will determine eligibility under the new Choice Program that the plan did not include. And I am looking forward to that discussion.

I am also glad to be joined this morning by representatives from many of our veteran service organizations. As veteran advocates and veterans themselves, I look forward to hearing their unvarnished opinion about the proposed consolidation plan and whether they believe it will help us accomplish our most important goal which is increased access to high-quality care for veterans we are all here to serve.

I thank you all for being here this morning and now yield to the Ranking Member, Ms. Brownley, for any opening statement she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for calling this hearing today.

After more than a decade of war, veterans deserve to have ready access to the best health care available to them. Time and again, that is shown to be care provided by the VA. I am pleased the VA is here today to talk about their new Veterans Choice plan that will consolidate the seven disparate care authorities that exist currently in law. This plan submitted to Congress in 2015 would bring under one umbrella a program that is easy to understand and more importantly to implement. The program is intended to bring high-quality, safe health care to veterans wherever they choose to live.

When Congress passed and the President signed the Veterans Access Care and Accountability Act in 2014, this was a promise to all veterans from all eras that they would get the care they earned on the battlefield in defense of our Nation.

The Choice Program was rolled out in a rushed timetable under conditions dictated by Congress. I believe the department imple-

mented the program to the best of their ability under trying circumstances.

Today, Mr. Chairman, I am interested in hearing from the VA what the estimate of this new care in the community will cost and how long it will take to implement, also what this consolidation ultimately means for veterans and their access to quality health care. After all, making it easier for veterans to access care is the goal that we all have in this room of this plan.

One aspect of health care often overlooked is helping those navigate the system with physical disabilities that force them to bring a caregiver with them. I have introduced legislation that would authorize payment of beneficiary travel expenses in connection with the care of a veteran with vision impairment, a spinal cord injury or disorder, or double or multiple amputations whose travel is in connection with care provided through the VA.

It is important that all veterans have access to quality health care whether at the VA or in the community, but the care needs to be at the standards we have come to expect from the VA.

I look forward to hearing from all of the witnesses today. I thank you for being here and moving forward in the coming days to bring the very best quality care to all of our veterans.

And I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you.

Joining us on our first panel this morning is Adrian Atizado, the Deputy National Legislative Director for the Disabled American Veterans; Carl Blake, the Associate Executive Director of Paralyzed Veterans of America; and Duane Williams, Georgia Leadership, Fellow for the Iraq and Afghanistan Veterans of America. Thank you all for being here today, gentlemen.

Mr. Atizado, we will begin with you. Please proceed with your testimony.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, on behalf of the 1.3 million wartime ill and injured veterans of the DAV, I want to thank you for allowing us to testify today.

You had asked to examine VA's plan to consolidate certain authorities that it uses to purchase care in the community into the proposed new Veterans Choice Program. You also asked us to assess whether the proposed eligibility criteria to access the new VCP are sufficient to increase access to care among veteran patients.

The way we see it, Mr. Chairman, we believe VA's entire plan will increase access to care, no doubt. Whether it is sufficient, though, will remain to be seen.

So, for example, the plan proposes to continue the existing geographic and temporal eligibility criteria of the current Veterans Choice Program as well as the availability of services criteria currently utilized in other authorities such as dialysis and PC3 contracts as well as the now defunct fee-basis care.

All these criteria have their own limitations and vulnerabilities from veteran patients' perspective in allowing them to access care in the community. Now, on a system level, these criteria would continue to administratively separate the new VCP from the VA health care system which we believe does not foster full integration

and limits the performance of these networks to the detriment of veteran patients.

Under the separated construct, Mr. Chairman, we recommend serious consideration that eligibility to use the new VCP should mirror the current eligibility for VA health care giving the highest priority to service-connected veterans.

However, DAV also believes clinical decisions about when and where and with who to receive care is one that should be between a veteran and his or her doctor without bureaucrats or regulations getting in that way.

Under this construct, all of VA's authorities are consolidated and its medical benefits package reflects what is generally available and acceptable in the private sector. The seamless integration of community care into the VA health care system would be able to provide a full continuum of care.

From a veteran patient's perspective, the future VA health care system with the integrated VCP should be responsive to the decisions between veterans and their providers. Veterans should be able to choose among the options within VA in the new Veterans Choice Program network and schedule appointments that are most convenient for them.

For emergency and urgent care coverage, we applaud VA for including them in its plan. In fact, DAV had specifically urged the inclusion of urgent care into VA's medical benefits package and to better integrate emergency care with the overall health care delivery system.

However, there is nothing more glaring that will deter appropriate access to emergency and urgent care in the community as the plan's imposition of co-payment to all veterans with little relief. VA clearly knows the value of ERs and urgent care clinics and their appropriateness as clinical settings because it owns and operates them in VA facilities across the country.

If certain veterans do not pay co-payments today when receiving VA emergency and urgent care, we question why VA's imposition of co-payments to all veterans who receive similar care in the community. Simply put, if the future VA health care system with the integrated new Veterans Choice Program are unresponsive to the medical needs of veteran patients, why should veterans be penalized with a co-payment for a health care delivery system's shortcomings?

At the very least, service-connected veterans should not face greater restriction in the future VA health care system when accessing care in the community.

Finally, Mr. Chairman, we understand the scope of the consolidated plan is limited. However, we do caution Congress and the Administration on this fragmented approach to providing veterans timely access to care in the community.

If Congress intends to increase veterans' access to high-quality care across a continuum of care including care in the community, not addressing gaps and inconsistencies in VA's plan, in VA's medical benefits package as it sits against all available services in the community, we believe that VA will assuredly continue certain fragmentations of care that veterans experience today into the future.

Veterans could be left unassisted across different providers and care settings fostering frustrating and unsafe patient experiences leading to medical errors, waste, and duplication that foster poor overall quality of care.

You have our commitment, Mr. Chairman, that DAV stands ready to work both with you, the Congress, and VA to ensure veterans have ready access to high-quality care both in VA and in the community.

Mr. Chairman, thank you for your time and attention and for the opportunity to present this testimony. I would be pleased to answer any questions you or Members on the Subcommittee may have. Thank you.

[THE PREPARED STATEMENT OF ADRIAN M. ATIZADO APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Atizado.

Mr. Blake, you can go ahead.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman.

Chairman Benishek, Ranking Member Brownley, Members of the Subcommittee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

Let me say up front that we believe that the VA's community care consolidation plan lays out a positive path towards the delivery of timely quality care and improving access for veterans. However, we do believe that there are questions that remain as it relates to the veterans that we serve, veterans with catastrophic disabilities like spinal cord injury and disease.

As eligibility dictates access to health care, so, too, does the capacity of the systems to provide that care. Over the years, the VA health care system has relied upon a number of methods and standards to measure access and timeliness of health care delivery.

We have seen the VA standard evolve from the 14-day wait time to the 30-day wait time. We have seen Congress and the Administration seemingly accept an arbitrary 40-mile, geographic-based access standard. The fact is, there is no evidence to suggest that arbitrary wait time standards are an indicator of quality.

Rather, they are bureaucratic tools to self-assess output performance. They are not a measure of quality care. To suggest otherwise is unfounded. Similarly, geographic-based access standards are not derived from industry best practices for the provision of health care.

The independent assessment on access standards conducted by the Institute of Medicine determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait times similar to the Veterans Choice Program 40-mile and 30-day standards.

PVA, along with our partners in the Independent Budget, DAV and VFW, strongly agree with the IOM's recommendation that decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their

families and their providers. We believe that this concept will also best serve the needs of our members and all veterans.

The irony of all this discussion about access standards is PVA members often travel farther than any other population in the specialized population of veterans or even all veterans in general seeking care from the VA. It is not unusual for PVA members to travel more than several hundred miles to reach one of the 25 SCI centers of care in the VA system. They do this because the VA SCI system of care is far and away the best option that they have to meet their specialized health care needs.

The access problems these veterans face are usually not wait times or distance. They are the burden of cost. Ms. Brownley, I would like to thank you for bringing attention to that issue in your opening remarks.

As a result, veterans may wait to be seen until their condition deteriorates requiring more costly and intensive care. This Subcommittee is reviewing the question of eligibility without even considering this important fact.

Congress should expand travel benefits to include non-service-connected, catastrophically-disabled veterans who are already granted a higher priority in the system to ensure that they are able to receive quality specialty care.

PVA believes that the 30-day and 40-mile eligibility standards that determine access under the new VCP do not consider what is best for veterans with catastrophic disabilities to include SCI and D or any other veterans seeking care for that matter.

PVA along with our IAV partners also support the plan to expand emergency care and urgent care in the community. However, we strongly oppose the proposal to charge $100 as a co-payment for emergency care and $50 for urgent care. This proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. These veterans should not be required to bear a cost share as it may disincentivize that veteran or their caregiver from accessing emergency treatment or urgent care defeating the whole purposes of expanding these two opportunities.

As an alternative, VA should also consider establishing a national nurse advice line to help reduce over-reliance on emergency room care. The Defense Health Agency has reported that the TRICARE nurse advice line has helped triage the care for TRICARE beneficiaries.

Those 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, when and where they should receive it.

This advice line must also include, must include SCI trained providers who are able to identify potential complications specific to an SCI or D veteran.

Mr. Chairman, I would like to thank you again for the opportunity to testify. Be happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Blake.
Mr. Williams, go ahead.

STATEMENT OF DUANE WILLIAMS

Mr. WILLIAMS. Good morning, Mr. Chairman.

Mr. Chairman, Ranking Member Brownley, distinguished Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America and our 425,000 members and supporters, thank you for an opportunity to share our views with you at today's hearing.

By way of introduction, I am a retired Army person having served 26 years active duty, six years in the reserves. I serve as the Chairman of the Veterans Affairs Advisory Board of DeKalb County, Georgia, and I am responsible for Veterans' Recognition Advocacy and Research Program on behalf of 41,000 veterans in that county.

I also serve as the Iraq and Afghanistan Veterans Leadership Fellow focused on veteran leadership, development, policy advocacy, and team building. These experiences help me to understand the needs and challenges of veterans accessing quality care.

IAVA is proud to have previously testified in front of this Subcommittee recommending the need for consolidation of care in the community of veterans enrolled in VA health care. We applaud Congress for requiring VA to put forth a plan for consolidation. We recognize the senior VA leaders for acknowledging the need for consolidation and for providing inclusive veteran-centric and transparent plans.

The 2015 Choice Improvement Act helped begin the process of removing confusion for veterans. However, IAVA's most recent member survey indicated that five percent of the respondents that use the Choice Program and their reviews were mixed. For the 95 percent of IAVA members who have not used Choice, 43 percent didn't use it because of confusion on how to use it and half were totally unfamiliar with the program.

In Atlanta, Georgia, the enrollment for health care at the Atlanta VA Medical Center is growing faster than the capacity for primary care. According to the 2013 vet pop data, the number of veterans living in the 28-county metro Atlanta area was 294,000. By 2014, the data reflects 361,000 veterans living in the same area. And during the same period of time, the Atlanta VA hired 600 additional employees.

Related to this, on January 20th, the Atlanta VA stated that the current completion for VA primary care appointments was 60 days. But by January 26th, the director advised me that the wait was reduced to 20.6 days. If these numbers hold true, the reduction in wait time by nearly 40 days within six days is remarkable. We hope other VA medical centers follow suit. We hope this Subcommittee will continue to monitor, analyze, and ensure the accuracy of wait time data.

As Congress moves forward to simplify this process for veterans, IAVA recommends that the Congress works with the VA. Use the VA as a plan, as a framework for legislation to avoid the one-off proposals that might be misinformed or put politics ahead of veterans. After all, the Congress provided different plans that added

to the confusion and inefficiencies leading to the need to consolidate care.

We believe Congress should be mindful of these lessons learned from them and leverage the VA's plan as a framework for consolidation of care.

Our second concern is VA's ability to effectively implement a plan to consolidate care across VA to avoid the mistakes made during the implementation of Choice. While the Choice Improvement Act of 2015 extended provider eligibility to any provider meeting VA criteria, the VA must use this opportunity to streamline and standardize the medical documentation requirements.

Under the 2014 law, reimbursement rates for non-VA providers is limited to no more than Medicare. Reducing the administrative requirements can remove a barrier to more providers joining the network.

VA intends for its health delivery model to be a patient-centered medical home for veterans. Therefore, VA holds responsibility for the direct coordination of services for each veteran. Care coordination is a core function of primary care. Significant numbers of VA patient needs are complex.

The factors that increase the complexity for our veterans are a number of them have multiple chronic health problems, social vulnerability, a large number of providers, and the patients lack the ability to coordinate their own care. Significant numbers of VA patients have anxiety disorders, dementia, depression, and kidney failure.

IAVA recommends VA continue to collaborate with all stakeholders who share their vision to put the veterans first and focus on value-based leadership to change the VA culture. Given the shortcomings related to training front-line personnel in the implementation of Choice and customer service, VA should continue to put forth efforts to train all employees in the consolidated care model.

Finally, IAVA encourages the Congress, VA and VSOs, the industry and other stakeholders to place increased importance on the quality of care that veterans receive, especially providers who haven't served veterans since their residency training.

In closing, thanks to this Subcommittee for your leadership and your commitment to veterans. Mr. Chairman, I stand ready to answer any questions you may have.

[THE PREPARED STATEMENT OF DUANE WILLIAMS APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you. And thank you all for your statements. I am going to yield myself five minutes for my questions.

You know, as a doctor who took care of veterans in my private practice and with some VA coordination and also working at the VA doing care, many of the things that you brought up today, I have experienced in reality.

And the frustration of veterans that I hear from now, and the work that my staff does to try to get veterans into care is so frustrating. And having a single system that really is based on clinical need makes much more sense and I completely understand that.

And the whole difficulty with the criterion, I think is an effort to contain costs. One of my biggest gripes in my time here has been the inability to figure out what it actually costs the VA to take care of a patient. So, we don't know if care in the community is more expensive than care in the VA, frankly, although it seems to add more to the total cost.

But let me just ask a couple of questions that have come up based on your testimony and some of the written statements. The Military Officers Association of America, for example, called on the elimination of these access standards and the establishment of clinically-based access standards instead.

Can you elaborate a little bit more on your thoughts relating to that? I mean, the miles and the time versus what is clinically right, does anybody want to comment on that?

Mr. Atizado, can you talk to me a little bit more about some of the things you brought up in your statement?

Mr. ATIZADO. Sure, Mr. Chairman. I think first and foremost, what has to be said is where we come from which is from the patient's perspective. This plan really comes from a systems perspective, from the providers' perspective.

And what we are trying to say is, in order to simplify eligibility and to ease access to care, whether it is in VA or in the community, there should really just be one eligibility criteria. Once you are enrolled in VA, you should have the option to use VA or the community, whichever is most convenient for the patient.

As it relates to the doctors' recommendation, unfortunately, as you had mentioned, these criteria are really cost-containment measures. And we understand that. It is a feature of the health care system today, and most likely, will remain a feature in the future VA health care system.

But by and large, the approach in the plan really is to disincentivize or make harder accessing care in the community. We think it should be the other way around. The plan should incentivize veterans to use VA, not disincentivize them from using the community. The plan should simplify accessing care as patients see it. It is very simple.

Mr. BENISHEK. Well, I agree with you.

Mr. ATIZADO. And our proposal really does that. Once you are in, you are in.

Mr. BENISHEK. Mr. Blake.

Mr. BLAKE. I think it is fair to say that part of the reason the Institute of Medicine couldn't find examples of 30 days and 40 miles is because that is not how the larger health care system in America works. I think it is based on the idea that I meet with my provider and we determine as a partnership, as it were, what is best for me as a patient, when should I be seen, where would it be most appropriate for me to be seen, what procedure would be most appropriate.

And while I think on some level that exists in VA in some places, the strictures that are in place right now, as Mr. Atizado mentioned, allow it to be maybe more rigidly managed is just not optimal. That is why we have joined with our partners in the IAV to say that the VA should move to a clinically-based access standard.

I don't know if Dr. Yehia would admit it, but, you know, we were involved in a lot of the meetings, and I think they understand that. But they have to figure out how to develop a workable plan within the construct that they have available to them. I think 30 days and 40 miles allows you as the Congress to control based on how much it is going to cost. And if you open up the possibilities with a clinically-based access standard, it is a little more uncertain what the cost might actually be.

Mr. BENISHEK. Well, my thoughts in talking to some of the VA administrators that I have talked to said that the different rules make their bureaucracy work so hard to try to get people to—one or the other, one of these criteria than we have now is just slowing the whole process down. And I think streamlining the eligibility would help in that regard because that is the biggest complaint I have had from the VA.

Mr. Williams, do you have any further comments on that?

Mr. WILLIAMS. Mr. Chairman, the only thing I would do if I put that in the context of the patient-centered medical home, the primary care physician has to be the person that decides what type of care the patient needs and what frequency they need. And I would think VA's primary care provider would know that. That is a frustration I dealt with myself.

That provider ought to be able to say that this patient needs to be seen for specialty care at this point, and I need that information back to me within a reasonable amount of time and get that done. And they have to do that for the patient.

Mr. BENISHEK. Thank you very much. I am out of time.

Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I think your statement regarding we really don't know what the cost of VA care is versus community care, we really don't know the answer to that. And that is a fundamental, I think, piece of data that we really need to understand.

And I was just wondering for all three of the panelists here based on your organizations and the research that you do to support our veterans, if you have any sense of an answer to that sort of fundamental question in terms of health care delivery through the VA versus community care.

Mr. BLAKE. I would only offer this much. I think there has been a number of studies that have probed at the question about cost differences and no definitive answer has ever been delivered.

I think from the perspective of having done some of the budget work with the Independent Budget, I think the challenge is the VA health care system is not the private health care system. And we have to accept that up front first, so you can't just assume—you can't make it an apples to apples comparison even down to cost because the nature of the system and how it provides its services is not entirely reflective of the private health care system.

So I don't know that we can ever get to a definitive answer and maybe that is the challenge. Maybe we need to set that aside as the question. Unfortunately, that is a key focus that Congress has to be focused on because you decide how much resources the VA is going to have to operate. And I don't envy that position that you set in.

Ms. BROWNLEY. Yeah. I just think, you know, intuitively there are some services that veterans receive. I am thinking about, you know, getting your eyes checked and getting a pair of glasses or audiology, services like that, which seems to me would be cheaper if that was all handled, you know, within the community than for veterans having to travel long distances and so forth and so on to get to their VA.

So, I mean, I think it is a hard question to try to answer because I think it probably breaks down into a lot of different pieces as it relates to kind of specialty care beyond primary care. So it gets difficult.

Mr. Williams, you had mentioned some of the surveying results that you have done with your organization, and I think you said that 43 percent of your veterans aren't utilizing the Choice Program because of confusion.

Did you get any results in terms of veterans not using the program because the providers weren't there in the community and set up with the VA to be able to provide that care at all or—

Mr. WILLIAMS. I don't think that was part of our surveys. I would have to get back with the IAVA leadership on the availability of providers in the community.

Ms. BROWNLEY. Because I think that, you know, I mean, we hear a lot about the Choice Program and, you know, I think in some sense about what we are talking about today and consolidating all of these programs. I think we all agree that consolidating these programs for community care is a good idea.

You know, this criteria for access is, you know, is up for debate. But I think the consolidation pieces minimizing the confusion for the veteran, I think we all agree that is absolutely the right way to go.

I mean, some of the criticisms that I hear, I was just talking to one of my colleagues from Florida earlier this morning and she was bending my ear about how the Choice Program in her district is just not working and she is hearing a lot of complaints from her veterans about the program and access to the program.

So I don't know where I am really going with this, but I do hear a lot of feedback from people that are still—I know that there is a lot of work to increase the amount of providers in the Choice Program specifically, but I don't think that we are—again, probably in some areas, we have the right amount of providers and other areas, certainly in my district finding the providers has still been a challenge.

So even if you wanted to utilize the program, even if you were willing to do all of the research to figure it all out and you met the criteria, in, you know, in some cases, the providers simply just aren't there yet. And perhaps part of that is because of the confusion.

But, you know, I would be interested to hear from the two other gentlemen about just, and I have like two seconds left now, but maybe we can talk about it later, you know, what the feedback is from your members in terms of the success or challenges within the program.

So I will yield back.

Mr. BENISHEK. Dr. Huelskamp, you are recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I would like to follow-up on the questions from Ms. Brownley about the provider network and see how we can—I think Mr. Williams talked about reducing some of the administrative burdens.

I will say in the 1st district of Kansas which I represent, it is probably the most rural and least served district by the VA. There are no VA hospitals, but I have 70 community hospitals. Just got the numbers last week. We have 1,309 providers. That doesn't mean they are all happy to get into that network. They are willing, but the administrative burden is overwhelming.

Every one of these facilities has been certified by Medicare for years. Now we have a separate certification process through the VA.

Mr. Williams, you brought up in your testimony, are there things that you can recommend that we can get the VA—could you reduce the administrative burden so these providers are there? They are ready and willing. They will take the Medicare reimbursement which beats Medicaid. The Medicare, they will take that reimbursement, but the paperwork is much, much more intensive than anything else in the network.

So some input from Mr. Williams. Mr. Blake or Mr. Atizado on that?

Mr. WILLIAMS. Sir, I would just have to say, and this is pulling away from that, but I met with some of the leaders from the Georgia Medical Association and that was one of their concerns when it comes to the cost of physicians working in the network with the administrative costs that it costs their physicians because they were even concerned about reimbursement rates for Medicare and Medicaid versus administrative requirements.

But they brought up that that was an issue with their participation in Choice, was the simple administrative overhead.

Mr. HUELSKAMP. Yeah. Mr. Blake or Mr. Atizado?

Mr. ATIZADO. Mr. Huelskamp, thank you for that question.

I guess I think the first thing we need to recognize is that the Choice Program really is a pilot program. It is a temporary measure that was meant to address an access issue. The administrative rules as it relates to the law that was passed adds to that confusion.

I do understand from Ranking Member Brownley's question that whether or not the networks are, in fact, meeting the need is a two-way street, you know. TRIWEST and Health Net have in my estimation tried to do a tremendous job in creating a national network in so many months and not having the appropriate description of demand from the VA health care system makes that job a little bit harder.

I do believe that network is working much better now. They are increasing appointments at an incremental rate. But the administrative burden for providers to join any kind of network is inherent, right? If we want providers to be of a certain quality, they have to meet certain standards. Whether that be Medicare, so be it.

Part of the provider agreement authority legislation that this Subcommittee has been wrestling with is that. Who are the pro-

viders we would want our veterans to seek care from? We can make that as hard or as simple as possible, but that really is a feature that is within our control.

Mr. HUELSKAMP. I think you raise a great point and especially your first one about this being seen as an almost temporary program as to deal with a problem. I will say in rural areas, this is an ongoing problem and it didn't just start two years ago. We drive hundreds and hundreds and hundreds of miles and you are driving by ten hospitals to get to the VA hospital. Then you wait in line. And that is not good enough.

And I think we have heard from the VA as well. They see this as temporary, a pilot program, an approach that maybe two years from now, it might go away. I will note to the Committee, don't forget the House bill didn't have some of these arbitrary standards. And we had some cost concerns and I understand that.

But what is magic about 30 miles? What is magic about 30 days or 40 miles? There is not, other than you have to drive that. And so I appreciate the input on that particularly.

Are veterans still just presuming, and maybe Mr. Williams particularly with your survey, are they presuming this is just a pilot program that will go away and there will be another variation of this in the future, and does that limit their participation or any of the three?

Mr. BLAKE. Well, I wouldn't say they presume it. I mean, everybody, I think, understands that this program will sunset either on a date certain or when the money runs out. You know, your district is one of those ones that has always sort of befuddled me.

It was sort of tailor made for the old fee-basis standards which had written in regulations geographic inaccessibility. And for the life of me, I never understood what it would take to define it. That is what was attempted with the Choice Program with 40 miles in particular.

Adrian mentioned an interesting point about the networks that TRIWEST and Health Net are trying to build. The challenge is building a demand-appropriate network. Within the construct of the framework that we propose with DAV and VFW is the idea that through the integrated network, which is the right way to deliver care by and large, it needs to be distilled down to the most local level.

Mr. O'Rourke looked at this idea in El Paso. They went out and figured out exactly what the community was capable of, particularly in the area of mental health, to figure out what it would take in a partnership between VA and the community to meet demand.

All that being said, most of our members from the PVA perspective just don't use Choice because the networks do not meet the demand that they have. And at the end of the day, the private sector struggles to meet the unique needs of SCI veterans, blinded veterans, veterans with polytrauma.

So there is a complicated circumstance that exists here where the VA has to meet demand for principally primary care and mental health care which are sort of the big elephants, but you can't forget that there are many veterans who the VA is their only and best option and how that gets right-sized with whatever the new VCP ends up looking like.

Mr. HUELSKAMP. All right. Thank you, Mr. Chairman.

Mr. BENISHEK. Dr. Ruiz, you are recognized.

Mr. RUIZ. Thank you, Chairman Benishek, Ranking Member Brownley, for holding this series of hearings centered on VA's proposal to consolidate community care.

We have asked the panelists to tell us how they would modify the eligibility standards that are necessary to create a veteran-centered VA. But to answer these questions, you know, we need to look at the cracks that the Choice Act has left behind or the cracks within the Choice Act because these are the cracks that our veterans are falling through and these are the reason experiences of veterans in my district that do not reflect the successes that the department boasts.

So my first question is, can you specifically identify what are those cracks? Which of our veterans are not getting the care through the Choice Program that it was intended to do?

Mr. ATIZADO. I will give you a good example, Congressman Ruiz. Veterans need home and community-based services. The Choice Program does not allow VA facilities or doctors no matter how clinically appropriate it is to use Choice money to buy home and community-based services.

In fact, only home and community-based services as we all know is a cheaper alternative to institutional care, less expensive, more veteran-centric. It is skilled nursing care. That is it. Out of all the home and community-based services that veterans can receive that VA can provide under existing law, that is it.

Mr. RUIZ. How about you, Mr. Blake?

Mr. BLAKE. Well, I would say that the Choice Program is simply not built to meet the specialized health care needs of veterans like SCI and D, substance abuse, polytrauma, and TBI, blinded veterans.

I think that wide spectrum of unique populations of veterans that the VA serves, I don't think the Choice Program is designed to serve because they might be able to go outside the system, only in a perfect world might it work, where full integration with the community so that it is seamless, but that might be a dream.

Mr. RUIZ. I think one of the problems with the eligibility criteria of a 40-mile distance is that you can have a VA clinic that does not offer the specialty care that our veterans need.

For example, in my community, we have a clinic in Palm Desert in the center of the Coachella Valley, but it does not have a pain specialist working at that clinic, does not have, for example, a dentist or other specialty kind of care. So our veterans still have to travel an hour, hour and a half to the VA hospital to get that kind of specialty care.

So when you talk about clinically appropriate eligibility, is that what you mean, like making sure that what they need in terms of the specialty care, they can acquire if it is not within the 40-mile distance?

Mr. ATIZADO. Congressman Ruiz, what we mean by clinically-based decisions is when veterans get to access the community care network. The way the plan is and even the Choice plan as it stands, it really requires veterans to, one, enroll in the VA health care system and then, two, be eligible for the Choice Program or

even this new Choice Program. So it is really two separate eligibility criteria to begin with.

Mr. RUIZ. Yeah. I think that we need to take pause and throw out a big caution out there. Many of our veterans are working poor, are retired, or work in rural areas. And we are working under the assumption that in those communities for some reason, those services exist.

I come from an area that has both affluent and under-served communities. And I can tell you that in the under-served communities, you don't have specialists. You don't have community homes. You don't have any of the care that we are assuming that veterans can achieve outside of the VA.

So I think that we have to really identify and not think that because we have the Choice Program because veterans can go to their neighborhood doctor that they are going to get the care that they need. We need to take into account the insufficiencies and the lack of resources and the vast majority of America that live in rural communities as well.

Hotline, tell me about the hotline and what evidence is out there that it actually saves money and also incentivizes patients to use the VA?

Mr. BLAKE. Well, I think there is a reference in my testimony what they have done through TRICARE shows that it is certainly a workable solution. That is not to say that TRICARE is the model of perfection in this case. But I think what we are trying to do is ensure that veterans are making the right decisions when it comes to emergency care and urgent care.

I think we all believe that urgent care is a must. It is something the VA has not really ever done and, unfortunately, I think you have seen in the community in private sector now, a lot of health care is delivered through an urgent care setting. And so it is probably time for the VA to get involved in that because that alleviates the pressure on primary care. In the health care setting in VA, it relieves the pressure potentially on the mental health care which is—

Mr. RUIZ. Right.

Mr. BLAKE [continued]. —a big part of it.

Mr. RUIZ. Urgent care was a result of a failed primary care system where people weren't able to access their primary care so they needed a quick in and out type of thing. But it can't replace primary care because when we are talking about a medical home, a place where a patient can get integrated care with case management that can really take care of the entirety of the patient, urgent care doesn't necessarily provide that as we think of them now.

So there are some benefits to urgent care, but we also have to make sure that the veterans also get home-based comprehensive primary care that they deserve.

Mr. ATIZADO. I agree with you, Congressman Ruiz. Yes, primary care is integral in coordination with care, but primary care is not all.

Mr. RUIZ. Correct.

Mr. ATIZADO. And it never will be all. And you are right. Urgent care has a place. There is an appropriate setting for seeking care

in that. And we don't think veterans should be penalized because that is the appropriate setting for care.

Mr. BLAKE. And I wasn't suggesting that urgent care is the solution. I mean, what we find now is a lot of veterans go to the emergency room. That would be true in the private sector except now you have urgent care everywhere, so the solution in the community has become everybody goes to urgent care. Veterans don't even have that option so they just overrun the emergency care setting in the VA while the primary care system just sort of lumbers along because it is overwhelmed as well.

Mr. RUIZ. Well, my time is up, but I wanted to say that the veterans that I take care of in the emergency department and the veterans that I take care of in the office who are struggling with their benefits, who are struggling to make ends meet, who are struggling to get back on their feet, who are struggling to find a home that are homeless, $50 co-pay for urgent care, $100 in co-pay for the emergency department is completely a barrier that will continue the burden of illness and disease that they already have. So I agree with that.

Mr. BENISHEK. Thank you.

Dr. Abraham, you are recognized for five minutes.

Mr. ABRAHAM. Thank you, Mr. Chairman, Ms. Brownley, for having this hearing.

Thanks to the witnesses. Appreciate your very direct testimony.

And like Dr. Benishek and Dr. Ruiz, I come from a private setting, so looking at it from the outside in, so to speak, this should be such a simple solution, but evidently it is being muddled up and the water is being muddled by bureaucracy.

I made some notes and I will go down them very quickly. Again, it should seem simple. I know that the VA and we as Congress have to watch the purse, but I am afraid we and the VA, especially on cost, is looking through the soda straw and not the overall picture simply because we in the medical field know that if that patient comes back and back and back for a problem that is not being addressed or not being fixed, costs just incrementally increase.

And if the VA is unable to give us a cost per patient, then I wouldn't bet the house that they could give us how many times that veteran is having to come back because that issue was not resolved. And that just adds exponentially to the cost.

So I am going to paraphrase, and please correct me if I misstate what I perceive that you told us in testimony, that the way to streamline and fix this issue is again simple. Once in, you are in. That should be fairly simple.

I like the nurse assistant line. I know that does work in the private sector. I know it worked in my clinic, saving patients going to the emergency room. We had a nurse on call and countless of thousands of dollars I am sure were saved from either waiting until tomorrow, treating that patient over the phone, going to a not emergent facility as opposed to an ER.

Mr. Blake, you said that no co-pay is a good thing and I would tend to agree with that. I will tell you that.

Mr. Williams, you said there is still a lot of confusion in Choice. I think that goes back to both the fault of the VA and the Congress. We should have done a better job of putting it out there with

bullet points and making it, you know, a one-pager. It should not be that hard to explain this program. It should not be.

Also, Mr. Williams, you said in your VISN that the VA added significant more employees and you saw wait times come down. Do we know or can we extrapolate that that actually improved care, or did it just eliminate wait times? I know it is a theoretical question, but just give me a gut feeling. What do you think?

Mr. WILLIAMS. Congressman, it was absolutely important to hire those employees to cut the wait times.

Mr. ABRAHAM. And, again, I know, but do you think by cutting the wait, and, again, I am just asking an opinion, in a non-emergent setting, does cutting the wait time improve the quality of care that that veteran gets? I am assuming it does, but I am asking you. You have talked to your veterans. Do they perceive that as being an improvement of quality of care?

Mr. WILLIAMS. In Georgia, the access to care is critical and access in a lot of our veterans' minds is interpreted as quality.

Mr. ABRAHAM. Okay. And I think one of you guys made a statement or maybe somebody on this panel about another issue is paying our providers, non-VA providers appropriately enough money to come into the system. And I can tell you it is still a very big problem.

In my VISN 16, we have arrears of the VA system to our ambulance services, to our providers in the millions of dollars. So you are spot on there. It is a big problem. And that, again, I will put that on the VA explicitly for not paying their claims.

So anything else? The no co-pays, the once in, all in, the increased—I am just looking for simple solutions to what should be a simple problem here.

Mr. BLAKE. Mr. Abraham, I want to go back to something you said at the beginning about escalating costs and I am using this to piggyback on comments that Ms. Brownley made at the beginning.

We have been advocating for travel reimbursement for, while it is a non-service-connected population, it is catastrophically-disabled veterans, and usually we get folks who balk at the idea that we recommend that for non-service-connected disabled veterans.

But they are already granted higher priority in the VA system because of the nature of their disabilities and the ability of the VA to meet their demands for health care when the private sector struggles with that challenge.

And one of the reasons we have advocated for the beneficiary travel issue is because what we have seen in our membership is those folks who are non-service-connected will choose not to go to the VA and wait as long as possible because it is costly for somebody with a catastrophic disability to fly long distances, drive long distances, or whatever it may be to go seek that care.

And the long-term cost to the VA when they finally show up, because they will show up and the VA is obligated by priority to care for them, will be substantially higher. So we would hope you would take a look at that as an issue, because it is a unique population that the VA serves because, yes, they are non-service-connected, but they have some of the most profound disabilities that VA serves.

And that is the reason they go to the VA and yet the VA, many times, they are bearing a higher cost burden than they should have to because the veterans are disincentivized to get that care as soon as possible.

Mr. ABRAHAM. Thank you.

I am out of time, Mr. Chairman. Thank you so much.

Mr. BENISHEK. Thank you.

Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you so very much. I appreciate it.

Thanks to the panel as well.

Let me ask you a question on dental care. I know it is very limited as far as eligibility for veterans, but are veterans receiving dental care, let's say in the community if no one is available within the 40-mile range or the 30 days? I mean, what is going on with that?

Mr. ATIZADO. I couldn't really tell you, Mr. Bilirakis. That is actually a very good question. I believe the eligibility for dental care as strict as it is already, getting it in the community is par for the course for VA when you are eligible for dental care.

But, you know, that question really goes to a much larger issue which is, as good as VA's plan is as a first step towards creating an integrated community health care system that is integrated in the VA health care system, it is a good first step.

The issue is it is not comprehensive enough. In other words, the authorities that the VA looked at to create its plan is not all its purchase care authorities. It is some of it.

And those other parts that is not included in this plan which could very well not be included in the solution or the next iteration of Choice, as I mentioned in our testimony, if you carry that forward, you will still have fragmented care, whether that be dental care or home and community-based services or specialty care. There are other purchase care authorities that VA has and uses that is not part of this plan.

Mr. BILIRAKIS. If you, in a perfect world with regard to the specialty care, if we wanted to open it up to the community for the veteran to have the ultimate choice, even if he lives within the 30-mile range, what have you, or she, what specialty would you recommend where the veteran would have direct access to community care? Can you give me a couple specialties?

Mr. BLAKE. I don't think you can cherry pick and say, well, we are just going to let this group of veterans with this unique need have this option. That is probably—

Mr. BILIRAKIS. Well, where is it they are having the most trouble accessing care in that specialty area?

Mr. ATIZADO. Well, a good example would be if you were in the high plains, cardiologists. Here in D.C., a dermatologist. It really depends on what is available in the community.

Mr. BILIRAKIS. Okay. So it depends on—

Mr. ATIZADO. And it can vary widely. The Merritt Hawkins survey, that kind of shows that actually.

Mr. BLAKE. I think that is why you can't just sort of apply a national fixed standard to it. When I mentioned earlier in my comments as they flesh out the details of an integrated network, you can't just sort of lay a national standard on it and say this is what

the network should look like. I think that is probably the challenge that TRIWEST and Health Net are experiencing now.

It has to be distilled down to the lowest level possible. That is the idea I think that Mr. O'Rourke was trying to get at with what he was looking at in El Paso because you have to understand every individual city, every individual town, the rural counties across America, everything is going to be different.

So you can't just say, well, we are going to grant all these folks who maybe have a cardiology need, you know, access and nobody else when some veterans might be perfectly served by the VA and some not in that little cohort alone.

Mr. BILIRAKIS. Okay. So, in other words, we would specify based on the area, the region in the country where there is a lack of maybe care, access to care in that particular region.

All right. Let me go on to the next question. VA's consolidation plan addresses eligibility for community care, but not eligibility for enrollment in the VA health care system in the first place.

So the question is, do you think that a review of VA's overall eligibility and enrollment is needed at this time, and would you support such an effort? And that is for the panel.

Mr. BLAKE. Well, Mr. Bilirakis, I would point you to the concluding part of my written statement which suggests that perhaps it is time to consider whether veterans should just be eligible to enroll in the VA health care system.

The vision of the Affordable Care Act which I hasten to mention because that brings up all kinds of political ramifications is to expand access to care for people in general. And we fought when the law was being written for the Affordable Care Act to ensure that VA was deemed credible coverage under that law.

And the law says VA is deemed acceptable coverage under the strictures of the Affordable Care Act and yet there is a large group of people, particularly in the priority group 8 arena who are denied even accessing that. So why would you deny them an option for health care and say, well, you can only go over here under the rules of the Affordable Care Act, but under the rules as set for VA, you can't actually come into the system?

So we think maybe it is worth considering whether there is this fear that if you just sort of open enrollment, sort of if you build it, they will come, that it will flood the VA system, but history has never proven that to be the case. When VA's system was open, veterans didn't flood the system. Even then, fully two thirds of all veterans chose not to enroll in the VA. So I think it is sort of a scaring assumption that, oh, all these veterans would enroll, which would increase utilization. It might, it might not. And I mean it is high risk, but there is a potential high reward from allowing veterans to access the benefits of VA health care.

Mr. BILIRAKIS. Thank you very much, I appreciate it.

I am out of time, Mr. Chairman. I yield back.

Mr. BENISHEK. Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Are there—and I will ask every panelist—are there any types of health care services that should be eligible for Choice without regards to any time or geographic requirements?

And the reason why I mention this is because obviously mental health has become such a big issue for our veterans, and we have had testimony before to this Committee about VA's mental health being at times drug-centric in its treatment. And so to me, having had veterans commit suicide in my district and meet with those families and try and trace it back, when it becomes evident that they couldn't navigate the bureaucracy to be able to get an appointment in time to save their lives. And so wouldn't it make sense to allow veterans to see who they feel more comfortable with, see who they want, when they want, in terms of access to mental health care, as an example, and are there other examples?

Whoever wants to start with that.

Mr. WILLIAMS. Congressman, I will say this from the perspective of with my sisters and my late wife being Marines. My wife was adamant after one visit to the VA that she would never, ever go back in after having walked through a gauntlet of men. And it brought up something I did not know about what had happened when she had first joined the military. I don't think we should make women have to go through a gauntlet because I think it also discourages some of those who need the health care from getting it because they just don't want to walk through a gauntlet of men.

Mr. COFFMAN. Okay. Mr. Blake?

Mr. BLAKE. I would answer the question in this way. I would throw out the concept of choice all together for a second. If you had a fully integrated health care network, which is a division, I think that the VA has even though this is billed as just for community care, the way the health care network should work is a fully integrated health care network, and you have the patient-provider relationship within the construct of that network. The veteran goes to their provider, that veteran and that provider, which is the way in the private sector it also works, decide what is best for that veteran. Should I be seen at the VA? Should I be seen in the community? What is available now, what is available later? What services do I need?

So the question of choice is sort of a false question.

Mr. COFFMAN. Well, I don't know if it is a false question to the veteran. Let me phrase it this way. Who should make the decision? Should it be the veteran making the decision or should it be a bureaucrat making the decision in terms of access to mental health care?

Yes?

Mr. ATIZADO. Mr. Coffman, so this shared decision is really what we are talking about. When a veteran meets their primary care provider, hopefully it's a VA primary care provider, that discussion should go something like this. Well, it looks like, sir, that you have this condition, here are your options. I prefer as a provider you go down this route, but these are options of therapies that you can use to deal with this issue. Well, that is great, Doctor. I tell you what, I would rather go this route, I would rather take this option. Where can I get that care?

That is the kind of decision-making we are talking about. The network should be responsive to that—

Mr. COFFMAN. Well, let's take a step back here.

Mr. ATIZADO. Sure.

Mr. COFFMAN. Who are you going to empower to make the decision? This is my question. We are not bureaucrats here, we are veterans. I assume everybody here is a veteran. Who makes the decision? Does the veteran make the decision in terms of their own mental health care or are you saying that it is a shared decision between a VA employee and the veteran?

Mr. ATIZADO. Okay, let me give you a straight answer. There is no one.

Mr. COFFMAN. Well, that is the problem.

Mr. ATIZADO. It really depends on—

Mr. COFFMAN. These veterans that I have in my district that committed suicide, they couldn't navigate this system. So let me ask everybody one more time. As a veteran—now, what branch were you in?

Mr. ATIZADO. I was in the Navy, sir.

Mr. COFFMAN. Branch?

Mr. BLAKE. Army.

Mr. COFFMAN. Branch? Navy or Army?

Yes or no, should veterans make the choice of their mental health care irrespective of the Choice Act? What is your position?

Mr. ATIZADO. If they are capable in making that kind of a decision, yes.

Mr. COFFMAN. Okay, great.

Mr. BLAKE. It should be an informed choice.

Mr. WILLIAMS. The veteran.

Mr. COFFMAN. Thank you.

Mr. Chairman, I yield back.

Mr. BENISHEK. Dr. Wenstrup, you are recognized for five minutes.

Mr. WENSTRUP. Thank you, Dr. Benishek.

I appreciate you all being here today. You know, my concern, I think everyone's concern here is that the veteran get care. And I think we get hung up on a little bit of optics. As someone coming from private practice, I guarantee you every member of my 26-doctor group would have been glad within our practice to have a sign up front that said we are VA providers and have the VA logo there. We just don't happen to practice within the walls of the VA and in part because it is a mess to deal with from the bureaucracy, and you can't be productive in the way that you can in private practice for a variety of reasons and we won't go into that.

But even recently in hearing, you know, VA officials were saying, oh, we are seeing more patients than ever before. That is because they increased the number of doctors and expanded their hours, but they didn't get more productive. And when you are in private practice, you have got to maintain the quality if you want people to keep coming to you. That doesn't exist in the VA, although I think we have some great providers. So I am not knocking them, but the system makes it very difficult to be productive.

So I am going to ask you, do you think there is an optical problem? And I don't like when we keep saying non-VA providers and I think we should just say that they are VA providers. They just happen to be outside the wall of the VA. And in that case you give people a choice on where they want to go.

And when you talk about lack of specialities in different areas, well, that exists for everybody and people make a choice on where they live. Some people move close to a hospital because they have a heart problem. I mean, those are choices people have and we can't expect the VA, just because you are a veteran, have every speciality follow you around wherever you happen to live. So people have to make choices like that, whether they are veterans or not, that is just the reality of things.

So my first question is, should we stop calling these providers non-VA providers like they have got some stigma? And do you think that veterans really really feel that they have to be within those walls to get proper care?

Mr. ATIZADO. Congressman Wenstrup, the idea that calling private providers non-VA providers is a little bit of a misnomer. That really talks to not the quality of care that private providers are able to provide, it doesn't talk about their—what it really talks about is the kind of care VA provides.

VA is a health care system unlike any other health care system in this country. Its dependencies stretch beyond the walls of a hospital or a CBOC. It has to work with VBA, NCA, IHS, rural community health centers. It is part of a social support ecosystem.

Mr. WENSTRUP. But there would still be that link.

Mr. ATIZADO. I understand there should be that link. So whether you call it a VA provider or not, the recognition has to be that the VA provides a different kind of care, that it has different responsibilities. It has a teaching mission, it has a research mission, it has all sorts of—

Mr. WENSTRUP. You know what? that veteran who is sick doesn't care. They want to be seen and they want to be taken care of. They are not saying, oh, you do research here? They don't care about that. It is about getting the veteran taken care of.

And so anyway, I am just going to move on from there because I want to make a point of something that we have discovered through this Committee when there was a study done. And you talk about costs and we have got to be concerned about costs, but a well visit to an average primary care doctor is about $85. Pay the copay if they want to go outside the VA. Guess what we discovered it costs? Because, see, no one in the VA talks about what it costs for your physical plant, your insurance, your supplies, your staff, your administration, they don't even know what that is until this study was done. It is about four to $600 per patient visit to go to the VA. We can't do that forever and it doesn't make any sense.

When you send someone outside the VA and if they want to go there, if they want to go there it may be $85 and the VA is not picking up all the malpractice and everything else and I think we have got to consider that. And I want the veterans to have a choice, but as a provider, you know, I would say, hey, I am a provider for Blue Cross/Blue Shield, United Healthcare, the VA, whatever, I am a VA doc.

And I think we have got to break that stigma and really look at what we are doing, so the patients do have a choice between going to the VA, going outside it if that is their preference, but really, start to look at the dollars and cents of what is taking place within the VA where it costs way too much to see a patient.

And I yield back.

Mr. BENISHEK. Thank you, Dr. Wenstrup.

Does anyone else have a question for the panel?

I really appreciate all of you coming here to testify and I really welcome your input as this process goes forward to feel free to come before any of us with further ideas as we explore how to make this better. So I really appreciate that and you are hereby excused from the panel.

Thank you.

Joining us on the second panel from the Department of Veterans Affairs is Dr. Baligh—and I am struggling with your name, sorry, Doc—Yehia, the Assistant Deputy Under Secretary for Health for Community Care, and he is accompanied by Kristin Cunningham, the Director of Business Policy for the VA's Chief Business Office. Thank you both for being here.

Dr. Yehia, you may begin when you are ready.

STATEMENT OF BALIGH YEHIA, M.D.

Dr. YEHIA. Thank you. Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to testify today regarding the Department's plan to consolidate community care programs, specifically streamlining eligibility criteria.

I am accompanied today by Kristin Cunningham, who is the Director of Business Policy.

I want to acknowledge our VSO partners, we have been working with them hand-in-hand since we started this process, and also your comments, Mr. Chairman, on the need to get to one system that works for veterans. And I am looking forward to discussing a little bit more about those clinical criteria that were mentioned.

This plan aims to clarify eligibility criteria, build on existing infrastructure to develop a high-performing network, streamline clinical and administrative processes, and implement a continuum of care coordination services.

These actions will improve access to care, expand and strengthen our relationship with community providers, allow us to operate more efficiently, and improve the veteran experience.

As you know, VA is taking part in an enterprise-wide transformation called MyVA. MyVA will modernize VA's culture, processes and capabilities to put the needs of veterans and their family members first.

Just a few weeks ago Secretary McDonald highlighted the department's 12 breakthrough priorities, all of which are designed to improve the delivery of timely care and benefits to veterans. One of those priorities is to improve community care.

Community care has been and will always be a vital part of VA health care for veterans. In 2015, VA issued authorizations that resulted in about 12 million community care appointments and that is compared to 8.8 million in 2013, representing an increase of about 36 percent. Even though we have been providing more community care, we are eager to seize the opportunity to improve the experience for veterans, community providers and our employees. However, we need help from Congress to consolidate the complex and varied eligibility criteria for community care into a single set

of standards. By doing this, veterans will have a clear understanding of their eligibility for community care and VA community providers will have a significantly lower administrative burden.

The eligibility criteria outlined in the plan aim to increase access to timely care and patient choice while being mindful of taxpayer dollars. The plan gives veterans a choice to access some or all of their health care in the community if they meet one of the following criteria that is related to access, geographic distance and availability of service.

A veteran would meet the access criteria if they are unable to schedule an appointment within VA's wait-time goals for providing that service or within the clinically necessary timeframe indicated by their provider.

In terms of geographic distance, a veteran may receive community care if they are 40 miles or further driving distance from the primary care provider or they face an excessive burden in accessing a VA facility.

Lastly, a veteran may access community care if the VA does not provide the service or if there is a compelling reason why the veteran needs to receive community care.

By implementing a single set of eligibility criteria, veterans will have a clear understanding of their community care benefit. However, built into these criteria is a flexibility that I and my fellow clinicians at VA need to respond to unique circumstances. This is critically important to ensure that we meet the needs of individual veterans.

The plan also addresses the challenges that many veterans face today when seeking emergency room care within the community. Due to complex laws and processes for veterans, VA is many times forced to deny a significant number of emergency treatment claims, leaving some veterans to shoulder that financial burden. By tackling these pain points, we anticipate that it will improve reimbursement of emergency room claims and reduce the need for manual review of every claim.

In addition, the plan asks for congressional authority to offer urgent care services in the community. This action will increase access to care and reduce the number of emergency room visits.

We are eager to move forward and we are open to any ideas that veterans, Congress, veterans' service organizations, and other stakeholders may have. We recognize this must be a collaborative effort and need Congress to provide necessary legislative changes and support moving forward to consolidate care, including the enactment of provider agreements and flexibility in funding for community care.

I appreciate the opportunity to appear before you today and I am prepared to answer any questions that you and other Members of the Subcommittee have.

[THE PREPARED STATEMENT OF BALIGH YEHIA, M.D. APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Doctor. I will yield myself five minutes for questions.

So can you go into a little bit more detail about one of the big problems that we have of course is this emergency reimbursement

issue. And, I mean, that happens all the time where a veteran goes to an urgent care clinic or the ER and the local hospital and then tries to get that approved and that is a pretty good example, I think.

So how specifically are you going to fix that problem?

Dr. YEHIA. Thank you for that question.

We knew when we started this work we have to tackle the emergency room benefit. We have talked with a lot of veterans, we received a lot of letters, as I am sure you have and others, about the challenges that many of them face when accessing community care as it relates to the ER benefit. And the biggest challenge is that they don't know if VA is going to end up paying for that care and I think that creates a perverse incentive many times to delay that care, and they feel they have to drive to a VA to be seen and part of that is the way that the laws and regulations have been written over time. We can't provide that clarity that we need.

And so what we are hoping to do in the plan is to streamline that. We are using principles based on industry, so a lot of the things that we talk about in the plan of consistently applying what is called the prudent layperson definition of ER, the idea of copayments to make sure that we incentivize the right health behaviors. Those all came from TRICARE, from health plans, they are standard and common practice in many health systems.

And then by doing that, we hope to minimize by a significant amount denied claims and kind of empower our patients and the veterans so they know that when they access the ER care in the community, that VA is going to be picking up the bill and they won't be shouldering that financial burden.

Mr. BENISHEK. I understand your thoughts, but specifically how are you going to get the VA to be assured that they are going to be paid? Is there going to be a central number to call? I mean, your goal is, you want to make it right, but the reality of it is, it is not right now and you didn't tell me anything specifically that is going to make it right, from what I could understand.

Dr. YEHIA. Well, let me clarify it.

So in our plan and to the Committee we have also provided some technical assistance that has specific legislative language to make it right. Right now when it comes to ER under our current authorities, we are the primary payer when it is service-connected care, we are the payer of last resort when it is non-service-connected care. And then there is a whole bunch of criteria that are outlined in rules and regulation where if someone passes a VA or—

Mr. BENISHEK. The question is, so is there somewhere in your plan that will allow a veteran to make a single phone call and find out? I mean, it doesn't sound like you have said anything that allows that uncertainty to go away.

Dr. YEHIA. Well, yes. I think the first step is we have to actually consolidate and fix the problem, and once we fix it and it requires congressional action, then we communicate and make sure that folks understand.

Mr. BENISHEK. I am not sure that requires congressional action, I think it may be more of a bureaucratic solution.

I want to discuss this, one of the things you said in your statement, the distance and then how do you define unusual or exces-

sive burden that may necessitate community care? Because that is a vague criterion. Can you tell me about that?

Ms. CUNNINGHAM. Sir, I will help Dr. Yehia with that.

In our current Choice law, the additional enhancements that were given to us in the May law, we were able to define the unusual or excessive burden. We implemented three of those provisions in June. The last provision required us to further define in regulation, we did that in the beginning of December and then rolled that out to our facilities.

And we looked at that providing either the ability for clinicians to make a medical determination that the person's condition required them to get care closer to their home or we identified things that were just the nature of simplicity or the frequency of the services.

So earlier during the VSO testimony, there was some discussion of getting, for instance, eye exams or audiology exams in the community because they are simple in nature. And those are actually some of the examples that we use when we talk about the simplistic nature of the type of service and being able to get that care under the unusual-or-excessive-burden provision.

Mr. BENISHEK. All right, thank you. I am out of time.

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman, and I thank the panelists for being here.

Just a very direct question, if you could just give me the rationale the VA has for imposing the copay of $100?

Dr. YEHIA. The copayment of $100 is meant to make sure that we provide care in the right venue. Many of our ERs are clogged up today and there is long wait times when folks go to the ER, and part of the problem is that a lot of non-emergent care is being driven to the ER.

And increased access to urgent care, which is what we are proposing in our plan, a robust primary care health care system, those are all kind of tools in the toolbox to ensure that folks use the right setting. So the idea of the copayment here is to make sure that folks are able to seek the right care setting when they receive their care.

Ms. BROWNLEY. Did you evaluate other ways in which to accomplish the goal that you are describing?

Dr. YEHIA. Yes. And so I think I view this as more of like a suite of packages. When we look at kind of the data that is out there on how to make sure that we appropriately use ER care, some of the things that come up is, if you have readily access to primary care. So there are initiatives that are going on at VA today that are working more on providing increased access to same-day primary care.

Urgent care, which is something that we propose in the plan as another option if you have, you know, the sniffles, you need a shot, you can go to urgent care as in the ER.

I think the nurse hotline that was suggested by the VSO partners is another tool that many health plans including TRICARE use.

All of those things are tools in the toolbox. I don't think they are meant to replace one or the other. They are actually supposed to

be kind of supplemental, so at the end of the day we make sure that folks are using the right setting.

In the future, as we kind of build this high-performing network, one of the other things that we really hope to do is focus on what is called super-utilizers and this came up a little bit earlier, those folks that are constantly going to the ER. There is a reason why they are doing that. Sometimes they don't have the right case management or they need other support, or need to be connected with certain services. And robust health plans and high-functioning organizations are able to identify who those folks are and provide services that they need.

So I think at the end of the day copayments, as I said, is just one tool that we hope to use to make sure that folks access care in the right setting.

Ms. BROWNLEY. Well, it just sounds to me that we have—you have mentioned a couple of tools in the toolbox and so it seems to me that we should try to utilize those tools first before we use a more punitive tool of a $100 copay, but I am sure we will be talking more about that as time moves forward.

So you had mentioned appointments and community care have grown over the last couple of years and you talked about 12 million appointments within the community care. So what does that compare to, what is the amount of appointments that the VA has provided over the same period of time? Is this a ten-percent number of overall appointments?

Dr. YEHIA. Yeah, I actually don't have that number off the top of my head, but I can take it for the record.

Ms. BROWNLEY. And in terms of the 30-day wait and the 40-mile driving distance rule, is the VA trying to look at other approaches on that? Have you decided for cost purposes that this has to be a hard-and-fast rule?

And I think we are trying to drill down on what the costs are. I mean, Dr. Wenstrup talked about, you know, and cited examples where it might be a lot cheaper in the community to receive services.

So if you could address some of that, please.

Dr. YEHIA. Sure.

So I think an important point to keep in mind is we are kind of considering this as an entire health care system, so the VA and community care and I view them as two sides of the same coin.

The criteria that are set that relate to access, wait time and availability of service are really meant to serve as the floor. So we heard a lot of comments about clinical criteria. Embedded into each of those, as I tried to highlight in my opening statement, are decisions that the doctor and the patient together in the office can make. But the challenge with just keeping something very local is we won't be able to explain to our veterans, can I access community care? The answer would be, well, you have to talk to your doctor. And I don't think that is good enough.

I think what we wanted to do is to provide at least some clarity and transparency and those are based on when you can't see a primary care doctor or they live far away from you, 40 miles driving distance, then you have the choice to access care. There might be criteria above and beyond that, that we described a little bit in

terms of unusual and excessive burden that in the office people can use to decide, but at least they know at minimum that they can access to community care if they hit that standard. The same thing goes with wait time and the same thing goes with availability of service.

So I think the concept here is to make sure there is a level of transparency to what people's benefit is. If it is completely left up to be in the office, then I think we are left a little bit of where we are today, and before Choice, where people don't really know what are the criteria that they have to access community care.

Ms. BROWNLEY. I have exceeded my time. I yield back.

Mr. BENISHEK. Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

Doctor, I appreciate your approach to this and I think you are trying to find the best practices and you are keeping the veteran and the patient in mind as much as anything else, and to have that continuity of care.

And I will go back and I am speaking from my personal experience as a practitioner and from those that I know are still out there every day that want to take care of veterans in their private practice or some that give one day a week to go to the VA. Their frustration at the VA is, you know, I spent all day and I operated on two people, if they had been part of my system here, I could have operated on eight veterans today and with the same results.

So I think you get that and understand where we are going. And I think you are headed in the direction where you see that the VA has to make those types of changes too, and try to get it to be more of a balanced type of system and not so drastically different from one another.

Can you comment on any efforts in that direction?

Dr. YEHIA. Yeah, I really appreciate that.

I think when we started kind of this work and part of the reason how we built this high-performing network is really putting at the center our partners, especially like DoD, our Federal partners and academics, because I practiced both at the VA and across the street in an academic facility and I have experienced similar things. And so the concept here is how do we make sure that we are good partners for our community providers. There was a number of comments earlier about that. I think the more consistent we can be and similar in areas to the private sector the better.

I think there was a few comments about the different paperwork that our community providers have to fill out to partner with us, for that paperwork burden to be exactly the same as it takes for them to sign up with a United or a Humana or someone else.

So I think our intention and our goal in the plan is to move as much as possible to what the industry does so that we don't put any excess burdens on community providers and for that matter our employees to operate differently.

The thing that gives me a little bit of pause is, once we start getting off on these one-offs and things like that, we create complexity and we lose that. And so that is something that we are trying to push forward as being respectful of the differences, but at the same time really pushing towards that industry standard.

Mr. WENSTRUP. And to that point, one of the complaints that I hear is, well, I am seeing patients now but, you know, I am waiting forever for pay.

Dr. YEHIA. Yes.

Mr. WENSTRUP. Whether it is hospital systems or private practice and that is very frustrating. And there is people that do this all the time and maybe they should be doing it and not within the walls of the VA, taking care of those claims, it might be more efficient and better. I don't know if you have any comments on that.

Dr. YEHIA. I do have comments on that. And I am looking forward to the next hearing that discusses specifically prompt paying claims, because I am on the phone all the time with health systems that are frustrated with Choice. I think, you know, in the short amount of time that we have to stand up this program ourselves and our contracting partners, I think have done a good job, but we are not where we need to be.

I think your comment about claims, it actually just so happens that today we released our first draft statement of work for what will be a new contract to support kind of this high-performing network and we are seeking input from industry on that. Part of that statement of work includes processing claims.

And so I am happy to share that with you, I shared it with the Committee Members—or Committee staff earlier this morning, but I think you might be interested in looking at some of those.

Mr. WENSTRUP. No, I appreciate it. And I think that the more that you approach those difficulties, if you will, the more you will see excellent providers in the community taking care of veterans and they want to anyway, and I think that that will be a win-win for everybody. So thank you.

I yield back.

Mr. BENISHEK. Thanks.

Mr. Takano, you are recognized.

Mr. TAKANO. Yes. Thank you, Mr. Chairman.

Dr. Yehia, as you streamline the eligibility requirements for the various care in the community pathways, what impact do you think it will have on the number of veterans who get their care in the community? Do you have any idea of how many more veterans will be seen through this new Veterans Choice Program?

Dr. YEHIA. So I will start and I will ask Kristin to jump in.

We have been seeing more and more unique veterans using community care over the last couple years. The numbers that I just received recently were in the last fiscal year, we had about a million and a half veterans, unique veterans that at some point accessed community care. That is about a third of our veteran population is receiving some of their care outside of VA's walls. And that really gets to this whole concept of this integrated health care system that is both internal VA care and kind of community care.

We think that as we improve the program, including streamlining eligibility, making sure that it is clear we have a good network that includes the best performers in the private sector that more people will use it. And when we articulate the costs of the program, we think that increased demand will come as the product is better, which will also increase the costs in some ways.

So I think that the—I don't have like a crystal ball of the exact number, but I think—

Mr. TAKANO. Of course not.

Dr. YEHIA [continued]. —the idea is, as we make it better and simpler and easier to use, more people will use it.

Mr. TAKANO. Well, you kind of alluded to what I wanted to get to know is, do you have a ballpark projection of the overall estimated costs of the program to be, you know, as you kind of rough out this number, aside from the 1.5 billion for emergency treatment? It is going to be helpful for us to kind of know this.

Dr. YEHIA. Yes, and I can't agree more.

So in our plan that we submitted, there is a section specifically on costs. We think that increased demand will be in the order of about $2 billion annually for the program. That includes a lot of the kind of eligibility criteria that Congress helped us out with over the course of the last year as we kind of continued to iterate and improve the program, kind of removing the enrollment date, some things about changing from a primary care provider to a primary care physician. So there has been a number of different things that have been passed over the last couple months that expand eligibility.

But roughly speaking, I think with the eligibility criteria that we are proposing in the plan, it would be about $2 billion on top of the Care in the Community budget.

Mr. TAKANO. On top of the, what was it we approved, like ten—

Dr. YEHIA. Yes, about—

Mr. TAKANO [continued]. —$12 billion? And we thought we would have it used up by now, but we have seen a number of impediments to actually spending down that money and we thought we would have to be appropriating more.

How many different appropriation accounts affects non-VA care would you say? I mean, my question is really, you know, how many different accounts do we have to sort of deal with for just this non-VA care space?

Dr. YEHIA. So I don't know the exact number. I know we have more than one and that has been a challenge that a lot of our field folks tell me.

Part of what we are proposing and one of our legislative proposals is to get that one funding stream. We did have some flexibility at the end of the last fiscal year, so thank you for that. That allowed us to kind of access the Choice fund to pay for community care. I think it will be very important to have kind of one pot of money, one funding stream for community care, so that our clinicians and our medical centers know exactly how much they have to spend in this area.

This has been a challenge because right now we go through Choice and if something doesn't work, we use another pot of money and it creates unnecessary redundancy. And so getting to that one funding stream I think will be important.

Mr. TAKANO. You might have already covered this, I was just sort of jumping between Committee meetings here, but how much will extending emergency care to veterans cost? Did you already mention that in your testimony?

Dr. YEHIA. I did not, but it is in the report. It is on the order of about 1.5 to $2 billion, that's both ER care and urgent care.

Mr. TAKANO. I am going to ask you this sort of offline, but I am real curious about drug treatment for veterans, whether it includes rehabilitation, just to what extent we have case management. I just want to understand that better in terms of our vets that are coming back with PTS and then some that are having some real substance abuse challenges. So I will follow-up with the Department later.

But, Mr. Chairman, my time is up. Thank you.

Mr. BENISHEK. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Dr. Yehia, thank you for your testimony and for all of your efforts to transform the VA and improve access, quality of care and outcomes for veterans.

Earlier in the day, I was at a conference that Under Secretary Shulkin organized around preventing veteran suicide, which I would argue should be the priority here. And the word priority means something, right? If you prioritize something, it puts that at the top of the list.

So I understand that there are 12 priorities, breakthrough priorities that the secretary outlined. I know there are a lot of moving parts and there are a lot of things to improve and to work on. But what strikes me is that if we really think that we have a crisis in veteran suicide and access to mental health today and it really requires urgency in resources, rethinking how we deliver that care and provide access to it, then we should really be organized around that. As you know and just for the benefit of the Committee and others who might not, in El Paso, which had the worst mental health access rates in the country and still struggles, I think we are third-from-worst today, which is an improvement, we essentially adopted a plan as a community with the VA and with your help to prioritize access to mental health care and to try to prevent veteran suicide. And the idea is that as important as it is to see a podiatrist to get your foot fixed or an endocrinologist if you have diabetes or a dentist to get your teeth fixed, preventing veteran suicide is more important than all of those. And ensuring that if you go to the VA, it is a—I know this is a term of art, but it is a center of excellence for PTSD, TBI, those unique conditions associated with combat and service.

And you, the VA, has helped by piloting a navigator concept or care coordinator who helps if you have one of these service-connected conditions you are seen in the VA by hopefully a world-class provider. If not, we are going to prioritize your care that is comparable to what a civilian would experience to the private sector. We have got great partnerships with Texas Tech, which is providing five psychiatrists so that we can expand capacity for care in the VA.

And yet we just looked at the numbers, you have 116 or Congress has authorized 116 mental health provider positions within the El Paso VA and right now we are at 91 filled, which leaves us 25 short, and I would argue that 116 is probably too little to meet the demand that you have in El Paso.

So what do we have to do? We have adopted the plan, we have got additional resources. If we are maximizing capacity in the community and implementing this transformation plan that you and the secretary have introduced and touted and which I am a big fan of, why aren't we seeing better results in terms of meeting what I think is the single greatest crisis facing veterans in this country, which is 22 veterans a day taking their own lives? If that is truly a priority, why are we not beating all the bushes, taking over the airwaves to recruit those mental health providers to communities like El Paso and others who are historically under-served, where I know for a fact because I talked to the surviving family members that veterans are killing themselves because they don't have access to mental health care?

Why can't we hire those 25 positions? What is the holdup?

Dr. YEHIA. So I can't agree more with your sentiment and as you know many of the elements in the plan that you had for El Paso, there is a lot of that in the plan that we presented for the entire VA. I think the part of the challenge is, as to quote Secretary McDonald, you know, the VA is the canary in the coal mine. I think we have to get out there and do more recruiting.

I have been on a number of trips with the secretary speaking at grand rounds in various hospitals across the country trying to recruit doctors, specifically mental health professionals and nurses to the VA. I have done it by myself as well, and I think we need to do that.

I think we have an opportunity as we start to kind of change the message a little bit about where VA is going, but we will get—

Mr. O'ROURKE. Let me interrupt you just because—

Dr. YEHIA. Sure.

Mr. O'ROURKE [continued]. —of very little time. My fault for taking too much time at the outset, but with the Chairman's indulgence. Could the VA instruct the director in El Paso don't hire any more podiatrists or endocrinologists, you have got them in the community, you can refer them, that is a condition comparable to what the civilian population has, PTSD is very unique to veterans, only hire your traumatic brain experts, your PTSD experts, your psychologists and psychiatrists?

I recognize your canary-in-a-coal-mine analogy that medicine in America is struggling with this and yet there is a way to resolve this with the current capacity, I know there is. I know there are psychiatrists and psychologists working in private practice who could be brought over to the VA with the right inducements, focus and leadership. Are we going to see that this year?

Dr. YEHIA. Well, I know that, as you know, Gail Graham who is working in El Paso at the Medical Center there, I think she is pulling out all the stops to try to recruit as many of those professionals as possible.

I don't think the idea that like as you mentioned there is approved FTE slots for those, so I don't think that a podiatrist is standing in the way of a psychiatrist coming in the door in El Paso.

Mr. O'ROURKE. I am talking about a single-minded, almost exclusive focus on getting that up. It doesn't mean that other things are unimportant, all these conditions are important, I would just say

this is the most important preventable way that veterans are dying that—

Dr. YEHIA. I think that is something that we have to kind of—we should chat a little bit more about that. I think there may be some different tools that we can use.

Mr. O'ROURKE. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. BENISHEK. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you very much, Mr. Chairman. And good morning, great to be with you.

I had a quick local question just off the bat and we have talked about this in the past, but New Hampshire, Alaska and Hawaii are the three states without a full-service VA hospital and we had a special agreement under the previous rule to drop the 40-mile requirement down to 20 miles. I am just wondering, the last time we talked that was under review and I wondered if that process has proceeded since November.

Dr. YEHIA. Thank you. We have continued to engage with various stakeholders as you mentioned, Alaska, Hawaii and New Hampshire. I have had calls with the field leadership in all of those different states to try to get a good understanding of what their specific needs are. This is a tough issue and I am looking for kind of suggestions and ideas here as well, because on one side we want to make sure that we streamline the program, create something that is easy to understand and administer and I think the more nuanced or one-offs that we do, the more complexity that is built in.

So I want to be respectful of the local circumstances there, but at the same time, I am also keeping my mind on how can we make sure that there is some uniformity so that every state is not treated differently.

So with all that said, I think some of the criteria that we have articulated in the plan really do provide good access to care for New Hampshire specifically. And one of the things that I think a lot of people sometimes gloss over, the availability of service is such a key component, because if that service is not offered at those centers it is automatically folks have the choice in the community. So even with the current criteria, I think that the folks specifically in New Hampshire will be well served.

Ms. KUSTER. And I think one way to do that is the expansion of the CBOCs, Community Based Outpatient Care. We just opened a beautiful new CBOC in Littleton, New Hampshire. But just for you to take back, I am still waiting for progress on two others, one in a town called Colebrook, New Hampshire, almost to the Canadian border, and another in a town that we call Berlin, New Hampshire. And they have to do with negotiations that are going on with community-based care and partnerships, which are a good thing, but I would love to get a little shoulder to the wheel here from headquarters in D.C. to move those along.

I also wanted to just talk about how we are very frustrated by the third-party administrator and I know that is not the purpose of this hearing, but I want to put that complaint out there. Senator Shaheen, Senator Ayotte and I, have done a series of events around the state talking directly with veterans. This is our primary, the

phone calls that we get in the office. It is just very very frustrating. And I know that the VA physicians and staff, medical professionals would prefer to be making the appointments anyway because they would prefer to have that relationship with the community provider, get the records back, be able to call the patient and say don't forget your appointment tomorrow.

So are we making any progress on that? Because frankly, I would rather just take that back and this third-party administrator is not working out for my constituents.

Dr. YEHIA. Yeah, I appreciate that. I think I have a call with some of those Senators later this week. And I will say this, that our partners are our partners. We modified a contract at the very beginning to implement Choice in a short amount of time. That contract, that PC3 contract was not designed to run the Choice program, it just wasn't designed to do that.

With that said, as I was mentioning a little bit earlier, today we released the statement of work. It is a draft statement of work, so it is the first step in a contracting process. I think you would be happy to note that in that contracting process or that statement of work the scheduling piece would reside at the VA and not with a contractor.

So we are making progress. I think it is going to take some time for us to get there, but I have heard from the Medical Centers, I have heard from veterans, and I think that is the direction we want to move. So slowly we continue to provide oversight and work with our TPAs to improve their performance, but in the end when we are drafting the right kind of car to drive this program those things would be residing on the VA side, not on the contractor side.

Ms. KUSTER. That is good news and I apologize for missing that earlier, I was over in AG talking about veteran farmers. So thank you very much for your testimony.

Mr. BENISHEK. Thanks, Ms. Kuster. And I reiterate or echo your feelings about this third-party administration thing and I realize that there was an urgency in getting the Choice started. I am going to ask a couple quick questions here too.

Do you know when the Choice fund is going to be depleted this year?

Dr. YEHIA. To do a little bit of math, we started with the $10 billion. Last year we spent, in the last fiscal year about 3.5 billion, this year we are anticipating about two billion, and then the remainder will be the year after.

I want to caveat that just a little bit. Over the last three months we have seen kind of a dramatic increase in Choice use, almost double the three months prior. A lot of that has to do with more proactive outreach to veterans. So rather than kind of the onus on them picking up the phone and calling, we are doing the calling and saying, would you like to partake in Choice, is this something that you want? And we have seen a dramatic up-tick.

So that is a little bit of the projections. I think we still haven't reached kind of steady state—

Mr. BENISHEK. Okay.

Dr. YEHIA [continued]. —but we will get there.

Mr. BENISHEK. Is the $2.1 billion estimate per year above current non-VA care costs expected to be the yearly program estimate going forward?

Dr. YEHIA. Is that outlined in the plan?

Mr. BENISHEK. Well, I mean, you estimated me $2 billion more, is that the estimate for yearly—

Dr. YEHIA. Yeah, we estimated the costs for the first three years. As you know, it is a little hard to try to predict past that, but in those first couple years, it would be $2 billion on top of the normal community care budget.

Mr. BENISHEK. So does the 2017–2018 budget request reflect the numbers that we have been talking about here? Isn't that coming out shortly?

Dr. YEHIA. I don't think that is—let me take that back.

Mr. BENISHEK. All right. Any other questions?

Thank you very much for your being here today, and you can look forward to some further questions from us as we go forward here. You are now excused.

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

And without objection, that is ordered.

The hearing is now adjourned. Thanks.

[Whereupon, at 11:52 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Adrian M. Atizado

Mr. Chairman and Members of the Subcommittee:

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

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

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

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

To be clear, DAV does not believe that simply increasing funding by itself-without making some significant reforms to the underlying VA health care system-will lead to better health outcomes for veterans over the next 20 years. However, no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true need and demand for services by veterans, when and where they need them.

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

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

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

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

Hospital Care and Medical Services:

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

Geographic and temporal eligibility criteria

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

We believe VA's proposed geographic and temporal criteria for community care eligibility in the New Veterans Choice Program (NVCP), while simple in concept- are arbitrary. It continues to administratively separate NVCP from the VA health care system, does not foster full integration, and limits performance to the detriment of veteran patients.

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

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

For veteran patients, waiting for a health service begins when the veteran and the appropriate clinician agree to a service, and when the veteran is ready and available to receive it. Thus, DAV, along with the co-authors of the IB, believes it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor - without bureaucrats, regulations or legislation getting in the way.

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

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

Availability of service eligibility criteria

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

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

Veterans-centric care means including veterans participation in their care. This means providing veterans options, whether that be a second option or describing all

the different treatments that are endorsed by clinical literature and even though the veteran's doctor may favor one over another, the final decision ultimately stops-or should stop-with the patient. When these options are not presented particularly for preference-sensitive conditions and treatment options, disagreements between the veteran and their provider can and does occur.

Grievances, Disputes, and Appeals

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

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

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

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

The Plan for Emergency and Urgent Care:

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

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

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

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

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

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

Prudent Layperson

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

Our resolution regarding emergency care also urges the VA to provide for a more liberal interpretation of its policy governing reimbursement to veterans who have received emergency care at non-VA facilities. VA readily admits that "[M]any of these denials are the result of inconsistent application of the "prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care."

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

24–Month Requirement

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

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

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

Copayment

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

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

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

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

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

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

Define Emergency Condition

Moreover, in the interest of parity in VA's legislative proposal to address its existing authorities to reimburse the cost of emergency treatment, we recommend "emergency condition" be defined. We urge serious consideration be given to reliance on the Emergency Medical Treatment and Labor Act (EMTALA), with a minor amendment to include behavioral conditions, so that the definition of an emergency condi-

tion for VA purposes would be "a medical [or behavioral] condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs. With respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child."

Outpatient Medication and Durable Medical Equipment; Extended Care Services:

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

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

Limitations of Plan and Approach

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

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

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

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

Prepared Statement of Carl Blake

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today. We appreciate the fact that the Subcommittee is addressing the very serious question of eligibility for health care services for veterans through the Department of Veterans Affairs (VA) community care plan. Let me say up front, that PVA generally thinks that the VA plan is a very good one. It clearly represents a model of how health care should be delivered. In fact, it mirrors in many ways the veterans' health care reform framework that PVA, along with our partners in The Independent Budget-Disabled American Veterans and Veterans of Foreign Wars-have presented to the full Committee, as well as to Senate VA Committee, the Commission on Care and the VA itself.

As eligibility dictates access to veterans health care, so too does the capacity of the systems providing that care. Over the years, the VA health care system has relied on a number of methods and standards to measure access and timeliness of health care delivery. Prior to the scandal that enveloped the VA health care system in the spring of 2014, the Department's wait-time goal was 14 days from a veterans preferred date for existing patients or 14 days from the date an appointment request was created for new patients. After the health care access crisis exposed that the 14-day goal was unattainable, VA reevaluated its standard and moved to 30

days from a veteran's preferred date. Less than a year later, VA changed its wait-time standard again to facilitate the implementation of the Veterans Choice Program. In an attempt to align its standards with industry best practices, VA elected to base its wait-time goal on clinical need first and rely on a veteran's preference when a clinically indicated date was not identified. There is no evidence to suggest that arbitrary wait-time standards are indicative of quality, rather they are bureaucratic tools to self-assess output performance. They are not a measure of quality care and to suggest otherwise is unfounded.

Over the years, VA has also relied upon a number of geographic-based access standards to determine eligibility. Through the Strategic Capital Investment Planning (SCIP) process, dating back to its fiscal year 2008 budget request, VA has used a 60-minute drive-time distance for veterans who live in urban areas and 90 minutes for veterans who live in rural areas as a standard for specialty care. In 2013, VA's long range SCIP process began to include a corporate target of 70 percent of veterans having access to VA primary care within a 30-minute drive time in urban areas and 60 minutes in rural areas. Additional geographic-based standards have accompanied statutory programs, to include 40 miles from a primary care provider (as well as 30 days) for the Veterans Choice Program, or 60-minute drive time from primary care, 120 minutes from acute care, and 240 minutes from tertiary care under Project ARCH. VA has also established geographic-based network standards for contracted programs. Under Project HERO, VA required Humana to provide access to required services within 50 miles of a veteran's home. Under PC3, HealthNet and TriWest are required to provide health care options within a 60 minute drive for veterans who live in urban areas, 120 minutes for veterans who live in rural areas, and 240 minutes for veterans who live in highly rural areas, when seeking general care. For veterans who need a higher level of care, the PC3 network must provide them with options within 120 minutes for urban areas, 240 minutes for rural areas, and an acceptable community standard for highly rural veterans. Geographic-based access standards are another means of narrowing the scope of how VA measures its performance and simplifies the budgeting projections. Geographic-based access standards are not derived from industry best practices for the provision of health care.

The independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait-times similar to the Veterans Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days-based calculations, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. PVA, along with our partners in The Independent Budget, strongly agrees with the IOM's recommendation that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families. [1]" We believe that this concept will also best serve the needs of our members and all veterans.

The Independent Budget has reported for years that VA's access standards are not aligned with veterans' perceptions. Moreover, the IB firmly believes that federally regulated, arbitrary access standards, such as living 40 miles from a VA clinic or waiting up to 30 days for an appointment, should not inhibit a veteran's access to care. That is why we propose to move away from federally regulated access standards. Under the IB's framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

The irony of all these access standards is PVA members often travel farther than any of the other special populations of veterans served by VA, or even veterans in general seeking care from VA. It is not unusual for PVA members, and other veterans with spinal cord injury or disease (SCI/D), to travel hundreds of miles to reach one of the 25 spinal cord injury centers located around the country. They do this because the VA SCI system of care is far and away the best option they have to meet their specialized health care needs. The access problems these veterans face are usually not wait times or distance, but the cost of travel. As a result, veterans may wait to be seen until their condition deteriorates, requiring more costly and intensive care. Congress should expand travel benefits to non-service connected, disabled veterans, to ensure they are able to receive quality specialty care. This Sub-

[1] IOM (Institute of Medicine). 2015. Transforming Health Care Scheduling and Access: Getting to Now. Washington, DC: The National Academies Press

committee is reviewing the question of eligibility without even considering this important fact. PVA believes that the 30-day and 40-mile eligibility standards that determine access under the new Veterans Choice Program (VCP) do not consider what is best for veterans with catastrophic disabilities, to include SCI/D. Moreover, arbitrary access standards will not increase eligibility or guarantee timely, quality care.

PVA strongly believes that veterans have earned and deserve to receive high quality, comprehensive, accessible and veteran-centric care. In most instances, VA care is the best and preferred option, particularly for veterans with SCI/D and other specialized health care needs. However, we acknowledge that VA cannot provide all services to all veterans in all locations at all times. This became clear from the access crisis that came to the forefront in April 2014 and has continued to burden the VA as more and more veterans seek care from, and through, VA. Adequate resources should be devoted to building a comprehensive health care system within VA supported by a dynamic, integrated health care network that leverages private sector providers and other public health care systems to expand viable options. This is essentially the concept the VA has proposed in its community care consolidation plan and is mirrored by the framework the IB has presented as well.

PVA supports the idea to move beyond arbitrary federal standards regulating veterans' access to care in the community. However, we are not convinced that the VA's plan goes quite far enough. We believe it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor-without bureaucrats, regulations or legislation getting in the way.

PVA, and our IB partners, also supports the plan to expand emergency treatment and urgent care in the community. However, we strongly oppose the proposal for an across the board $100 co-payment for emergency care and $50 for urgent care. This proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. These veterans should not be required to bear a cost-share as it may disincentive the veteran or their caregiver from accessing emergency treatment or urgent care. For many disabled veterans who are unable to work and living off their earned benefits, a trip to an urgent care clinic for $50 might be just enough of a burden that they delay being seen. We know this delay means an increased chance that something as seemingly benign as a small wound becomes a costly infection.

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. Those 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. Such an advice line must have available SCI trained providers, who are able to identify potential complications specific to an SCI veteran. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance of emergency room care without having to increase cost-shares for veterans.

Additionally, PVA, as well as the IB, has raised serious concerns with the requirement that eligible veterans must be "active health care participants in VA" in order to access these benefits. The strict 24-month requirement is extremely problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to limited capacity, despite their timely, good faith efforts to make appointments following their separation from military service. This barrier has caused undue hardship on veterans who are undergoing the difficult transition from military service back to civilian life, and has resulted in veterans receiving unnecessarily large medical bills through no fault of their own. VA is aware of this problem and has requested the authority to make this exemption; however, the consolidation plan does not specifically address this needed change. Furthermore, this restriction could negatively impact healthier veterans who do not need as much health care as others and may go more than two years without accessing VA care. This requirement could encourage veterans to seek unnecessary services from VA in order to remain eligible for VA's emergency and urgent care services.

Ultimately, a comprehensive health care network should not be designed to limit eligibility and exclude veterans seeking care. PVA has long argued that limiting eligibility to VA health care services undermines the intention of the Affordable Care Act (ACA). PVA played a key role in ensuring that VA health care was deemed ac-

ceptable coverage under the ACA. And yet, millions of veterans are still denied enrollment into the VA due to the prohibition on new Priority Group 8 enrollments.VA should immediately lift the ban on Priority Group 8 enrollments to make veterans who need health care eligible for these critical services. If VA will not make that decision, then Congress should pass legislation to do so.

Mr. Chairman, I would like to thank you once again for the opportunity to testify. We encourage this Subcommittee, and all of Congress, to closely examine the VA's community care consolidation plan and provide the necessary resources and support to see this plan through to implementation. While there are issues that must still be worked out with this plan, this is a real step towards ensuring greater access to critical health care services for veterans. We would be happy to answer any questions that you might have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2016

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** - Grant to support rehabilitation sports activities - $200,000.

Fiscal Year 2015

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** - Grant to support rehabilitation sports activities - $425,000.

Fiscal Year 2014

No federal grants or contracts received.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

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Carl Blake is the Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

Prepared Statement of Duane Williams

Chairman Benishek, Ranking Member Brownley and distinguished Members of the Subcommittee:

On behalf of the Iraq and Afghanistan Veterans of America (IAVA) and our 425,000 members and supporters, thank you for the opportunity to share our views with you at today's hearing: "Choice Consolidation: Evaluating Eligibility Requirements for Care in the Community."

By way of introduction, I am retired from the U.S. Army having served 26 years on active duty and 6 additional years in the reserve component. Currently I serve as the Chairman of the Veterans Affairs Advisory Board of DeKalb County, Georgia, which is responsible for the county's veteran recognition, advocacy and research programs on behalf of its 41,000 veterans. I also serve IAVA as a Georgia Leadership Fellow, focusing on veteran leadership development, policy advocacy and team building. These experiences help me better understand the needs of veterans but also the challenges they face accessing quality care in a timely and efficient manner.

IAVA is proud to have previously testified in front of this Subcommittee recommending the need for consolidation of care in the community for veterans enrolled in VA health care, and we applaud Congress for requiring VA to put forward a plan for consolidation. We also want to recognize senior leaders at VA for acknowledging the need for consolidation and providing an inclusive, veteran-centric and transparent plan.

Last year, when the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 became law, it helped begin the process of removing a lot of confusion for veterans. However, according to IAVA's most recent Member Survey, only five percent of respondents had taken advantage of the Choice Program, and their reviews on satisfaction were mixed. For the 95 percent of IAVA members who had not used it, 43 percent reported not using it because of confusion as to how to use it. It's clear that simplification is needed.

Confusion over the Choice Card is not the only barrier to accessing timely and quality care. In IAVA's member survey, nearly half of the respondents were not even familiar with the Choice Program.

In my home of Atlanta, Georgia, the enrollment for health care at the Atlanta VA Medical Center (VAMC) is growing faster than the capability for primary care. According to VA population data, the number of veterans residing in the 28-county metropolitan Atlanta area in 2013 was 294,000. The 2014 VA population data reflects more than 361,000 veterans living in that same area. To meet this increased use, in the past 18 months, the Atlanta VAMC has hired an additional 600 employees.

Related to this move, on January 20, 2016, Atlanta VAMC stated the current wait for VA initial primary care appointments was at 60 days, but after speaking to the VISN 7 VHA Director on January 26, she advised me she was able to help the Atlanta VAMC Director reduce the 60-day wait time down to 20.6 days. If this number holds true, the reduction in wait time by nearly 40 days in the matter of 6 days, is remarkable. We hope other VA medical centers will follow suit, and we hope this Subcommittee will continue to monitor, analyze and ensure accuracy of wait time data, including at the Atlanta VAMC.

As Congress hopefully moves forward to simplify a confusing process for veterans, IAVA highly recommends Congress work with VA and use its plan as the framework for legislation in order to avoid one-off proposals that are misinformed or put politics ahead of veterans. After all, it was Congress who provided the numerous different plans that added to the confusion and inefficiencies which resulted in the need to consolidate care. We believe Congress should be mindful of these lessons, learn from them and leverage the VA's plan as the framework for consolidation of care moving forward.

Our second concern centers around VA's ability to effectively implement a plan to consolidate care across their enterprise in a way that avoids many of the mistakes made during the implementation of Choice and truly puts veterans at the center of every decision. While the VA Budget and Choice Improvement Act of 2015 extended provider eligibility to any health care provider meeting VA criteria, the VA must use this opportunity to streamline and standardize the requirements for medical documentation. Under the Choice Act of 2014, reimbursement rates for non-VA providers is limited to no more than the MEDICARE reimbursement rate, thus

standardizing and reducing administrative requirements can remove a barrier to more providers joining the network.

The VA intends for its health delivery model to be the patient-centered medical home for the veterans under its care; therefore, the VA holds responsibility for direct coordination of services for each veteran. Care coordination is one of the core functions of primary care. A significant number of the VA's patient needs are complex, and as the complexity increases, the challenges in facilitating the delivery of the appropriate care increases. Factors that increase the complexity of care include: multiple chronic health problems, the social vulnerability of the patient, the number of providers and the patient's ability to coordinate their care. Due to the significant number of VA patients with anxiety disorders, dementia, depression and kidney failure, it is necessary for the VA to maintain significant control and accountability for the provision of veterans' care.

To address these inconsistencies and shortcomings, IAVA recommends the VA continue to collaborate with all stakeholders who share their vision of putting the veteran first and focus on values-based leadership in an attempt to change the culture of VA across the country. Given the shortcomings related to training frontline personnel on the implementation of Choice and customer service generally, the VA should also continue its efforts with myVA and make sure all VA employees are trained properly and consistently on the VA plan to consolidate care.

Finally, IAVA encourages everyone, Congress, VA, VSOs, industry and other stakeholders, to place an increased importance on the quality of care veterans are receiving, especially new providers who have not served veterans since their residency training. It is important under the medical home model of primary care that the VA continues to coordinate and be accountable for the care provided to veterans given the complexity of care required.

In closing, IAVA would like to thank this Subcommittee for your leadership and continued commitment to our veterans. It is a privilege to testify in front of the Subcommittee today, and we reaffirm our commitment to working with Congress, VA and our VSO partners to ensure veterans have access to the highest quality care available, and our country fulfills its sacred obligation to care for those who have borne the battle. We do believe there is an opportunity to transform the VA for today's veterans if we all work together.

Thank you, and I'd be happy to answer any questions you may have.

Biography

As Leadership Fellow, Mr. Williams is a catalyst for veteran leadership development, policy advocacy and team building. He spent 26 years in the Army, two years in the National Guard and four years in the Army Reserves. In his last combat assignment, he was responsible to the MNFI Surgeon and MNFI Commanding General for independent coordination with various government and non-governmental agencies to support health sector partnership programs with the Iraqi government. He is currently the Chairman of the Veterans Affairs Advisory Board of DeKalb County, Georgia, responsible for the county's veteran recognition, advocacy and research programs on behalf of the 41,000 veterans in one of Georgia's largest counties. Mr. Williams holds advanced degrees in Religion and Public Policy.

Statement on Receipt of Grants or Contract Funds

Neither Mr. Williams, nor the organization he represents, Iraq and Afghanistan Veterans of America, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

Prepared Statement of Baligh Yehia, M.D.

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) proposal to consolidate VA's community care programs to increase access to health care, specifically the portion of the proposal that would streamline eligibility criteria to reduce confusion and frustration among Veterans, community providers, and VA staff. I am accompanied today by Kristin Cunningham, Director, Business Policy in VHA's Chief Business Office.

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in demand for care, it is essential for VA to partner with providers

in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans and community providers, as well as VA employees.

Acknowledging these issues, VA is taking action as part of an enterprise-wide transformation called MyVA. MyVA will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. Included in this transformation is a plan for the consolidation of community care programs and business processes, consistent with Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, the VA Budget and Choice Improvement Act, and recommendations set forth in the Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (Independent Assessment Report) that was required by Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).

On October 30, 2015, VA provided Congress with its plan for the consolidation of all purchased care programs into one New Veterans Choice Program (New VCP). The New VCP will include some aspects of the current Veterans Choice Program established by section 101 of the Choice Act and incorporate additional elements designed to improve the delivery of community care.

One aspect to the New VCP would be establishing clear eligibility requirements for community care. Currently, overlapping eligibility criteria for different methods of accessing community care creates confusion among Veterans, community providers, and VA staff. Eligibility to enroll in and access VA's health care system would not change with the New VCP. However, the New VCP would define a single set of eligibility requirements for the circumstances under which Veterans may choose to receive health benefits from community providers as well as expand and simplify access to emergency treatment and urgent care. This will enable timely and convenient access to care in alignment with best practices.

Background

Current eligibility creates confusion due to multiple, overlapping criteria for each different method of purchasing care. The New VCP would reduce confusion by standardizing requirements across facilities regarding when a Veteran may choose to receive community care, while still providing local flexibility to respond to unique needs of Veterans (e.g., local services, geography, and unusual or excessive burden). The need for simplifying eligibility criteria directly addresses the recommendation to "streamline programs for providing access to purchased care and use them strategically to maximize access" outlined in the Independent Assessment Report [1]. The eligibility criteria will be grouped into the following categories:

- **Hospital Care and Medical Services:** Patient eligibility criteria for the New VCP will provide Veterans with timely and convenient access to care based on wait times, distance to a VA Primary Care Provider (PCP), or availability of services.
- **Emergency Treatment and Urgent Care:** Eligibility criteria will increase access to these services and simplify access rules to prevent the denial of claims for the appropriate use of these services.
- **Outpatient medication and Durable Medical Equipment (DME): extended care services:** Eligibility criteria will not be altered as any adjustment would constitute a fundamental change to the VA health benefit.

VA compared the current eligibility criteria for purchasing community care to commercial health plans and Federal program approaches to develop the New VCP criteria. A number of findings from this review informed design of the patient eligibility criteria for the New VCP.

Eligibility for VA Health Benefit and Eligibility for Community Care

Eligibility for community care is independent of eligibility to enroll in VA health benefits. A Veteran must be eligible for and enrolled in the VA health benefit before VA will evaluate the Veteran for eligibility for community care. Eligibility for enrollment in the VA health benefit is based on level of Service-Connected (SC) disability, other special authorities (e.g., awardees of the Medal of Honor and former Prisoners of War), and income. These characteristics determine a Veteran's enrollment pri-

[1] Independent Assessment Report Section B: Health Care Capabilities

ority group. Enrollment priority groups range from 1 to 8, with 1 being the highest priority. All enrolled Veterans enjoy access to VA's comprehensive medical benefits package; however, some benefits (e.g., dental care) have additional statutory eligibility requirements. After a Veteran is enrolled in VA health care, the eligibility criteria for VA's various methods for purchasing care in the community then can be applied to determine when a Veteran may receive his or her health benefits outside of a VA facility.

Unique Considerations for VA

There are a number of factors that make VA unique compared to commercial health plans.

- **Coverage -** VA is required to provide coverage to Veterans in areas where VA does not have physical facilities or an established provider network. Commercial health plans generally do not offer products where they cannot meet coverage requirements.
- **Other Health Insurance (OHI) -** Approximately 78 percent of Veterans have OHI and only rely on VA for certain services (e.g., hearing aids and eyeglasses). Changing the services Veterans are eligible to receive in the community or what they pay for those services could affect Veteran's reliance on VA versus OHI, including TRICARE, Medicare, and Medicaid.
- **Teaching and Research Missions -** In addition to providing high-quality care to men and women Veterans, VA has research and education missions critical to the VA system and the nation as a whole. In 2014, VA supported 2,224 medical and prosthetic research projects totaling $586 million in research investment[2] and provided clinical training to 41,223 medical residents, 22,931 medical students, 311 Advanced Fellows, and 1,398 dental residents and dental students[3]. In addition, many Veterans value participation in VA training and research and consider them to be an important part of the VA care experience. Over time, decreasing utilization of VA facilities may jeopardize VA's ability to deliver on these missions.

Current State

VA has multiple sets of eligibility criteria for the various authorities and methods of purchasing community care. Several of these criteria overlap, creating confusion among Veterans, community providers, and VA staff and providers. Broadly, these criteria have focused on providing surge capacity and have been grouped into three categories:

1. **Wait-Times for Care:** VA was not able to provide the service within an acceptable time frame, based on medical need.
2. **Geographic Access/Distance:** A VA facility was not available within an acceptable travel distance of the Veteran's home.
3. **Availability of Service:** A facility in the local VA network either did not provide the required service or there was a compelling reason why the Veteran needed to receive care from a community provider.

Additionally, eligibility varies by the category of care (hospital care and medical services; and emergency treatment):

Emergency Treatment

Currently, a Veteran is eligible to receive emergency treatment through community care by authority of 38 United States Code (U.S.C.) Section 1703, 38 U.S.C. Section 1725, and 38 U.S.C. Section 1728. Eligibility for emergency treatment varies by authority.

Since determination of these claims is nuanced, and unclear for Veterans, there are a large number of denied claims. When denied, the financial responsibility for these claims, which can be substantial, often falls on Veterans or their OHI, resulting in unanticipated financial challenges for Veterans. As an example, between the beginning of FY 2014 and August 2015, approximately:

- 89,000 claims were denied because they did not meet the timely filing requirement.
- 140,000 claims were denied because a VA facility was determined to have been available.
- 320,000 claims were denied because the Veteran was determined to have OHI that should have paid for the care.

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[2] Source: Veterans Health Administration, Office of Research and Development
[3] Source: Veterans Health Administration, Office of Academic Affiliations

- 98,000 claims were denied because the condition was determined not to be an emergency. [4]

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 OHI. 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. Additionally, VA is not authorized to reimburse Veterans for urgent care, which is typically lower cost than emergency treatment, and encourages health care in the appropriate setting.

Future State

The objective of the New VCP is to create a set of criteria that are simple and intuitive for Veterans, community providers, and VA staff. This will be accomplished by eliminating the multiple overlapping criteria for accessing Hospital Care and Medical Services, including Dentistry, in the community. The single, nationally defined set of eligibility criteria for the New VCP can be consistently implemented while providing VA facilities the flexibility to respond to unique circumstances, such as excessive burden in traveling to a VA facility or the medically-indicated need to see a provider in a timeline shorter than the VA wait-time standard for a service. In addition, the New VCP includes simple criteria for accessing Emergency Treatment and Urgent Care. This should increase access and reduce denied claims while incentivizing appropriate use of these services.

Eligibility criteria for each category of care are as follows.

Hospital Care and Medical Services

The eligibility criteria for Hospital Care and Medical Services, including Dentistry services, in the community will continue to be focused broadly on wait-times for care, geographic access/distance, and availability of services. The criteria will be streamlined into a single set of rules applied across the VA health care system. To ensure VA meets the unique needs of Veterans, VA will have flexibility at the local level through clarified guidance on exceptions. The process also will include clear appeal and grievance mechanisms for Veterans to dispute eligibility determinations.

When Veterans are determined to be eligible for community care, VA will provide them with information on providers and appointment availability at VA and in the community. This will allow Veterans to choose a convenient appointment from the provider of their choice. The primary change in this proposed vision is to focus eligibility for geographic access/distance on access to a PCP. PCPs play a critical role in coordinating care and providing preventative care, so convenient access is necessary. Veterans eligible for the New VCP under either of the geographic access/distance criteria will have the option to choose a community PCP. The community PCP could then refer the Veteran to specialty care in the community or at VA as appropriate and authorized by VA. This approach is consistent with best practices, which emphasize providing access to a PCP.

Emergency Treatment and Urgent Care

As part of the New VCP, VA had proposed an update to emergency treatment and urgent care in the community authorities, as one option to attempt to simplify Veterans' experiences in seeking care. VA estimated that the expanded emergency treatment and urgent care proposal could cost over $1.5 billion, independent of other aspects of the New VCP.

Conclusion

As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in VA's plan into an executable, fiscally-sustainable future state. In addition, VA plans to review feedback and potentially incorporate recommendations from the Commission on Care and other stakeholders including Veterans, community providers, VA staff, and industry leaders. VA will work with Congress and the Administration to refine the approach described in the plan, with the goal of improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs.

Delivering the New VCP will not be successful without approval of recommended legislative changes and recommended budget. Expanded Access to Emergency Treatment and Urgent Care is important in providing Veterans with appropriate access

[4] Source: VHA Chief Business Office, Office of Informatics

to these services, but is severable from other aspects of the program and could be implemented separately. VA is willing to work with Congress to address the cumbersome emergency treatments authorities which have a negative impact on Veterans both reducing access to critical services and increased financial liability.

Transformation of VA's community care program will address gaps in Veterans' access to health care in a simple, streamlined, and effective manner. This transformation will require a systems approach, taking into account the interdependent nature of external and internal factors involved in VA's health care system. MyVA will guide overall improvements to VA's culture, processes, and capabilities and the New VCP will serve as a central component of this transformation. VA looks forward to a successful implementation of the New VCP and partnering with Congress to support requested legislative authorities and additional resources. This transformation will position VA to improve access to care, expand and strengthen relationships with community providers, operate more efficiently, and improve the overall Veteran's experience.

Thank you. We look forward to your questions.

Statements For The Record

MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN Benishek, RANKING MEMBER Brownley, and Members of the Subcommittee, on behalf of the more than 390,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present MOAA's views on the Department of Veterans Affairs (VA) eligibility requirements as outlined in its proposed Plan for Consolidating Community Care.

MOAA does not receive any grants or contracts from the federal government.

MOAA is grateful for the Subcommittee's steadfast commitment and exceptional support to our nation's veterans and their families. Notably, the passage of the two key bills, the Veterans Access, Choice and Accountability Act of 2014 (VACAA P.L. 113–146, or the Choice Act) and the Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act), as well as additional funding to address shortfalls in several Veterans Affairs Health Administration (VHA) accounts. These bills and funding are foundational steps to reforming VA to better serve our veterans and their families.

The Secretary of VA, Bob McDonald, and his leadership team have also committed significant resources and attention to not only fixing current access problems, but are also moving swiftly to implement reform through a major effort called MyVA. We applaud the Secretary's vision and determination to get MyVA implemented and institutionalized as much as possible before leaving office.

EXECUTIVE SUMMARY

The guiding question before the Subcommittee today is, "Will the eligibility requirements outlined in the Department of Veterans Affairs' (VA) plan to Consolidate Community Care Programs be sufficient to increase access to care among veteran patients?"

The Military Officers Association of America (MOAA) appreciates the opportunity to explore the question with the Subcommittee and to share our thoughts on the Secretary's proposed New Veterans Choice Program (VCP) Plan, congressionally mandated in Title IV, Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

Generally, MOAA supports the plan to consolidate VA's multiple and disparate purchased care programs into one New VCP. We believe it has the potential to improve and expand veterans' access to health care. Much depends, however, on the Department's success in working with its employees, Congress, the VA Commission on Care, veterans and military service organizations (VSOs/MSOs), and other stakeholders as the agency moves forward in developing and implementing the plan.

MOAA commends VA Secretary Bob McDonald for his MyVA vision and tenacious leadership as he leads the largest and most complex integrated health system in America in a new direction, seeking to transform the Department into a veteran-centric organization by "modernizing VA's culture, processes, and capabilities in order to meet the needs, expectations, and interests of Veterans and their families first." We are also pleased to see the New VCP aligns with the Secretary's MyVA transformation efforts.

VA established a strong communications channel and process to engage stakeholders. This unprecedented collaborative process included frequent and ongoing dialog and feedback which continues today as VA moves forward in further developing and implementing the plan. Such effort indicates VA's sincere commitment to putting veterans and families first and is at the center of its plans for consolidating community care.

While MOAA is very encouraged by the Secretary's transformation efforts, we respectfully urge Congress, the Commission on Care and the VA to:

- Adopt The Independent Budget's (IB) recent concept paper, a Framework for Veterans Health Care, incorporating the Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW) recommendations for transforming the VHA into a more robust system of health care for veterans.
- Eliminate the current arbitrary federal access standards (based on wait times, distance to a VA facility, or availability of services) and consider establishing a new clinically-based standard for both in-house and community care, where decision-making involves the veteran (including family/caregivers) and physician or medical professional in the process (per the IB VSOs) to provide a less complicated standard for accessing care.
- Support VA's plan for expanding access to emergency treatment and urgent care services, but oppose the copay requirement for veterans accessing such care, particularly those with service-connected conditions.
- Direct resources and funding at modernizing the VA human resources system and requiring VA to implement a workforce management and succession planning strategy for attracting, training, retaining, and sustaining high quality personnel.

The ultimate test of any successful reform is whether VA is able to deliver the things veterans and their families value most-high quality, accessible, comprehensive, and culturally competent medical care and services that will meet their unique needs and circumstances.

BACKGROUND

The MyVA initiative was launched soon after Secretary McDonald's confirmation and the passage of the Choice Act. MyVA is an enterprise-wide transformation initiative. According to the Secretary, the initiative will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first.

Issues related to access to medical care have long plagued the system. After news broke of secret waiting lists at the Phoenix, Arizona VA medical hospital in the early 2014, MOAA wrote a letter to the President and leaders of the House and Senate Veterans Affairs Committees to say bureaucratic red tape and gross inefficiencies were preventing veterans from accessing care and required immediate attention.

MOAA urged the President to establish an independent, high-level commission to examine the VHA to better understand the challenges that lie ahead so the VA is prepared to meet the long-term needs of millions of veterans who have served our nation. Lawmakers heard our message and passed the Veterans Choice Act on August 7, 2014, which included establishing a VA Commission on Care.

The Commission was established on August 7, 2015 to examine the access of veterans to health care from VA and how best to organize VHA, locate health care resources, and deliver health care to veterans over the next 20 years. It is expected to submit its findings and recommendations to the VA and Congress early this year.

The Choice Act also directed an independent study to look at the delivery systems and management processes of VHA in order to provide a holistic view of the system and its relationship within the VA. The Independent Assessment was completed on September 1, 2015.

Within three months of the passage of the Choice Act, VA implemented the Choice Program on November 5, 2014. The program allows eligible veterans to receive health care in their local communities from private or non-VA providers. But VA struggled from the beginning to transition to the Choice Program. Accessing the program was problematic and eligibility requirements were confusing and frustrating not only to veterans, but also to VA employees and providers trying to implement the program. As a result, veterans continued to experience long wait times for care.

At the urging of MOAA and several partners in The Military Coalition, VA expanded the Choice Program rules on December 1, 2015. VA changed the eligibility rules to measure distance from a veteran's home of record to the closest VA facility

using the more reasonable driving distance criteria rather than the former straight-line method. The change increased patient eligibility so more veterans could get care at private hospitals and clinics closer to home, more than doubling the number of veterans eligible for the program.

Even with the change and more individuals eligible for the program, veterans continued complaining about having trouble accessing medical care through the Choice Program.

On July 31, 2015, Congress took bold action by passing the VA Budget and Choice Improvement Act to address lingering Choice Program problems and to fix a major budget crisis that had been brewing in VA because of increased demand from veterans for health care services.

The law provided for important modifications and enhancements to the Choice Program, such as:

- Eliminating the prior enrollment date requirement of August 1, 2014 for veterans to have been enrolled in the VA health care system, allowing all veterans enrolled in VA health care to be eligible;
- Allowing the agency to waive the 30-day wait time for veterans needing care;
- Increasing the number of providers in the program; and,
- Changing the distance requirement, allowing veterans seeking primary care who live within 40 miles of a VA medical facility, including a community-based outpatient clinic that does not have a full-time physician to use Choice for that care.

Additionally, the bill also provided some significant reforms to improve health service delivery and access in the future, including directing the Secretary to submit a plan to Congress by November 1, 2015, on how it will consolidate all non-VA care programs under one, the Choice Program.

VA submitted its Plan to Consolidate Community Care Programs October 30, 2015. The plan proposes consolidation of all seven purchased care programs into one New Veterans Choice Program called the New VCP.

CURRENT STATUS OF THE CHOICE PROGRAM

Despite frustrations with the Choice Program implementation, most agree there has been significant progress in improving access in a relatively short period of time. Though access to care is improving, VA continues to experience multiple systemic issues across the agency, impacting current mission as well as its ability to modernize to meet the growing demand and changing veteran population.

In fact, the 2015 Independent Assessment Report required by the VACAA cited four systemic findings that impact VHA's ability to execute its mission (Page xii):

- A disconnect in alignment of demand, resources and authority.
- Uneven bureaucratic operations and processes.
- Non-integrated variations in clinical and business data tools.
- Leaders are not fully empowered due to a lack of clear authority, priorities and goals.

Although the veteran population is expected to decline over the next decade, a unique mixture of demographic factors is leading to increased demand for VA services and is expected to continue for the foreseeable future.

Aging Vietnam veterans are using more services at increased costs. Successful marketing of the Choice Program to increase awareness has led veterans to seek care who may previously have decided not to use the VA. The conclusion of conflicts in Iraq and Afghanistan is bringing in a new generation of Post-9/11 veterans to the system. A growing number of women veterans, now 10 percent of the military, are seeking VA treatment at higher rates than their male counterparts.

Aging infrastructure; antiquated financial, human resource, and technology systems; and budget shortfalls further limit VA's ability to make much-needed change and improvements on its own.

Today's VA health system is more complex and access requirements more complicated than ever, even after decades of reform efforts and enhancements like the Choice Program. Veterans must contend with a multiplicity of access points, eligibility criteria and gatekeepers in trying to access health care and services. The experiences of veterans using VA health care vary widely across the country. The inconsistencies and complexities across the health system erode the trust and confidence veterans have in their system, particularly when they are told that new programs like Choice will help them get the care they need sooner, rather than later.

MOAA members reflect some of the mixed experiences and feelings veterans have with VA health care, including accessing the Choice Program. Some of their comments include:

- **90 Year Old Male WWII Veteran**-*"I've always had a great experience with my audiology care and responsive service at the VAMC in Phoenix, Arizona."*
- **70+ Year Old Female Vietnam Veteran**-*"I did not intend to use the Choice Program. I have always been satisfied with the responsive on- and off-site services offered at the Sheridan, Wyoming VAMC. However, I was advised that I "have no choice" with the inaccurately named VETERANS CHOICE PROGRAM. I must acquiesce in the new procedures for off-site services or pay for those services myself.The vets on the bottom of this avalanche of bureaucratic insanity are worse off than ever in their access to timely healthcare."*
- **40+ Year Old Male OIF/OEF Veteran**-*"Thank goodness the VAMC in Los Angeles, California stepped in and helped me get my benefits and medical care I desperately needed."* This wounded warrior was forced out of the military with no assistance in helping him with his transition. He ended up being rated 100% unemployable, and the VAMC helped him get immediate medical care and services, giving him and his family the longer term security they needed.
- **32 Year Old Male OEF Veteran**-*"I'll never go back to the Washington, DC VAMC again."* This veteran was in a very unstable condition when coming to MOAA for help. He was suffering with chronic pain and post-traumatic stress from combat and had been sexually assaulted post-deployment before leaving active duty. The system was unresponsive in helping him move up his appointment to see his primary care provider, directing him instead to seek care in the emergency room if he thought he needed immediate mental health attention-the ER would then send him to the clinic to see a behavioral health provider.

Implementing the Choice Program has brought to light many of the systemic issues mentioned earlier and with it the perfect opportunity to consider a new vision for VA health care that might otherwise have been missed.

VA has certainly embraced the opportunity for a new vision for reform in its New VCP concept. The plan is a step in the right direction to simplify community care and integrate the entire system to enhance the veterans' experience and health outcomes.

THE NEW VETERANS CHOICE PROGRAM (NEW VCP)

The Secretary and his staff deserve great credit for the work undertaken to coordinate and produce the New VCP, particularly given the tight time constraints for producing the end product. The proposed plan to consolidate community care provides a good foundation for Congress, the Commission on Care, the VA, and other stakeholders to consider in the process of deliberating the future of VHA.

MOAA, like many of our VSO and MSO colleagues working with VA to develop the New VCP concept, believes the plan offers the potential for expanding and improving access to care, particularly for veterans in need of emergency services and urgent care. Regardless of what the system of care in the future will look like, the nation has a responsibility to ensure veterans have access to the care, benefits and services they have earned, deserve and value.

The key elements of a health system veterans and their families/caregivers value most include high quality, accessible, comprehensive, and veteran-centric care-a system that is simple, easy to understand and navigate, and is seamless whether the care is delivered in-house or in the community.

VA's intent in its plan for consolidating community care program is to have "clear eligibility criteria, streamline referral and authorization processes, make customer support available when needed, and eliminate ambiguity around eligibility and personal financial obligations for care."

VA states the New VCP criteria will also be flexible enough to respond to the unique needs of veterans and eligibility requirements. This will be evaluated over time depending on health care innovations and changes to the veteran population.

However, VA's plan for hospital and medical services continues to base eligibility on wait times, geographic access to care and availability of services. That is, the same confusing and inconsistently applied eligibility criteria used in the current Choice Program.

VA does propose expanding eligibility for emergency treatment and urgent care services. MOAA is very supportive of the expansion but opposed to requiring veterans to pay a cost share to access these services. VA's plan would require copays of $100 for emergency treatment and $50 for urgent care services for veterans with or without a service-connected condition. We believe this is a major departure from

current eligibility requirements and will negatively impact veterans and their families. Such a requirement presents yet another set of criteria for VA to manage and another impediment to veterans accessing care.

The new VCP is an ambitious plan. Any significant reform of VHA will require strong, sustained leadership at all levels of the Department. Ten of the top 16 VHA executives are new since the Secretary took office, and VA is facing some of the most troubling human resource challenges of its time in recruiting, training, retaining, and developing a viable workforce for the future.

Clearly, VA must reform. What remains to be seen is whether VA will have the strong, consistent leadership, vision and commitment at all levels of the organization necessary to drive the real, cultural and transformative changes needed across the entire VA Health Administration (VHA)-one that remains focused on veterans and is agile enough in adapting to the changing veteran population and advances in American medicine.

At its January 2016 VA Commission on Care meeting, Dr. Kenneth Kizer, the former Under Secretary of Health Administration from 1994–1999, told commissioners the issues facing VA today aren't much different from earlier times when he led the last major reformation.

When commissioners asked him what needs to be done to fix VA, Kizer said, "These are all fixable issues with the right leadership and commitment." He went on to say, "VA's biggest challenge is leadership-the culture is driven by the right leadership in the right places at all levels, including Congress."

Multiple ideas and solutions to reform VHA have come forward in recent months, providing a unique opportunity to take a fresh look at health care.

One such idea MOAA believes should be seriously considered is the Independent Budget's (IB) VSO concept. The IB's Framework for Veterans Health Care approach builds upon VA's progress in transforming VHA, but goes beyond the legislative, regulatory and bureaucratic constraints confining the system today.

For example, the IB recommends moving away from arbitrary federal access standards to a clinically-based decision made between a veteran (to include family/caregivers) and their physician or health care professional, offering great potential for simplifying eligibility requirements and expanding access across the system, beyond just community care.

The IB framework starts with the idea of what a veterans' health care system should look like, rather than what VHA should look like. MOAA believes this is an important distinction for the Commission on Care to consider when making its recommendations to Congress.

MOAA RECOMMENDATIONS

While MOAA is very encouraged by the Secretary's transformation efforts, we urge Congress, the Commission on Care and the VA to:

- ***Adopt the Independent Budget's (IB) Framework for Veterans Health Care approach by incorporating the concept recommendations in any plans for transforming the VHA.***
- ***Eliminate the current arbitrary federal access standards and establish a new clinically-based standard for both in-house and community care, to include veterans (and family/caregivers) and their physician or medical professional in the decision-making process to yield a less complicated standard for accessing care.***
- ***Support VA's plan for expanding access to emergency treatment and urgent care services, but oppose the copay requirement for veterans accessing such care, particularly those with service-connected conditions.***
- ***Direct resources and funding at modernizing the VA human resources system, requiring VA to implement a workforce management and succession planning strategy for attracting, training, retaining, and sustaining high quality personnel.***

CONCLUSION

MOAA is grateful to the Members of the Subcommittee for your leadership in supporting our veterans, their families and caregivers.

We look forward to working with Congress, the Commission on Care and the VA as we seek to reform VHA into a world-class system that puts veterans and their families/caregivers at the center of their health care.

Biography of Rene Campos, CDR, USN (Ret.)
Deputy Director, Government Relations

Commander Rene Campos rejoined the MOAA staff in February 2015 as the Deputy Director, Government Relations, managing matters related to military and veterans' health care, wounded, ill and injured, and caregivers. She previously helped establish a military family program at MOAA, working on defense and military quality of life programs and policy issues. In September 2007, she joined the MOAA health care team, specializing in Departments of Defense and Veterans Affairs health care systems, as well as advocating for seamless transition programs and women in the military issues.

She began her 30-year career as a photographer's mate, enlisting in 1973 and was later commissioned a naval officer in 1982. Her last assignment was at the Pentagon as the Associate Director, Office of Family Policy in the Office of the Deputy Under Secretary of Defense for Military Personnel and Family Policy.

Commander Campos serves as a member of The Military Coalition (TMC) - a consortium of nationally prominent uniformed services and veterans' organizations, representing approximately 5.5 million current and former members of the seven uniformed services, including their families and survivors, serving on the Health Care; Morale, Welfare & Recreation and Military Construction, and Base Realignment & Closure; Veterans; and Personnel, Compensation and Commissary Committees.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, thank you for the opportunity to offer our thoughts on the Department of Veterans Affairs' (VA) plan to consolidate its community care programs.

The VFW strongly believes that veterans have earned and deserve timely access to high quality, comprehensive, and veteran-centered health care. For the past year, Congress and VA have devoted time and resources to determining when such care should be delivered at VA medical facilities and when veterans should be afforded the opportunity to receive care through private sector health care providers. To the VFW the answer is simple: when a veteran and his or her doctor determine it is clinically necessary, the highest quality and the most accessible option.

Since the access crisis erupted in the spring of 2014, the VFW has taken a proactive approach to evaluating the state of the VA health care system. Through our work we have collected direct feedback from tens of thousands of veterans regarding their experiences receiving health care. What we have learned is that veterans turn to VA despite 80 percent of them having other health care options because they like the quality of care they receive, they believe VA health care is an earned benefit, and VA is best suited to care for their service-connected injuries and illnesses. While VA is the preferred option for eligible veterans, it is not always the most convenient one. That is why the VFW strongly believes that community health care providers must be integrated into the VA health care system to expand access to timely, high quality, comprehensive and veteran-centric health care to the veterans who rely on VA for their health care needs.

The VFW supports many aspects of VA's plan to consolidate its community care programs. Specifically, the VFW strongly supports VA's plan that would move away from federally mandated wait-time standards and enable veterans and their doctors to determine how long they are clinically able to wait for their health care. We agree with VA that the amount of time veterans wait for care should not be confined by statute. The number of days a veteran is able to wait for care must be a determination based on his or her medical conditions and symptoms. For example, a veteran who is likely to have heart complications and is experiencing chest pain cannot wait 30 days to be seen by a cardiologist, which is the current practice, regardless if it is at a VA medical facility or private sector hospital. However, a veteran who requires a routine medical examination may be able to wait longer than 30 days.

Furthermore, allowing access to be defined by a patient and his or her doctor would align VA access standards with industry best practices. In a recent Institute of Medicine (IOM) study on access standards, IOM recommended that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families."

IOM's study also recommends that VA "continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet the demand." That is why the VFW supports VA's intent to create high performing networks based on the availability and capabilities of each health care market. Doing so would ensure VA is able to identify private sector pro-

viders who are ready and able to deliver timely, high-quality, comprehensive and veteran-centric health care and empower those providers to care for America's veterans.

However, the VFW does not agree with VA's plan to continue to use the arbitrary 40-mile standard to determine when veterans are afforded the opportunity to access the private sector providers within its high performing networks. Instead of using distance to determine when veterans are able to leave VA, distance should be used to determine when VA must expand health care options to ensure all veterans are afforded the opportunity to receive veteran-centric and coordinated care when they need it and where it is most appropriate.

That is why the VFW strongly believes that private sector health care providers who participate in VA's high performing networks must be integrated into the VA health care system and considered an extension of VA health care. Meaning, a veteran must receive equal or greater quality of care through a high performing network private sector provider than a veteran would receive from a VA medical facility. To the VFW, this includes the ability to seamlessly schedule and navigate from a VA medical facility to a private sector provider and vice versa.

For example, a veteran who has a private sector primary care provider must be able to schedule a specialty care appointment at a VA medical facility and have all related medical records from that visit transmitted to the veteran's provider to ensure the veteran's care is integrated as it would be if he or she were receiving all his or her care at a VA medical facility. Conversely, a veteran who receives his or her primary care at a VA medical facility must have a seamless experience when receiving specialty care through a network provider.

That is why the VFW believes that once a veteran and his or her doctor determines clinically based limits on a veteran's ability to travel, that veteran must be allowed to pick from options available within the local high performing network, including all public and private sector options.

To properly size high performing networks to each community, the VFW recommends establishing metrics to identify clinical access gaps based on veteran population density and distance to care and services available within high performing networks, including VA and community providers. Such access gap metrics would serve to identify areas where the veterans' health care system must expand capacity through agreements with community health care providers, sharing facilities with private or public health care entities, or building capacity.

We do not have to look far for an example of how distance is used to expand capacity instead of determining when veterans are able to consider non-VA options. Instead of requiring every veteran who lives within 75 miles of a national cemetery to be interred in that cemetery, the National Cemetery Administration's (NCA) goal is for 96 percent of all veterans to have interment options within 75 miles of their home. This includes viable burial options at cemeteries that have been built, expanded, or improved through NCA cemetery grants.

When the demand exists, NCA proposes the construction of a new national cemetery. However, NCA also uses agreements and grants with states, United States territories and federally recognized tribal organizations to establish, expand, or improve veterans' cemeteries in areas where NCA has no plans to build or maintain a national cemetery. Cemeteries assisted by an NCA grant are required to be exclusively reserved for veterans and eligible family members and maintained by the same standards as an NCA managed national cemetery - meaning that veterans interred in NCA assisted state, territorial, or tribal cemeteries are afforded the same honors as those interred in a national cemetery.

The VFW also supports VA's plan to expand access to urgent care at VA medical facilities and through private and public urgent care clinics across the country to fill the gap between emergency room care and outpatient care. We also support VA's plan to loosen its definition of an emergency to expand access to private sector emergency room care. However, the VFW strongly opposes any recommendation to bill veterans for service-connected care. Any cost share associated with emergent or urgent care eligibility must be aligned with VA's current copayment structure, which exempts veterans who do not have the financial means to pay cost shares and veterans who receive cost-free care due to service-connected disabilities.

To curb overreliance of emergency room and urgent care, the VFW recommends that VA establish a national nurse advice line that would help veterans determine the appropriate level of care needed to address their medical concerns. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. As a result, the number of beneficiaries who have turned to an emergency room for their care is much lower than those who intended to use emergency room care before calling the nurse advice line. VA could leverage its existing pool of nurse and medical advice lines to estab-

lish a national advice line to emulate DHA's success or partner with DHA to expand the TRICARE Nurse Advice Line to veterans.

As this Subcommittee continues to evaluate VA's plan to consolidate its community care programs, the VFW will continue to ensure the voice, preference, and health care needs of veterans are prioritized and ensure VA health care reforms serve the best interest of our Nation's veterans.

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 2016, 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.