

EXAMINING THE VETERANS CHOICE PROGRAM AND THE FUTURE OF CARE IN THE COMMUNITY

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

JUNE 7, 2017

SENATORS

	Page
Isakson, Hon. Johnny, Chairman, U.S. Senator from Georgia	1
Tester, Hon. Jon, Ranking Member, U.S. Senator from Montana	3
Murray, Hon. Patty, U.S. Senator from Washington	10
Moran, Hon. Jerry, U.S. Senator from Kansas	13
Sullivan, Hon. Dan, U.S. Senator from Alaska	17
Sanders, Hon. Bernard, U.S. Senator from Vermont	19
Rounds, Hon. Mike, U.S. Senator from South Dakota	21
Blumenthal, Hon. Richard, U.S. Senator from Connecticut	25
Tillis, Hon. Thom, U.S. Senator from North Carolina	28

WITNESSES

Shulkin, Hon. David J., M.D., Secretary, U.S. Department of Veterans Affairs; accompanied by Baligh R. Yehia, M.D., Deputy Under Secretary for Health for Community Care, Veterans Health Administration	5
Prepared statement	7
Response to posthearing questions submitted by:	
Hon. Johnny Isakson	63
Hon. Dan Sullivan	64
Hon. Bernie Sanders	64
Hon. Mazie K. Hirono	68
Hon. Joe Manchin III	69
Steele, Jeff, Assistant Director, National Legislative Division, The American Legion	31
Prepared statement	33
Response to posthearing questions submitted by Hon. Mazie K. Hirono	69
Atizado, Adrian, Deputy National Legislative Director, Disabled American Veterans	37
Prepared statement	38
Response to posthearing questions submitted by Hon. Mazie K. Hirono	70
Fuentes, Carlos, Director, National Legislative Service, Veterans of Foreign Wars of the United States	44
Prepared statement	45
Response to posthearing questions submitted by Hon. Mazie K. Hirono	71
Stultz, Gabriel, Legislative Counsel, Paralyzed Veterans of America	48
Prepared statement	50
Response to posthearing questions submitted by Hon. Mazie K. Hirono	72

APPENDIX

Association of American Medical Colleges; prepared statement	75
Stacy, David, Government Affairs Director, Human Rights Campaign; pre- pared statement	82

EXAMINING THE VETERANS CHOICE PROGRAM AND THE FUTURE OF CARE IN THE COMMUNITY

WEDNESDAY, JUNE 7, 2017

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

The Committee met, pursuant to notice, at 2:36 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Rounds, Tillis, Sullivan, Tester, Murray, Sanders, Brown, and Blumenthal.

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

Chairman ISAKSON. Let me call this meeting of the Veterans' Affairs Committee of the U.S. Senate to order. I thank everybody for their attendance today, particularly, Secretary Shulkin. Thank you for being here today, and thank you, Dr. Yehia, for being here today. Thanks to all our VSOs who are here, who will be on the second panel. I know sometimes waiting through the first panel for the second panel, it takes a long time, and sometimes there are not as many Members of the Committee here. When you get to testify is when the big guy gets to testify, but believe me, we pay close attention to every bit of testimony that comes in. We appreciate your participation because we consider ourselves a team from the standpoint of the Veterans Administration.

In my opening remarks, I want to focus on that for just a second. I do not think there is any question that the fact that David Shulkin was confirmed 100 to nothing; the first Presidential appointee that was voted in unanimously. Yesterday, we had a voice vote passage of a bill we could not move in the U.S. Senate a year ago, which is a unanimous vote as far as I am concerned. We did so because we found common ground where we needed to. We plowed new ground where we had to, but most importantly, we kept the veterans foremost in our minds, not ourselves as politicians or the press or somebody who wanted to play games.

What we are going to talk about today is probably the most challenging subject we will deal with in this term of Congress as far as the Veterans Administration is concerned. Accountability had its pitfalls and had its potholes, but it was doable, and we proved it was doable. I want to thank the Ranking Member, Jon Tester, for his leadership in helping us get that through, and not the least,

Jerry Moran who also was a tremendous help on our side, and Marco Rubio is not on the Committee but was a very active member who promoted accountability from the beginning. And we finally got it done.

Today, we are going to be talking about the Veterans Choice issue. I was here in August 2004 when we started the great Veterans Choice debate. It was on the conference committee when we did the final bill that we passed, and finally, the decision to pass what we finally passed, we capitulated in terms of available funding to some point it would die unless we fixed it. Well, we are at the point where if we do not fix it permanently, we are going to have a program that is either going to be out of money, out of gas, or out of both.

We also have learned a lot in the last 27 months about how the Choice Program has worked the way we designed it, and we know there are some things we need to change. We know we have to look at the 40-mile rule and the 30-day rule and make them better rules for the veteran and for the Veterans Administration and making something that works for Choice rather than an incumbent to Choice.

We need to see to it that VA, for all intents and purposes, is unleashed to provide the highest-quality service it can and make the decisions it makes on the ground at the time they need to make them. We need to give them the funding and the commitment and the resources to be able to do that.

But, on the same token, I think we have to be as open minded on making Choice work in the future as we have been on finally getting accountability done yesterday. There are going to be some things that some people are going to find hard to take or hard to talk about. There are going to be people thinking change is bad. Change is not bad. Change is good. What we are going to have to do on Choice is change some. We have to change some ideas, change some direction, and change some results.

In the end, we remember our goal is to see to it that veterans have the choice to get the services they need, whether it is care in the community or in the VA hospital or clinic in a timely basis. That way the VA can run its health care system the way it sees fit to meet the demands of those veterans and deliver them the highest-quality service possible.

Dr. Shulkin yesterday demonstrated that he had the acumen, the intellect, and the intestinal fortitude to make the kind of decision you have to make to really bring a system into the 21st century. Yesterday's decision in terms of Cerner and bringing in the medical records was huge.

I have been personally very pleased at the response of the President, of elected officials, of Members of Congress, and of many people in the industry, because that is a giant leap forward, where our software will be interoperable between the DOD and the Veterans Administration, where veterans will not fall through a hole once they leave active duty to go on to the Veterans Administration and be lost for a year before we finally find them.

I think we will ultimately realize savings, innovation, and advancement, and we are going to be sure that we hold Cerner ac-

countable and the Veterans Administration accountable for those to be the results of this decision.

I want to publicly commend Secretary Shulkin on having the fortitude to do that, pulling that trigger, so to speak, and pledge my support to help in every way possible to see the transition is smooth and works.

With that said, I welcome Dr. Shulkin here today. Dr. Yehia, I welcome you here today, because I know you are the real brains behind a lot of these recommendations. I am not going to take the heat off of Dr. Shulkin. I am going to put some of it on your back as well.

I want to thank the Ranking Member for being such a good partner in this effort and turn to him for his opening statement.

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

Senator TESTER. Well, thanks, Mr. Chairman. I want to, before I get in my prepared remarks, echo the Chairman's comments about what happened with the DOD electronic medical records. I think the challenge is also what he just said, and that is making sure it is done efficiently, effectively, and timely. We look forward to not only holding Cerner, but your feet to the fire on that as we move forward.

Thank you, Mr. Chairman, for having this hearing today. I am looking forward to this hearing because Choice has been such a train wreck.

I held listening sessions in Missoula and Billings last week, two of the biggest communities in Montana. Veterans have told me that the Choice Program has not improved access. In fact, it has made it worse. In the process, it has caused a lot of veterans and community providers to lose faith in the VA. Even though it is contracted out, we get the blame.

When we passed Choice, 3 years ago, the fact of the matter is we passed it to increase the availability of health care in a more timely manner, and quite frankly, I cannot speak for all the States here, but Montana has done just the opposite.

So, we have got a lot of work to do to win some folks back, and that should be really the focus of our conversation today, as it should be every day, and that is the veterans.

Earlier this year, I was pleased that we could come together in a bipartisan manner to make some much-needed changes to Choice. It was one of the first bills that President Trump signed. As those changes are fully implemented, I know more veterans will hopefully have more timely access to care in their own communities when the care cannot be provided by the VA.

However, it is no silver bullet. We need a dramatic revamp of the VA's Community Care Program, but we need to be thoughtful in that approach. Rather than just giving a veteran a card to seek health care, which I know would be easy to do, as we talked yesterday, the path forward should be an integrated program with the VA being the backstop and the community providers filling in the gaps. Why? Because in the end, we owe it to our veterans to make sure they have the best health care possible, and if there is a

screw-up, ultimately, you and I both know, Mr. Secretary, it is going to end up on your desk. So, we have got to do it right.

The VA should continue to serve as a coordinator and primary provider of care while the private sector fills in the gaps, and it is clear that the VA provides critical and necessary services to millions of veterans who benefit from specialized care, specialized care that in some cases is far better in the VA than it is in the private sector. These services are far, far, far too important to risk to outsource them because our veterans are depending on them.

That is especially in the case of places like Montana, where local providers are often unable to absorb those veterans or to provide the specialized care that those veterans require.

Now, do not get me wrong. There is an important role for community care in the delivery of health care to veterans, and we need to utilize that. But I will tell you, I reject any proposals to divert critical resources to community care that would hollow out the VA and impair its ability to provide care to millions of veterans who rely upon VA services that you guys provide, and I might say in almost every case you provide it very, very well.

Mr. Secretary, over the past few weeks, we have had a number of discussions about the Department's proposals for the future of VA health care, and I know this is not a hearing to dissect the budget. But I really want to reiterate my concern from yesterday about the large increase for community care seemingly being made at the expense of in-house VA care.

I want to talk about how you arrived at those numbers, and I expect, as always, you will give it to me straight, because I am not going to be the guy up here who allows the Administration to chip away at VA health care. I will tell you why: because if I do, the next panel we hear from, the VSOs, will be all over me, and they should be. We should not reduce access to the VA because Washington is not staffing hospitals or clinics or because resources are not being appropriately allocated. Sending veterans to the private sector does not absolve the VA of the responsibility or the benefits. The VA is just as responsible when a veteran has a bad experience in the private sector as they are if they had a bad experience in a VA hospital. So, we cannot let the VA lose oversight of the quality of care that our veterans have earned, regardless of where it is.

Sending the veterans into already underserved communities based on poorly designed or questionable metrics really does smack of setting the VA up for privatization. We have had these conversations before. Make no mistake about it. Under any of these conditions, veterans will unnecessarily suffer, and I do not think either one of us want that.

So, I am encouraged to take what we hear today into account, and we will take your suggestions and move forward in the next Choice Program, Choice 2.0, whatever you want to call it, to make sure it works better, make sure it works as Congress intended when they passed it 3 years ago.

With that, I just want to say thank you, guys, for being here. I appreciate your work, and quite frankly—and I am going to say so far, but I anticipate it is going to continue—I appreciate your forthrightness about what is going on within the VA. Admitting to prob-

lems is the first step toward solving them, and I think you guys have taken the first step in a lot of cases. I commend you on that.

You did—and you were confirmed by 100 to nothing, as you pointed out to the Chairman earlier today.

Chairman ISAKSON. Thank you, Senator Tester, and thank you for your support. I echo all the—I endorse all the statements that you made and the challenge we had to meet to make these changes.

Our first panel and our first testimony will be from Dr. David Shulkin, the Secretary of the VA, who will be accompanied and assisted, I am sure, by Baligh—let me make sure. Is Baligh right as the first name, and Yehia is the second name? I am always afraid I am going to mess that up. We welcome you for being here and enjoyed our meeting yesterday.

Let me say to both of you, normally, we give you 5 minutes, and then we will submit your testimony for the record. I am going to be very liberal on how much time. You take the amount of time you think that you need to lay out your presentation on Choice, and after that, we will do a question-and-answer from the Members of the Committee. We will call the second panel forward and do a Q&A with them.

It is a pleasure to introduce Dr. Shulkin, the Secretary of Veterans Affairs of the United States of America.

**STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED
BY BALIGH R. YEHIA, M.D., DEPUTY UNDER SECRETARY FOR
HEALTH FOR COMMUNITY CARE, VETERANS HEALTH AD-
MINISTRATION**

Secretary SHULKIN. Great, great. Thank you, Chairman Isakson, Ranking Member Tester.

I thought both of your opening statements were excellent, so hopefully, we are going to have a good hearing ahead of us.

I am going to take less than 5 minutes because I really want to be able to make sure that we address all of your questions, and so thank you again for the opportunity to be here to talk about the Community Care Program that the Department has and included in that, of course, the Choice Program.

I did want to say that I thought that yesterday afternoon, VA really took a big step closer to getting the type of accountability legislation that we need, so I want to thank all of you for doing that. Really, on behalf of the veterans in this country, I want to give a deep thanks to Senator Rubio, who sponsored the accountability bill, and to you, Chairman, and to the Ranking Member for your support and leadership and all the Members on the Committee.

I think the Senate sent a pretty clear message to veterans that veterans are your priority, and that the VA has to be there to serve them.

I also wanted to say thank you for helping us enact the Veterans Choice Program Improvement Act, and my thanks as well to the Ranking Member for sponsoring the bill and to other Members on the Committee who were cosponsors, and in particular to Senator McCain for his help.

As more veterans than ever before picked Choice, we are seeing increased demand. Just in the first quarter of fiscal year 2017, we saw 35 percent more authorizations for Choice than we did in the first quarter of 2016. So far, in fiscal year 2017, we have approximately 18,000 more Choice-authorized appointments per day than we did in fiscal year 2016, but we still have a lot more work to do.

That is why we are seeking support for the Veterans Coordinated Access and Rewarding Experiences Program, the Veterans CARE program. Let me just go over that again because you need a good acronym in Washington. The Veterans Coordinated Access—that is the C and the A—Rewarding Experiences program, the CARE program.

I have testified before, and I will report again today, that our overarching concern remains veterans' access to high-quality care when and where they need it. That is regardless of whether the care is in VA or in the community.

Our goal is to modernize and consolidate community care. We owe veterans a program that is easy to understand, simple to administer, and that meets their needs. That is the CARE program, and now it is time to get this right for veterans, so we need your help.

Today, the criteria and processes for veteran access to community care are too often arbitrary, administrative, and unnecessarily cumbersome, but it does not have to be that way.

Here is how veterans could experience VA health care with your help. The veteran talks with their VA provider. That is a conversation over the phone, virtually, or in person. The outcome is a clinical assessment. The clinical assessment may indicate that the VA specialist is best for the veteran, or it may indicate that community care is best to meet the veteran's needs. If community care is the answer, then the veteran chooses a provider from a high-performing network. That is the veteran choosing a provider from the high-performing network. Assessment tools help veterans evaluate community providers and make the best choices themselves.

We may help veterans schedule appointments in the community, or in some circumstances, veterans can schedule the appointments themselves. We make sure community providers have all the information they need to treat the veteran. We get the veteran's record back. We pay the veteran's bill. This is all about individualized, convenient, well-coordinated, modern health care and a positive experience for the veteran. If the VA does not offer the necessary service, then the veteran goes to the community. If the VA cannot provide timely services, the veteran goes to the community. If there are unusual burdens in receiving care, the veteran goes to the community. If a service at a VA clinic is not meeting quality metrics for specific services, veterans needing that service go to the community, while we work to support that clinic to improve its performance. Veterans who need care right away will have access to a network of walk-in clinics. In its simplest term, if the VA does not offer the service, if the VA cannot provide the service in a timely manner, or we are failing to meet community standards, veterans will have the opportunity to receive community care.

So, the Veterans CARE Program will ensure veterans get the right care at the right time with the right provider. With Veterans

CARE, veterans drive their experience. They have more choice, and they have more say in their care. Because care is coordinated around the individual clinical needs of veterans, the CARE Program is tailored to veterans. Because veterans will know who to call to get care, the CARE Program is easier for veterans. Because veterans will have more flexibility to get the right care in the right place, the CARE Program is more convenient for veterans. And since eligibility is based on clinical needs, not administrative criteria like 40 miles or 30 days, the CARE Program is veteran-centric and patient-centric.

The whole process requires only a VA team, a network of community providers, and the veteran, all while decreasing the number of handoffs involved.

But, we cannot do this without your help and without legislation, so thank you. We look forward to any questions you may have today.

[The prepared statement of Secretary Shulkin follows:]

PREPARED STATEMENT OF HON. DAVID J. SHULKIN, M.D., SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND DISTINGUISHED MEMBERS OF THE COMMITTEE. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Community Care Program, including the Veterans Choice Program, which allows for Veterans to access the care they need and deserve. I am accompanied today by Dr. Baligh Yehia, Deputy Under Secretary for Health for Community Care in the Veterans Health Administration (VHA).

VETERANS CHOICE PROGRAM EXTENSION

We are extremely grateful for the recent efforts of Congress that resulted in the enactment of the "Veterans Choice Program Improvement Act," which removed the expiration date for the Veterans Choice Program and allows the Department to use the full \$10 billion originally allocated to care for Veterans in the community. It also made VA the primary coordinator of benefits and allowed for better health information exchange between VA and community providers. These changes will lead to more Veterans getting community care and will reduce the administrative burdens of using the program for Veterans, community providers and Federal partners, and VA staff. While progress has been made, there is still more work to be done to serve our Nation's Veterans.

FUTURE OF VA COMMUNITY CARE

VA needs a different approach to ensure we can fully care for Veterans. We need your help in modernizing and consolidating community care. Veterans deserve better, and now is the time to get this right. We believe that a redesigned community care program will not only improve access and provide greater convenience for Veterans, but will also transform how VA delivers care within our facilities.

This redesigned program must have several key elements. First, we need to move from a system where eligibility for community care is based on wait times and geography to one focused on clinical need and quality of care. This will give Veterans real choice in getting the care they need and ensure it is of the highest quality. At a minimum, where VA does not offer a service, Veterans will have the choice to receive care in their communities. Second, we need to make it easier for Veterans to access urgent care when they need it. This will ensure that Veterans will always have a choice and pathway to get their urgent needs addressed. Third, the new program must maintain a high performing integrated network that includes VA, Federal partners, academic affiliates, and community providers. We need to ensure that VA is partnering with the best providers across the country to take care of our Nation's Veterans. Fourth, it must assist in coordination of care for Veterans served by multiple providers. Finally, we must apply industry standards for quality, patient satisfaction, payment models, health care outcomes, and exchange of health information. By doing so, Veterans can make informed decisions about their care and VA can have the tools to better compete within communities.

We believe redesigning community care will result in a strong VA that can meet the special needs of our Veteran population. Where VA excels, we want to make sure that the tools exist to continue performing well in those areas. Veterans need the VA and for that reason, community care access must be guided by principles based on clinical need and quality. VA needs the support of Congress to level the playing field with industry by making it easier to modernize our infrastructure, leverage IT technologies, hire the best talent, and operate more like the private sector. A good example is management of our real property and infrastructure portfolio, where numerous barriers prevent VA from being agile in response to Veterans health care needs in different geographic areas. We want to work with Congress to discuss the best ways to bring common sense to this area.

VA also needs tools to improve our recruitment, hiring and retention of the best professionals to serve our Veterans. These tools could include improvements to hiring and pay authorities to better address vacancies in our medical center and VISN director positions, to help at least in part address disparities with the private sector. As a final example, there is Federal law that requires VA facilities to have a smoking area. We all know the impact on health from smoking, and smoking cessation is the most immediate and dramatic step a Veteran, or anyone, can take to improve their health. VA strongly supports H.R. 1662 which would repeal this requirement. Action in these areas will make VA more modern, and be an enabler for our dedicated workforce to be more effective in their service to Veterans.

In order to improve care for our Veterans, we want to work with Congress to develop needed legislation for the future of VA community care. This legislation would have to be enacted by the end of the fiscal year to ensure that VA has sufficient time to proceed with regulations and other changes needed to implement the new vision. If we can accomplish this together, we would set VA on a bold new direction to not only increase access to community care but also transform the VA itself. We are committed to moving care into the community where it makes sense for the Veteran. Finally, I want to make sure that everyone understands that making better use of community care must be done in a fiscally responsible way. We cannot continue to grow our funding in the same way we have done over this past decade. And, I want to be clear that I am committed to strengthening the VA system and will not support efforts to privatize this much needed and essential system. The ultimate judge of our success will be our Veterans. With your help, we can continue to improve Veteran's care, in both VA and the community.

Thank you and we look forward to your questions.

Chairman ISAKSON. Thank you very much, Secretary Shulkin, for a concise statement yet a very thorough statement regarding the proposal on the CARE Program.

Let me begin by talking about the quality metrics that you talked about in terms of health care facilities in communities. You will be relying on a lot of community information in terms of quality of health care, in terms of making your decision as to who in the private sector would deliver care to a veteran if the veteran could not get the care from the VA; is that correct?

Secretary SHULKIN. Yes.

Chairman ISAKSON. Are the quality metrics available today in a seamless standard format?

Secretary SHULKIN. Here is what we have available today. As you know, we have recently published the wait times of our veterans that are on the website right now. The VA is ahead of the private sector on that. We hope the private sector will follow our lead and begin to start publishing wait-time data. So, we have VA data but not public data.

What we do have for both the VA and the private sector are patient satisfaction scores, called CAP scores, that are the same surveys in the VA and outside in the private sector.

We do have quality metrics. We have quality metrics for inpatient care, where there are more metrics in the private sector than the VA, but what we are really doing now is developing those metrics—and so is the private sector—for ambulatory care. So, be-

tween all of those measures, there is enough to make the types of comparisons we are talking about, and it is only going to get better over time.

Chairman ISAKSON. An eligible veteran comes to the VA for health care, and the VA clinic that he goes to that is near him or the hospital that serves him as a veteran does not offer that service, whatever it might be. That automatically gives him the opportunity to go, he or she to go to the private sector in community care; is that correct?

Secretary SHULKIN. It does, yes.

Chairman ISAKSON. Second, if the community quality rating is not good, does that automatically give them a chance to choose community service, community care, rather than go to the VA?

Secretary SHULKIN. What we are doing in this program, we are designing it to be that way. We want to make sure that if the service is low performing, if it is below what the veteran could get in the community, that they have the opportunity. They do not have to leave the VA. They are given a choice so that they are able to get care in the community or stay at the VA, because if a veteran has a good experience and they have trust in their provider, they are going to want to stay where they are. But, that is the purpose.

The whole idea here is to improve the VA, not to get more care in the community, and the very best way that I know how to improve health care is to give the patient—in this case, the veteran—choice and to make those choices transparent, to let everybody see, because then if you are not performing as high a quality service, you are going to want to provide a higher-quality service, because you want to be proud of what you are working on. And I want the VA to be improving over time. I think this will help us do that.

Chairman ISAKSON. You tell me, Dr. Yehia, if this is a correct statement or not. Under the old statement, we set in an arbitrary qualification to use the community care to be the number of days you had to wait for an appointment or the number of miles it took a canary to fly from where you lived to where the clinic was available. Is that not correct?

Dr. YEHIA. That is right.

Chairman ISAKSON. Now we are talking about a judgment call made as to whether or not a veteran who is eligible for VA health care can go to the community care servant or go to the VA. Is that correct?

Dr. YEHIA. That is right. We are empowering the veteran and their care team to make those decisions rather than having arbitrary administrative roles.

Chairman ISAKSON. But, there is going—somebody at the VA is going to be a part of that decision. It is not going to be just the veteran making that decision. They are not going to go to the community care alone. Who is that person in the VA that makes that decision?

Dr. YEHIA. Their doctor and the care team that supports them.

Chairman ISAKSON. So, this doctor, his doctor at the VA is the person that will ratify his decision to go to the private sector based on—or go to community care based on the fact of either the quality metrics in the community or based on the fact they cannot offer the service that the veteran needs. Is that correct?

Dr. YEHIA. That is right.

Chairman ISAKSON. Do you consider that as a—I am going to take a little bit more in my time. This is important. Do you consider that a threat to you, Doctor?

Dr. YEHIA. No.

Chairman ISAKSON. You are a doctor, and, David, you are too?

Dr. YEHIA. Well, I think, patients come to doctors to get a clinical assessment and to get their advice. That is how we are trained as we go through medical school, so it is our responsibility to have those conversations, figure out what makes sense for them. So, the advantage of the CARE Program compared to the current Choice Program is it helps us decide the right place, the right doctor, the right location, and the right time for that patient to get their care. So, I actually think it is going to empower doctors in the system and patients in the system to make decisions that make sense for them.

Chairman ISAKSON. I want you to listen to this.

I would assume veterans who are otherwise eligible for VA health care but are not using it, because they got private health insurance or something else, it would be more attractive to come to the VA for their services because you have got that choice, and it is made in the way it is made?

Dr. YEHIA. Yes. In some circumstances, we have been seeing, you know, “if you build it, they will come.” More people are interested in receiving VA health care than before.

Chairman ISAKSON. So, the concern that some might have, that this is a threat to VA and VA health care, it, in fact, in many ways is going to put an additional pressure on VA and VA health care to provide services to a greater number of veterans. Because I happen to agree with Senator Tester. None of us sitting at this table want to dissolve the VA, do away with VA health care, or close anything.

On the other hand, we do not want to perpetuate a problem. We are trying to solve what has been a huge problem, which we could not solve 27 months ago when we kind of cut and run on it. Now we have got the chance to do it. So, we have no goal whatsoever to reduce the role of the VA health care system in the life of a veteran or take away or close a single clinic or a single facility. We want to make sure that we have the best service available to the veteran, and if we do that, if you build it that way, talking about the system, they will come. Then, the VA will be even more—have an even brighter future than it has got today as well, so I appreciate the response to that.

Senator Tester.

Senator TESTER. I would want to kick it over to the good Senator from Washington.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman.

Secretary Shulkin, in your draft veteran care plan, you outline a number of pilot projects that sound to me uncomfortably like proposals that are made by the so-called Strawman Document—it is from the Commission on Care—and by the extreme—and to me unacceptable—plan put forward by the Concerned Veterans of Amer-

ica, and those include creating a VA insurance plan and separating it from care delivery, dividing the governance of a VA insurance plan and the health system, an alternative care model that sends veterans directly to the private sector.

The goal of those types of initiatives, as originally stated in the Strawman Document, is, quote, “As VA facilities become obsolete and are underused, they would be closed when availability and accessibility of care in the community is assured.” Those policies serve not only to dismantle the VA and start the health care system down a road to privatization, I just want you to know I will not support them, and I will fight them with everything I have.

So, I want to ask you: why are you agreeing to pursue those unacceptable policy options?

Secretary SHULKIN. Well, first of all, I appreciate you sharing your thoughts and as clearly as you have.

I share your goal. I am not in support of a program that would lead towards privatization or shutting down the VA programs.

What I am in support of is using pilots to test various ideas about governance, about the way that the system should be organized, and the way that we should evolve, because I do not know, without testing different ideas, whether they are good ideas or not.

We do not recommend—we did not take those principles and recommend that is how the VA should be organized. I do not believe that, but what we are open to, in the spirit of innovation and in the spirit of testing, different ideas and different pilot sites. But, I do not want the consequences that you talked about.

One of the reasons why this is early on and we want to get feedback from all of you is to make sure that even the things that we are piloting are things that we want—we want to drive them toward desired outcomes.

So, I would be glad to work with you on those, but I do want to make sure—since I do not think we are going to get everything in this piece of legislation that we are ultimately hoping to get to in terms of a desired result, I want to make sure that we give ourselves room to innovate and to test new ideas.

Senator MURRAY. Well, Dr. Yehia, these types of proposals did not appear in your earlier drafts of the plan for a new non-VA care plan. Why the change?

Dr. YEHA. Well, I think they are more like testing these different ideas. When you think of the Center for Medicare and Medicaid, their Innovation Center, this is a little bit of what these pilots are designed after. That body of CMS is really driving innovation in health care. They are testing value-based models. They are testing accountable care organizations, and they are figuring out what works. And those things that work, they are spreading across.

So, I think in the spirit of innovation and testing our different ways to integrate with the community, it makes sense to see if it works or it does not work.

Senator MURRAY. Well, here is what is missing from the conversation, is how you plan to actually build and strengthen the VA system for the long term. You have not put forward a comprehensive plan to do some of the things that the VA really needs to do—get more front-line providers, increase appointments, expand services, build and upgrade facilities, bring more veterans into the sys-

tem. Those to me are the things that you do if you are trying to build and strengthen the VA system that we have, that veterans want.

The proposals that you have lead me as singularly moving us in an opposite direction, and if you propose to only invest—invest in certain select types of care like TBI or PTSD or polytrauma or prosthetics, hospitals cannot be viable when you invest in only a handful of lines like that.

So, let me ask you the question in reverse: how are you going to build a comprehensive VA system?

Secretary SHULKIN. Well, Senator, I think what you have just outlined is our agenda, to be able to build up and strengthen the system. We call it “modernize the system,” the way that you have.

About 10 days ago, I gave a comprehensive report on 13 areas of risk. They included exactly what you said, what we need to do to make this a stronger system that is going to be sustainable into the future. That is my goal. That is the only thing I am trying to do.

I do believe, though, that you make a stronger system by giving your patients, your customers, more choice. That is how I believe every company has improved their product and has differentiated successful—

Senator MURRAY. If you only give your—

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. Customers a choice to get out, you are going to rob the resources from the system that we need to make sure is working.

Secretary SHULKIN. I could not agree more, and in fact, that is why we are not recommending that this be an unfettered Choice Program in 2017.

I hope that we will get to the point that I do believe that VA has the investment that it needs to become the modern system that it will be able to successfully get patients in and out.

Senator MURRAY. I have one more area I want to cover. You know where I am coming from.

Secretary SHULKIN. Yes.

Senator MURRAY. I want to also say that I am really concerned that the VA is continuing to propose billing veterans’ private health insurance for care for service-connected conditions. In your draft veteran care plan, you propose charging veterans \$50 for walk-in clinic care. Your requested bill language puts on cap on how high you can make those copayments and would allow you to charge veterans for service-connected care.

So, I am deeply concerned about that, and I just want to ask you: Do you think it is appropriate to break the Nation’s longstanding commitment to provide care for injuries received in military service and ask veterans to foot the bill?

Secretary SHULKIN. Well, let us make sure that we have the same understanding. My understanding is we did not ask to bill other health insurance for service-connected disabilities, so that is not what we are proposing. I do not know why there is confusion over that.

Senator MURRAY. But, you do propose charging veterans \$50 for walk-in health care.

Secretary SHULKIN. OK. So, a walk-in, a walk-in benefit is a brand-new benefit. We do not offer that today. What we are talking about in this is expanding the benefit to provide veterans the ability to get convenient care in their neighborhoods.

The way that we are proposing it is there would be no change in the copay or benefit structure for the first two visits of a brand-new benefit. Following that, then after two visits—because there is a cost. We are adding a benefit, but we cannot add an unlimited new benefit. So, after two visits, we would propose that there be a copay cost, but this is no takeaway. This is an added benefit, because we believe it is the right thing to do.

Senator MURRAY. I think it is a break in the tradition—

Secretary SHULKIN. Yes.

Senator MURRAY [continuing]. I have deep concerns about that. And I am way over my time.

Chairman ISAKSON. Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Chairman, thank you very much.

Dr. Shulkin, Dr. Yehia, thank you very much for joining us today. I want to thank you for appearing before our Appropriations Subcommittee, now about a month ago, and particularly thank you for the conversations that we had in my office prior to that hearing. I indicated then and would indicate now publicly, that is the best set of conversations I have had with VA officials in the 7 years I have been a member of the U.S. Senate. So, I find your leadership refreshing from what my experience has been.

I hope that—I guess I would ask that question: what is the attitude like at the VA today, different than it was in the past, in the short time that you have been there? You were there before being Secretary. You are now there as a Secretary. What is the VA like today in comparison to what it was last year or the year before or the year before that?

Secretary SHULKIN. I think people have not come to the exact same conclusion that you have. I think that there are a lot of people still watching, and there may be some people that are hopeful and some people that are concerned about changes. So, whenever you are going through change and you are trying to make decisions quicker and create decisions that have been years in the making and have not been made, you are going to have some people that are anxious. I think people are sitting and saying, "I hope that this is the right direction," but there are a lot of people that are more cautious than you.

Senator MORAN. Thank you for that honest answer.

Let me suggest to you, Mr. Secretary, that one way that I think that all of us on this Committee and Members of Congress can be helpful to you is to continue the dialog with us, to be responsive to our inquiries. Again, I think that has not been a practice in the past, and often, circumstances that I have been in, the requests that we make for information end up with a standard form letter reply that tells us next to nothing, where at best, you can say you responded because you sent me a letter. But, it did not tell me anything about what I was asking about.

Secretary SHULKIN. If you get those letters, send them back because I agree. It is just a waste of the postage stamp.

Senator MORAN. I appreciate that. Again, I would say when it comes to the Choice Program, which I think will be perhaps the most important piece of legislation this Committee considers in the foreseeable future, with the greatest level of consequences to veterans in Kansas and across the country, that I would ask for your commitment that this is going to be a joint effort with VSOs.

I asked you when we first met, before your confirmation, that you quickly meet with veterans service organizations and solicit their input and have honest dialog with them. I would ask you to do the same thing with us as we try to figure out what makes sense.

This Committee represents a set of different geography and different set of circumstances that I think we can bring to the table in trying to solve problems from our largest cities to our smallest towns.

Secretary SHULKIN. Yes. We are starting where Senator Tester started us, which is that the Choice Program——

Senator MORAN. Now I am nervous.

Secretary SHULKIN. No, no, no, no. [Laughter.]

No, he is right. The Choice Program was not working for veterans the way that it should, and you were instrumental, Senator Moran, in pointing that out to us all along.

So, this is now a journey, and I have to tell you, we have been engaging the VSOs. We have been in listening sessions. We have changed this plan a half dozen times because of their feedback, and I think even Senator Murray is going to find that we are going to be open and responsive to concerns. So, we are looking for that type of relationship with you.

Senator MORAN. I appreciate that. For example, I learn something about the Choice Program almost every day, certainly every week in conversations with veterans and conversations with health care providers.

I completed another round of 127 visits, one to each hospital in the State of Kansas, where I learned things about the Choice Program that I probably should have known, but it never occurred to me, the way it was operating, at least from that provider's perspective. And, again, I think all of us here can provide information that can be helpful in getting a Choice Program that serves our veterans well.

In response to Senator Murray's question, you said something that caught my attention: This will not be an unfettered Choice Program.

Secretary SHULKIN. Yep.

Senator MORAN. I wanted to give you the opportunity to explain to me and to the Committee what that means.

Secretary SHULKIN. Yes. There are some that have suggested that the very best approach is just give veterans a card, a voucher, and let them go whatever they want to go. And I think that there are some significant concerns about that, and you are going to see this proposal is not that.

This proposal is to develop a system that is designed for veterans, that coordinates their care, and gives them the options when it is best for in the VA and when it is best in the community.

Unfettered choice is appealing to some, but it would lead to essentially, I believe, the elimination of the VA system altogether. It would put veterans with very difficult problems out into the community with nobody to stand up for them and to coordinate their care, and the expense of that system is estimated to be, at the minimum, \$20 billion more a year than we currently spend on VA health care. So, for all those reasons, I am not recommending that we have unfettered access.

At some point in the future, if you design the system right, giving veterans complete choice, I believe, in principle, is the direction we should be headed in but not in 2017.

Senator MORAN. Mr. Chairman, I would conclude by indicating to Secretary Shulkin and with my appropriator's hat on, we cannot afford to provide two different systems of service.

Secretary SHULKIN. That is right.

Senator MORAN. They cannot overlap with each other. They have got to find the place in which they have a purpose. We cannot afford to do both.

Secretary SHULKIN. Yes. I agree.

Senator MORAN. Mr. Chairman, thank you.

Chairman ISAKSON. Thank you, Senator Moran.

Senator TESTER?

Senator TESTER. Yes. Thank you, Mr. Chairman, and I am almost inclined to have the Secretary say that Tester was right again for the record.

Secretary SHULKIN. I will not do that again.

Senator TESTER. OK. All right. I did not think you would. [Laughter.]

Look, I have got a couple things. I know we said that—I did not want to make this a budget hearing, but there are a couple things in the budget, I really do have to touch on.

Secretary SHULKIN. Yes.

Senator TESTER. One of them was the President's Budget Request lays out a plan that would pay for expanded access to private-sector care by taking money from disabled vets or, even worse, elderly disabled vets. Is it the intent, do you think, the Administration is going to move forward with that, or are you going to be able to put any input into that to make sure that that does not happen?

Secretary SHULKIN. Well, we certainly noted the strong concerns not only of Members of Congress, but certainly from the VSOs. And I will tell you, we are going to take that concern very seriously. Nobody wants to be taking away unnecessary benefits from veterans and certainly not putting them into poverty, so that is a significant concern.

We have tried to go back. Remember this is a budget that adds multiple billions of dollars more into veterans' benefits, into both health care and on the mandatory side. We have gone up from 2016 to 2018 on mandatory benefits over \$12 billion, so remember this is more benefits going to veterans.

We felt an obligation to go back and look at our current programs and say, "Are they designed the right way? Is there a way to refine them?" So, we need to continue to look to get that right.

Senator TESTER. Good.

I want to go back to the Choice Program, community care versus VA care, and tell you where—we are probably all on the same page around this rostrum, but as we are all on the same page and the budget comes out and gives a 33 percent increase for private-sector care versus a 1.2 increase for care provided directly by the VA, it does not take very many budgets like that and pretty soon you are not going to have any vets going to the VA, because all the money is going to community care. And they will follow the money. I promise you, they will follow the money.

I think that—I do not want to put words in the VSO's mouth. They will have a chance here in a bit. But, I think most of the veterans I talk to say build the VA's capacity.

In Montana, we do not have enough docs. We do not have enough nurses. We do not have enough of anything. Quite frankly, that takes away from the experience and the quality of care. So, by putting 1.2 percent increase for care provided directly by the VA and 33 percent for private-sector care, we are privatizing the VA with that budget.

Secretary SHULKIN. Well, I told you I was not going to say that you were right again, but there is a lot—there is a lot that you said that I think we both agree with. The goal is not to privatize the VA.

What we are asking for in this is something we do not have. We need additional flexibility between the money that goes into the community and the money that can be spent in the VA. Right now, we are restricted to a 1 percent ability to transfer money between.

We are seeking that you give us more latitude there for exactly the reason you are talking about, Senator. We need our medical centers and our VISNs to be able to say that they need to build capacity in the VA where it is not available.

The reason why we are letting people go into the community now is because if the VA does not have it, we have to get them that care.

Senator TESTER. I got it, but if we do not make the investment so they can get that health care, they will never get that health care within.

Secretary SHULKIN. Right.

Senator TESTER. OK.

Secretary SHULKIN. Yes.

Senator TESTER. Good. Now, I had a meeting with some vets up in Kalispell. They said that you bring on new docs; they are fuzzed up about the VA. They love it. They are in for about 2 or 3 years, and they get burned out. One of the reasons they get burned out is an issue that you addressed earlier, and I want to go back to it. That is the doctor's ability to refer patients to the private sector without having to refer to somebody above them and maybe even go to Denver in our case and then back. I do not know where the puzzle goes to.

But, I do know that doctors are not allowed, even for a simple x-ray in the private sector or an MRI, to be able to do that, and

they get fed up with it. Doctor, Doctor, you would probably get fed up with it too if you were treating a patient.

Are you saying that they are going to be allowed to be able to access the doc, in consultation with the veteran, and going to be able to clinically decide whether they need to go in there, and there is not going to be a bunch of red tape attached?

Secretary SHULKIN. Well, you know, both Dr. Yehia and I see patients in the VA, so we understand the frustration when people tell us how to practice medicine.

This plan is to put the decisions back into the hands of the patient and the provider.

Senator TESTER. Good.

Secretary SHULKIN. But, we—but listen, you know, this is—we have to also make sure that the resources that we spend of the taxpayers are appropriate. So, we are going to give guidelines, but we are not going to be micromanaging.

Senator TESTER. That is fine.

And just real quick, because my time has run out, do you need that to be a part of the Choice bill that we write up, or do you have that authority right now to do that?

Secretary SHULKIN. Well, right now, you have the TPA in the middle. Remember, we have this multiple-step process, so we need legislation.

Senator TESTER. So, you need legislation. Thank you.

Secretary SHULKIN. We do.

Senator TESTER. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Tester.

Senator Sullivan?

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and, gentlemen, thank you for your testimony.

I want to start by echoing the Chairman's comments about the move that you took yesterday, Mr. Secretary. You know, I think, as you and I talked about before the hearing, people have been talking about integrating the DOD and armed services—or active duty systems on health care for, gosh, decades. So, you took the step. Thank you. I am sure it is not going to be without hiccups, but I think you have the support of this Committee behind you on that.

Secretary SHULKIN. Thank you.

Senator SULLIVAN. A number of us actually serve on this Committee and the Armed Services Committee, so we can kind of keep an eye on it from both ends. So, thank you for that.

I also wanted to thank you and Dr. Yehia. I know both of you put a lot of time in the issue of the Tribal Sharing Agreements in Alaska. You know how important it is to our State, not just the Alaska Native vets, who have a tremendous record of patriotic military service, but to non-Native vets. I know you are focused on that. I just want to thank you for providing that kind of top-level focus.

I wanted to talk about a couple things, Mr. Secretary, that you and I saw when we took a trip out to Alaska together, some which were Alaska-specific, some of which were national issues.

Let me begin by, if you remember, we ran into a number of vets. Really, I think the first time, you and I learned a lot out there on this issue of providers not being reimbursed quick enough by the VA, and then them turning to the young, you know, 25-year-old soldier who just came back from Iraq, hitting him up with a big bill and a collection agency riding him. What are we doing to address that? That obviously was an issue we saw in Alaska, but I know it is a national issue. How are we trying to address that? There is nothing more stressful than a young guy who gets approved to go the VA—or woman—gets an appointment, gets a surgery, and the next thing you know, he has got an \$80,000 bill that some collection agency is after him and ruining his credit score. How are we trying to address that nationally?

Secretary SHULKIN. Well, we did see that way too often, particularly early on with the Choice Program.

With the extension, with the Choice Improvement Act, that is something that is actually now changed in law. That VA has taken over the responsibility of being the primary coordinator of benefits. That takes the veteran out of the middle.

Part of what we have experienced with the Choice Program is a different set of rules for when veterans get care in the community and a different set of rules when they get care in the community. So, we confused veterans, we confused providers, we confused our own staff. We are moving toward a single set of rules for care in the community, and we are never going to put the veteran in the middle again like what we did.

The one exception that I still am concerned about is emergency care, and as you know, there was a court case recently that required—it is called the *Staab* decision—that required VA to pay emergency medical care, and it is going to take us a year to write the regulations to do that. So, a veteran may find themselves in the position you are talking about that.

Senator SULLIVAN. Yes.

Secretary SHULKIN. That worries us a lot, but we are probably about 9 months away from fixing that problem.

Senator SULLIVAN. Good.

You know, Senator Tester mentioned the issue of a lack of docs, particularly in big rural States like his and mine. We are close to introducing, I think with the support of the VA, the Serving Our Rural Veterans Act, which would establish pilot residency programs in big rural States. I should just call that the Shulkin bill because, to be honest, that was your idea when we were out in Alaska. We just want to get your commitment. I think you will see bipartisan support here, but we want to kind of finalize that with the VA to make sure you guys are good to go with that one.

Secretary SHULKIN. Well, one of the things we know, you do not have a medical school in Montana or one in Alaska. When you train physicians and they have a good experience where they train, particularly at VAs, they want to tend to stay there, and that is what we want. We want them to ultimately see a career in the Federal Government in this way, so we are very supportive of that.

Senator SULLIVAN. Good. Great.

Let me ask a final issue. You know—and you saw it when you were in Alaska. The Choice Program up there was an utter dis-

aster, as it was in a lot of States, and you committed—and I think the VA has done a good job on it. We are not 100 percent there yet, in Alaska, pilot program that was really focused on trying to fix some of these Choice issues. How often do you receive updates, now that you are the Secretary, on the performance of that pilot program, and how do you measure performance?

And I will offer that up to both of you.

Secretary SHULKIN. Yes. Yeah, I would rather have Dr. Yehia answer that.

Dr. YEHIA. Yes. We stay in close contact with our colleagues in Alaska because, really, they are serving as a model of where we are going with care and also with our new RFP proposal. It is how you get care locally more in the hands of that patient, their care team, and the local community provider.

I think they are having some issues with staffing they were continuing to work through because of the great number of volume that they do—

Senator SULLIVAN. Yes.

Dr. YEHIA [continuing]. Of delivering care in the community, but for the most part, the experiences of the veterans has been excellent, and the timeliness of actually getting care into the community has improved from before. We are happy with the progress that is being made there.

Senator SULLIVAN. But, you are continually monitoring it?

Dr. YEHIA. Absolutely.

Senator SULLIVAN. OK. Thank you.

Mr. Chairman, thank you. I have one final question I will submit for the record, but it actually relates to the vacant and underutilized list of buildings, where I think you had a VA building in Anchorage, AK, that is actually very utilized and very important, and it was on the list. So, we will submit that for the record, just to get clarity on that. It may have been a mistake on the VA's part.

Secretary SHULKIN. We could have made a mistake there. Yes.

Senator SULLIVAN. OK. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Senator Sanders.

HON. BERNIE SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman.

Good to see you, Dr. Shulkin.

Secretary SHULKIN. Good to see you.

Senator SANDERS. Let me tell you my starting assumptions when I look at these issues. I start off with the assumption that for those veterans who get into the VA system in a timely manner, generally speaking, they think—and having talked to all of the veterans' organizations about this, I think they confirm it—that, generally speaking, the quality of care is good, that the average veteran in this country, in fact, is very, very proud of the care that they get at the VA, despite a lot of attacks that we have seen over the years and despite the reality that there are problems within the VA, in any system as huge as the VA, not to mention there are many problems in our general health care system outside of the VA as well.

All right. So, here is my concern. I want to see the VA be strengthened, provide the highest-quality care in a timely manner to all of our veterans, and I think what concerns me is, as I understand it—correct me if I am wrong—that today there are some 45,000 vacancies—doctors, nurses, other medical personnel.

I know some years ago, we appropriated some \$5 billion into bringing more medical personnel into the system. I believe of that fund, there are only \$600 million remaining. Is that a rough—

Secretary SHULKIN. Yes. \$595 million. Yes.

Senator SANDERS. 595. All right. Close enough.

How much money are you going to need to fill those vacancies to make sure that our veterans get quality care in a timely manner?

Secretary SHULKIN. We need what the budget says that we have. That is enough money for us to fill those positions and be able to take care of the veterans in the way that you have said. I agree with everything that you said that we want to do.

Senator SANDERS. OK. How long do you think it will take? I know it is easier said than done, but how long do you think it will take to fill those vacancies?

Secretary SHULKIN. Well, we generally fill about 32,000 a year. So, this is going to be a little bit of an accelerated effort to be able to fill those critical positions, but I do not think it is an impossible effort. I think that with a focus on making sure that these positions are filled, we are going to get that done over the course of this next year.

You will always have turnover, Senator, so you are constantly—you know, people leave. You are constantly refilling. So, you know, the usual is about 32,000 a year.

Senator SANDERS. OK. Let me move to another area, an area that Senator Murray has led the effort on, that I have been working with her. We have made, over the years, some progress in assisting caregivers, which I think is just a huge issue. I mean, you often have wives, sisters, family members who have devoted much of their life, Mr. Chairman, to taking care of heroes and heroines who were wounded in battle. I know that we passed legislation to take care of the post-9/11 generation.

I think it becomes humane and cost effective to expand that program. Mr. Chairman, I would hope that we can work together to do that. I think right now, as we speak, you have folks who have devoted their entire lives. They are often exhausted. They have given up their own careers to take care of veterans from Vietnam or Korea, even World War II and more recent wars. I would hope that we could expand that program.

Would you say a word, Dr. Shulkin—

Secretary SHULKIN. Yes.

Senator SANDERS [continuing]. On how you see where we might want to go with the Caregivers Program?

Secretary SHULKIN. Well, as you know, the Caregivers Program, as currently authorized by Congress, only is authorized for post-9/11 veterans. I believe if you are going to look for the greatest value—and I am totally supportive of caregivers for post-9/11, but the greatest value would actually be in our elderly veterans, because what you want to do is allow people to remain in their homes

as long as they possibly can because that is where, frankly, most of us would rather be than move to an institution.

Senator SANDERS. Can I interrupt you to just ask you?

Secretary SHULKIN. Yes, yes.

Senator SANDERS. I think you are absolutely right, but even from a dollars and cents point of view, doesn't it make sense to give support to those people who care for veterans in their homes rather than putting them in nursing homes?

Secretary SHULKIN. I think it does. I think that would be very cost effective.

What we have done—and I will tell you part of what I hope that you are seeing them doing—when we have problems in the VA and things are not working, I am calling them out. I called out the Caregivers Program for essentially not working. We were giving caregiver benefits and then withdrawing caregiver benefits 90 percent of the time in some cases. So, I suspended all of the revocations of caregiver benefits. Now no one is getting them revoked until we review the policies and we make sure that we have it right, first of all.

Second, we are looking at every benefit that we have, and many of them, not surprisingly, are different parts of VA—some are in VBA—to help support elderly, people that need help in their home, with home aides and caregivers in the home. We do not call them “caregivers,” but we have benefits for them.

So, what we are going to be introducing in the next several months—I would say 2 months—is a revised set of criteria to be able to help support more veterans, particularly the elderly veterans, and where we find gaps, we are going to come back to you—we know Senator Murray is very interested in this as well—and ask for your help to be able to do the right thing for our veterans.

Senator SANDERS. Thank you very much.

Chairman ISAKSON. On a personal note, I have talked with the Secretary about this and talked with Senator Murray about this. With caregivers, it is a huge problem. When you can benefit not only the veterans, but benefit and lessen some of the burden on the VA, if we do it right. I would like to work with it as well and continue to do so on that.

I want to recognize Senator Rounds for his 5 minutes of questions and ask you to yield to Senator Blumenthal when you finish in case—I have got to go return a phone call real quick, and I will be right back. I am sure Senator Tester will take my place. Yeoman's work. Right?

Senator Rounds.

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

Senator ROUNDS. Thank you, Mr. Chairman.

Gentlemen, I just want to talk a little bit about the difference between the proposed CARE plan and Choice as it is today, and I am assuming that if CARE were to step in that Choice would go away.

Secretary SHULKIN. Mm-hmm.

Senator ROUNDS. Right now, the way that I understand it with Choice, the veteran makes the choice if they have been more than 30 days or more than 40 miles away, which is a lot of South Dakota, in terms of they make the choice of choosing a provider.

Under the new program that you have proposed, the VA, they would make a trip to a VA facility in order to see a physician to begin with, who would then make the decision as to whether or not they would be able to be treated in their home community. Am I wrong on that, or did I misunderstand?

Secretary SHULKIN. It would be an option for a veteran to come into a medical center to see somebody or to simply call on the phone or do a text message through their HealtheVet system or any other way. So, it is not meant to be a physical consultation. It is just talking to your care team.

Senator ROUNDS. So, the VA would then receive a phone call from a veteran, and then the VA would decide, "You come in, or we will allow you to go to the physician of your own choice."

Secretary SHULKIN. It should be a joint decision, but yes. Essentially, you have got the right.

Senator ROUNDS. It does not sound like it is a joint decision.

Secretary SHULKIN. Well, when I treat patients, I would listen to my patients, and I understand what their needs are. If they say to me, "Listen, I do not have a car. I have decreased visual acuity. It is hard for me to get around," I say, "Listen, I want you close to home. I do not want you driving 30 miles and looking for a parking spot."

I think what good doctors and good providers do is they recognize this is a joint decision.

Senator ROUNDS. Well, because right now—and we have talked about this before, but I just want to bring it up again.

Secretary SHULKIN. Yes.

Senator ROUNDS. In South Dakota, we have had veterans who have literally gone to an optometrist, received a prescription, and simply asked the VA to fill a set of glasses and been told, "Drive 170 miles if you want your glasses."

Secretary SHULKIN. That is ridiculous.

Senator ROUNDS. It is, and yet what you are suggesting is that same alternative could once again become a reality in rural States if we do not provide some sort of evidence or some sort of assurance that a veteran outside of that area has some say other than simply requesting permission of the VA to use a local physician.

Secretary SHULKIN. Well, if we are making veterans do that, we are implementing this program wrong.

Now, having said that, it is——

Senator ROUNDS. Then, why not make it clear so that there is no misunderstanding?

Secretary SHULKIN. Yeah, yeah. We are going to be issuing guidance for sure, but we——

Senator ROUNDS. How about putting it in the law?

Secretary SHULKIN. About——

Senator ROUNDS. How about putting it in the rules?

Secretary SHULKIN. Well, yeah.

Senator ROUNDS. Because—here is the reason why I am saying that. In 2009, we had the Emergency Care Fairness Act. It was signed by President Obama in 2010. That allowed for veterans to go to an emergency room, regardless of whether it was a VA facility or a non-VA facility, and that law made it pretty explicit that the

VA would pay for that emergency room care just as if they went to a VA facility.

2011 came. 2012 came. 2013 came. Those were denied time after time after time by a VA that said, "Well, our rules do not say that. We do not interpret the law that way."

Furthermore, in 2014—I believe that is the *Staab* case. The *Staab* case has now been in court. It has been decided. It has been appealed. The VA lost. It has been appealed again, and the VA lost. What I believe I just heard you say was that it is going to be a year before we have the rules in place to pay for emergency room care for some of these veterans that have been waiting for years to get reimbursed?

Secretary SHULKIN. Yes. Let me be clear about that. Your history is accurate. From the day I became Secretary, I instructed the VA: there will be no more delays in moving forward to pay those cases. We lost in court. It was not even close. OK. Every—

Senator ROUNDS. They refused to even listen to the final request—

Secretary SHULKIN. Right.

Senator ROUNDS [continuing]. For an appeal.

Secretary SHULKIN. Yes. Our refusal to accept reality is only hurting veterans. So, we are moving forward with that, and nobody should do anything to delay that anymore, but—

Senator ROUNDS. So, now, how much do we owe those veterans right now under that plan?

Secretary SHULKIN. About \$2 billion.

Senator ROUNDS. \$2 billion. And you are suggesting that it will take a year to create the rules?

Secretary SHULKIN. To write the regulations.

Senator ROUNDS. In the meantime, we have got veterans who have been waiting for 7 years now for reimbursement for emergency room care? Is not there some kind of an alternative here for an emergency determination as to a rule that the court has ordered it be paid?

Secretary SHULKIN. Well, this is still in court under appeal. We will hear sometime this summer, but—

Senator ROUNDS. So, who makes the decision as to whether or not the VA should continue with an appeals process such as that after the courts have turned them down?

Secretary SHULKIN. Yes.

Senator ROUNDS. You have got veterans—in one case, one who is 94 years old with a \$10,000 bill, and they just decided they are not going to pass away until they get that bill paid.

Secretary SHULKIN. Yes.

Senator ROUNDS. Now, maybe we ought to just delay that appeals a little bit longer, and the gentleman can live a little bit longer. But, it seems to me that we are barking up the wrong tree—

Secretary SHULKIN. Well—

Senator ROUNDS [continuing]. If we are going to have another appeals process before we take care of these veterans.

Secretary SHULKIN. Well, once again, there is going to be no delay. We are doing everything we can to get those bills paid.

Senator ROUNDS. Mr. Secretary, with all due respect—

Secretary SHULKIN. Yes.

Senator ROUNDS [continuing]. You just told me it is going to be a year to write the rules.

Secretary SHULKIN. Well, that is the way that this works. We cannot pay unless we have the regulation that allows us to pay, and, you know, I wish we had started this earlier. But, we are doing this now.

Senator ROUNDS. I think this—you know, I like what you are trying to do at the VA.

Secretary SHULKIN. Yep.

Senator ROUNDS. We need the reforms.

Secretary SHULKIN. Yep.

Senator ROUNDS. With all due respect, if that is the approach that we take when it comes to one in which we have already lost in court and we are talking \$2 billion owed to veterans, but we want the veterans out there who right now might be seeing a Choice Program which is being improved and one that they can actually get in rural areas to the physician of their own choice, and now we want them to believe that in the future, the VA will, if it is only their authority—that they will make the appropriate decision to allow them to continue to go to a doctor outside of the VA based solely upon the VA's decisionmaking process?

Secretary SHULKIN. We are following your rules. We are instructed we are only allowed to pay, use taxpayers' money, when we have regulations that allow us to pay it.

I am saying I am not willing to put the veterans in the middle, and everybody at VA now knows they are to write those rules and get this fixed as soon as possible.

Senator ROUNDS. With all due respect, once again, Mr. Secretary—

Secretary SHULKIN. Yes.

Senator ROUNDS [continuing]. The law was written in 2009. It was signed into law. It was signed by the President in 2010, and in 2011—

Secretary SHULKIN. OK.

Senator ROUNDS [continuing]. You rewrote the rules at the VA to interpret it different than what the law says. Now you have got a court case, which has continued on, and you have lost in every single appeal. Now you are suggesting that we are going to continue the appeal, and then you are going to write the—

Secretary SHULKIN. OK. So—

Senator ROUNDS. I am sorry, but there is something wrong with this process, sir.

Secretary SHULKIN. Well, you and I agree that this should not have happened to the veterans, and you and I agree that we have lost the case. That is why I am proceeding to pay these bills. You and I may not agree.

Senator ROUNDS. I thought we said we were going to go through the appeals process.

Secretary SHULKIN. Yes, yes. I am going to explain to you why I believe it is the right thing to go through the appeals process, because we are agreeing to pay these bills on veterans who are not service-connected and who have other health insurance. That \$2 billion that I have agreed that we are going to pay, I am going to

take away from other parts of my budget that should be helping veterans that really need our help, that do not have other health insurance and are service-connected. So, from a policy point of view, I believe the court made the wrong decision, so I am going to fight that out in court.

But, I am not going to keep putting the veterans in the middle. We are going to pay those bills, because we have lost this case up until time the court tells us otherwise, and I will not delay a day to keep these veterans out of the middle.

Now, if I can use my authorities to avoid the type of veteran that you have talked about from being penalized, I will issue those types of waivers, because I think it is the right thing to do, and I want to work with you on it. But, I believe that the VA should not be using its money this way, but until I have a day that a court agrees with me, I am not going to put a veteran in the middle.

Senator ROUNDS. Well, Mr. Chairman, my time has expired, but I just think this is one of those programs where—

Secretary SHULKIN. Yes.

Senator ROUNDS [continuing]. A good example of where we may have to agree to disagree today, but this has got to be resolved, Mr. Chairman. Thank you.

Thank you, Mr. Secretary.

Chairman ISAKSON. Thank you for your attention to it, Senator Rounds. You have been a real leader on this particular issue.

Senator Blumenthal.

**HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman. I want the record to reflect that Senator Rounds would not yield to me and that he took all my time. [Laughter.]

I want to follow up on this case, but I do not want to take all of my time with it—

Chairman ISAKSON. Sure.

Senator BLUMENTHAL [continuing]. Because as a Department of Justice lawyer as well as Attorney General, I would like to pursue the very important questions that Senator Rounds is asking you, particularly as to what authority you may have or—

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. More likely the Department of Justice to just drop the appeal and decide that you are not going to subject the VA to the burden of doing these reimbursements in the face of the possibility—and I hate even to raise it—that a court could reverse the rulings below, and then you will have reimbursed a lot of people—

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. With potential liability to whomever.

Secretary SHULKIN. Yes. I would be glad to talk to you more about that, and listen, I understand. This is a situation that I inherited. I want to do the right thing. You both have a lot of experience in this. I would like to talk to you about it.

Senator BLUMENTHAL. But, perhaps on a bipartisan basis, Senator Rounds and I can explore this issue.

Secretary SHULKIN. Yes. Thank you.

Senator BLUMENTHAL. I know your heart is in the right place.

Secretary SHULKIN. Yes.

Senator BLUMENTHAL. That is the important thing, and let me just begin by saying I appreciate the very significant contribution that you have made already in your new position as well as throughout a career of dedication to improving American health care for veterans and for the American people in general.

I want to express, first, my appreciation to your commitment to CBOCs in Connecticut and around the country, because I think they are a way of strengthening the VA health care system and enabling more health care to be available to veterans where they live, closer to their homes, and more timely. We have found that fact to be true in Connecticut, and as you may know also, Connecticut is seeking to enhance its CBOCs. I hope that you will commit to continuing that effort.

Secretary SHULKIN. Mm-hmm.

Senator BLUMENTHAL. The record should reflect that you are nodding and you are in agreement, so I think—

Secretary SHULKIN. I am always open to anything that will improve the care for our veterans.

Senator BLUMENTHAL. Second, on the issue of improving health care, raising what may seem to many to be a small issue, Internet connections in VA facilities, I appreciated the VA's commitment to providing Internet connections in the West Haven facility. It has not yet been completed. My understanding is that a contract has been signed, but the faster we can make those Internet connections available in Connecticut, West Haven, and throughout the country, my understanding is that there are a number of other facilities where inpatient veterans cannot communicate with the outside world through the Internet, which is unfortunately for their medical care, because as we all know, a patient who is isolated and alone and depressed and otherwise out of touch with the world is not likely to improve or recover as fast as somebody who feels support from the outside world.

I was alerted to this issue by a veteran friend of mine who was undergoing cancer care, and I have been campaigning for it, so to speak. I appreciate your cooperation.

Women veterans. I would like to ask for your commitment that you will continue to pursue any and every opportunity for expanding and enhancing health care for women veterans, whether it is under the Choice Program or any of the other programs. I am deeply impressed with the advocacy by women and by the VSOs on their behalf, and I want to thank them for their advocacy, not only the Iraq and Afghanistan veterans, the post-9/11 veterans, but all veterans who have served. I think your heart is—

Secretary SHULKIN. Yes.

Senator BLUMENTHAL [continuing]. In the right place on that one too.

Secretary SHULKIN. Yes.

Senator BLUMENTHAL. And, finally, before my time expires, I would like to know on the new electronic health records system, what you can do to allay some of our—at least my skepticism

founded on close to 7 years of experience of hearing "It is all going to be OK" from both sides, the Department of Defense and the VA.

I know that Senator Tester has expressed very powerfully his feeling that implementation must be done efficiently, effectively, and timely. We are talking about a major commitment of resources with the best will in the world. It cannot happen without resources. Do you have a commitment from the President of the United States that those resources will be forthcoming this year or next year?

Secretary SHULKIN. The President is very excited about the possibility of putting finally this together as one system that is going to serve active military and veterans, and he is extremely supportive.

We do not know what those resources and what that plan looks like exactly at this time. So, until I have a fully developed plan, I do not think it is fair to ask for either Congress' full support or the President's full support until I can say exactly what we need.

But, I will not be putting forth a plan that I do not believe has a high likelihood of success.

Senator BLUMENTHAL. Well, for the President to be excited is good in this instance. For the President to be supportive is fine, but I have to tell you, show me the money. I hate to question your credibility, and I am not doing that, but I feel we really need to be very hardheaded and demanding here because changing the system and saying we are going to abandon the present system may have unintended consequences. I hope that there will be that kind of—because the veterans deserve it.

Secretary SHULKIN. Yeah, yeah.

Senator BLUMENTHAL. I know everybody in this room feels that we have betrayed a trust here. I do not mean to be too harsh on anyone. Again, with the best will in the world, the resources simply have not been forthcoming, and I trust you to devote your full energy to it.

Secretary SHULKIN. Yes. You know, I said earlier this week that I personally led the implementation at several institutions of EMR systems. I have never done anything on this scale. So, I am approaching this with an extreme deal of caution, knowing the false starts.

I am comforted by the fact that the DOD is a couple years ahead of us and has really worked hard to plan this out in a well-designed way, but I have said that we need approximately 3 to 6 months to come up with what this plan is, what the resources are needed. I will not proceed unless I feel that this is a plan that we can execute on.

I do have the President's commitment to modernize this system. I think you are seeing it in the budget this year that he is willing to put the resources necessary to get this system back to where it needs to get.

I am feeling optimistic about the path forward but cautious enough to share some of your concerns.

Senator BLUMENTHAL. We are talking about real money here because the Department of Defense has already spent \$4.3 billion. It is expected to spend \$9 billion. Your commitment will have to be in roughly that same range. I deeply respect and I am grateful for the President's commitment in the budget to devoting more re-

sources to the VA. But, we are talking about a different order of magnitude here.

Secretary SHULKIN. Yes.

Senator BLUMENTHAL. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. In the interest of bipartisan equity and at your request, Senator Blumenthal, let then record reflect that the addition 3 minutes and 37 seconds you took actually exceeded Senator Rounds' 5 seconds. [Laughter.]

Senator BLUMENTHAL. I offer my deep apologies.

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

Senator TILLIS. You helped me save my time by making that same point, but it was a very important discussion. I want to continue with electronic health records.

Dr. Shulkin, how many electronic health record platforms do you have in the VA?

Secretary SHULKIN. We have one.

Senator TILLIS. You have one central system today?

Secretary SHULKIN. Yes. Well, there are 130 versions of one central system.

Senator TILLIS. That was really my point.

Secretary SHULKIN. Yeah, yeah, yeah.

Senator TILLIS. You have 130 individual instances of electronic health records—

Secretary SHULKIN. Yes.

Senator TILLIS [continuing]. Within your own enterprise that you have to rationalize and integrate to get an enterprise platform.

Secretary SHULKIN. Yes. That is a considerable problem for us.

Senator TILLIS. I am just trying to point to the implementation challenge here.

Now, 30 to 40 percent of your community care or your care provided is through community care. To what extent does the electronic health record right now flow seamlessly between that 30 to 40 percent of community care providers?

Secretary SHULKIN. Well, we have partial interoperability. We have it, of course, with the DOD, and we have it with about a thousand providers in the community.

Senator TILLIS. But, to a certain extent—

Secretary SHULKIN. Partial.

Senator TILLIS [continuing]. A part of the enterprise that you have control under, you have over a hundred instances within your enterprise. You have several hundred, maybe thousands of instances outside of your enterprise.

Secretary SHULKIN. Absolutely.

Senator TILLIS. Now you have the added instances that would be any of the providers through Choice.

Secretary SHULKIN. Yes.

Senator TILLIS. That is before you actually start integrating with the DOD—

Secretary SHULKIN. Right.

Senator TILLIS [continuing]. Which is why it is completely reasonable to think it is going to take you 3 to 6 months to rationalize

the system. It is also why I think it is very important that we get people in permanent positions on your team——

Secretary SHULKIN. Absolutely.

Senator TILLIS [continuing]. To take responsibility and have accountability for execution. I think there are nine or so that we have not received nominations for. They need to be expedient with getting their paperwork done. We need to get them confirmed so that you can execute, because that 3-to-6-month window is probably going to slide more to the 6-month side if we do not have the permanent leaders in place.

Over what period of time did it take to actually settle on the commercial off-the-shelf system, the same platform the DOD has? Was that just a unilateral decision, or did you go through a selection process?

Secretary SHULKIN. No. I took a look at about 17 years of commission reports, recommendations, hearings, external consultants, spoke to people, brought in experts from the outside, including CIOs and CEOs, and then I made the decision.

Senator TILLIS. Good. You made a great decision. I am glad to see that you did not confuse it with an RFP process that would have put you further away and added more cost.

I am the Chair of the Personnel Subcommittee in Senate Armed Services. I would like to get feedback from you all on things that we may even want to put in, in terms of report language, to get the Department of Defense ready on a reasonable timeframe, on a reasonable basis, to know when you would connect to them. But, it is only after you have rationalized all these underlying systems that that would be relevant. I would like to get that information so we could potentially have it considered for the NDA.

I want to go back to something that I think is critically important here when we talk about “show the money.” We have got to show you the money. If we add additional requirements and we do not provide money, then something else suffers. Just in the exchange that you had with Senator Rounds, that money is coming from somewhere. We need you to better communicate to this Committee. If they agree with the court decision and they want to see that decision move forward, then they need to understand where those resources are going to come from, or we are going to have a subsequent committee [hearing?] where we beat you over the head for slowing down something, which you are slowing it down simply because you do not have the resource stream that you originally thought you did before a new requirement came before you.

So, in your capacity as Secretary, it is very important for you to speak assertively to us when our actions either for not new capabilities or actions outside of all of our control like court decisions are actually squeezing your resources. Do I have your commitment you are going to do that in a very up-front, sometimes even aggressive way?

Secretary SHULKIN. I think you saw the beginning of that right here.

You know, regarding the \$2 billion, it is not that I do not want to pay that for veterans. This is that I am going to need to take that \$2 billion away from veterans that I fear need the help more.

Senator TILLIS. We need to know where that is coming from.

Secretary SHULKIN. That is right.

Senator TILLIS. You know, that is why—to the veterans services organizations—when I am sometimes seen as opposing a well-intentioned proposal by my colleagues, it is because we ask you to do something more with no more resources.

Secretary SHULKIN. Right.

Senator TILLIS. We cannot have it both ways. We cannot on the one hand ask you to make people feel good about another priority that we want when we have not sufficiently resourced the priorities that we have already set.

So, I think it is very important for when people ask you to achieve other levels of service without the total resources to make it very clear that that is what they are doing, so that we can have more discipline to achieve fulfilling the promises that we currently have, and then we will get to other ones that we want to fulfill.

I am going to go way under 3 minutes and 40 seconds, but maybe just a couple more, Mr. Chair.

So, the three things that I would just like for you to report back—you do not have to talk now or respond now—but the underlying systems, there are basically three phases of underlying systems and processes that you need to get right. One is appointments, and we all know that. We need an appointments platform that is rationalized, consistent, executed well across all the VISNs.

We need the health care record, which we have talked about, and I think it is pretty clear that you are on the right path, but you have got a lot of work to do.

Then, we also need to focus—I think Senator Sullivan referred to the billing system. I have literally gone across my State and told medical providers to use us as caseworkers when they are not getting paid promptly. That will be disruptive to you all, but until we can get rid of the red tape, we will just use our scissors to cut through it, at least for providers in North Carolina. I hope my other colleagues have extended the same offer to their providers.

And, I would like to have, I would like an update from you all when you can get to it, the 12 breakthrough priorities. I feel like the electronic health records are a part of what you were talking about doing for information technology, so that is a part of it. I would like to get an update so that I can figure out how much of that is leverage-able and what our current progress is.

I would like to think that the good work that was done over the last 2 years is not being repurposed. You have assured me that it is not.

Secretary SHULKIN. Right.

Senator TILLIS. I think it would be helpful to frame our discussions, going forward in the context of those priorities, what legislation action you need and what slips when we add new priorities to you.

Thank you.

Secretary SHULKIN. Thank you.

Chairman ISAKSON. Thank you, Senator Tillis. Appreciate your participation and your patience in waiting till the very end. Thank you very much.

Dr. Shulkin, thank you very much for your testimony—

Secretary SHULKIN. Sure.

Chairman ISAKSON [continuing]. Your leadership, and we continue to stand behind you to help you in any way we can.

Dr. Yehia, thank you for making all the big decisions at the VA and giving Dr. Shulkin all the credit. We appreciate it very much. [Laughter.]

We will now take Panel No. 2, the VSOs. If you all will come forward. [Pause.]

I would like to welcome our second panel for testimony today and appreciate your patience in listening through the first panel. Your opinions as the VSOs are very important to us and a critical way for us to make decisions for the future of the Veterans Administration. Each of you will be recognized for up to 5 minutes and then stay for Q&A, if you will.

First is Mr. Jeff Steele, Assistant Director of National Legislative Division of The American Legion; Adrian Atizado, Deputy National Legislative Director of Disabled American Veterans; Carlos Fuentes, Director of the National Legislative Service, Veterans of Foreign Wars; and Gabriel Stultz, Legislative Counsel, Paralyzed American Veterans.

We will start with you, Mr. Steele, with your testimony. You are recognized for 5 minutes.

**STATEMENT OF JEFF STEELE, ASSISTANT DIRECTOR,
NATIONAL LEGISLATIVE DIVISION, THE AMERICAN LEGION**

Mr. STEELE. Thank you, Chairman.

Let me quickly echo and thank you for your leadership on the passage of the accountability bill yesterday.

Chairman ISAKSON. Thank you. We will get the door closed, so we can all hear you. Thank you very much.

Mr. STEELE. Thank you for your leadership, Chairman Isakson—

Chairman ISAKSON. Thank you.

Mr. STEELE [continuing]. Ranking Member Tester, Senator Rubio, on the accountability bill's passage yesterday.

Some use the term "choice" to imply quality. Some use the term "interchangeably" to mean access, and some champion the term as a "right" or "freedom." The bottom line is that veterans receive care at VA because they have earned it. The VA is, in fact, a public trust, and the President has vowed to keep it a public system, a vow we wholeheartedly support.

Chairman Isakson, Ranking Member Tester, and distinguished Members of this Committee, on behalf of Charles Schmidt, the National Commander of The American Legion, it is my duty and honor to present The American Legion's position on the Veterans Choice Program and the future of care in the community.

The Choice discussion has distracted many in Congress and the community from focusing on what is really at stake here, and that is the future of VA. Let me be perfectly clear. The American Legion is not interested in preserving VA for the sake of VA itself. We support and protect VA because of the institution it represents, and that is guaranteed medical care and benefits support for veterans who have earned it, period.

In our written presentation, The American Legion outlines the needs for the consolidation and unification of community care con-

tracting practices or recommendations for public-private partnerships, suggestions on ways to increase capacity and other innovations that will support VA sustainability to ensure that VA remains a world leader in education, science, and health care.

As a supplement to our written testimony, I will take a moment to address provider agreements. The American Legion appreciates the challenges VA faces in rural communities and wants to ensure that VA has the ability to contract with the most qualified and available medical services. Federal procurement regulations are daunting and cumbersome, but they were implemented to ensure that the Federal Government maintains good stewardship of people's tax dollars while seeking the highest possible quality and value.

The American Legion recognizes that the added burden these regulations place on small businesses interested in working with the government can, in some cases, discourage them from selling to the government, and this added burden exacerbates an already limited marketplace for some primary care and specialty services in many geographical areas.

The American Legion is not in favor of granting VA unlimited exceptions to the protections set forth in the Federal Acquisition Regulations, or FAR, but we do support an easing of compliance in limited circumstances. Any waiver allowing VA to bypass FAR compliance exposes VA to risk of abuse and will need to include increased and intense oversight that maintains the intent of the FAR and the integrity of the program.

So, it is with great caution that The American Legion supports allowing VA relief from under FAR Part 19 and other necessary parts of the regulations in order to help encourage greater participation among qualified community providers who seek to serve veterans through VA provider agreements.

The American Legion calls on Congress to grant limited exceptions to the FAR while instituting rigorous oversight so as to discourage abuse and safeguard integrity in the procurement and service delivery process.

The VA has a great and awesome responsibility and will always require vigorous and vigilant oversight. VA must answer to veterans, Congress, and the people of the United States by providing expert caring service with complete and total transparency.

We are a democratic republic, and with that comes an obligation, the obligation to use that transparency responsibly. As Americans, we have the responsibility to question authority, self-educate, and stay informed. Relying only on social or even mainstream media as the sole source of information is lazy and irresponsible, which is why The American Legion personally visits and evaluates VA medical centers, regional offices, and VA central offices continuously throughout the year.

We review structures, programs, policies, and meet with millions of patients, beneficiaries, VA staff, medical providers, leadership, and stakeholders through our network of departments, our VA volunteer services, our accredited representatives, and our System Worth Saving Program.

Our research is well documented. It is available for public review on our website, and our recommendations represent the voices of

the largest veterans service organization in the country. Based on that experience and research, The American Legion adamantly opposes the degradation of organic VA health care services and calls on this Congress and Administration to reinforce and strengthen the Department of Veterans Affairs so that it can do what we all agree its needs to do—support veterans because they have earned it.

Moving forward and appreciating the sincere need for community care, The American Legion simply urges Congress to fund the Community Care Program at appropriate levels, which should be no less than what is currently being allocated, without cannibalizing other areas of the VA budget.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Steele follows:]

PREPARED STATEMENT OF JEFF STEELE, ASSISTANT DIRECTOR, NATIONAL
LEGISLATIVE DIVISION, THE AMERICAN LEGION

The American Legion believes in a strong, robust veterans' healthcare system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances, there are situations where the system cannot keep up with the health care needs of the growing veteran population requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, or an add-on to the existing system, The American Legion has called for the Veterans Health Administration (VHA) to "develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account."¹

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE; On behalf of National Commander Charles E. Schmidt and the over two million members of The American Legion, we welcome this opportunity to comment on the veterans choice program and the future of care in the community.

Make no mistake about The American Legion's position—we insist on a robust program that will support the sustainability of the VHA model of coordinated care, and we do not support degrading VHA's organic services. In fact, American Legion resolution number 372, passed at our National Convention in Ohio last year sums it up nicely:

"now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Cincinnati, Ohio, August 30, 31, September 1, 2016, That The American Legion opposes any legislation or effort to close or privatize the Department of Veterans Affairs (VA) health-care system; and, be it further

RESOLVED, That Congress enact legislation that provides the VA the authority to consolidate its multiple non-VA community care programs; and, be it further

RESOLVED, That Congress enact legislation that would allow veterans to use their Medicare health care coverage, or private health care coverage, when receiving medical care or services in a VHA health-care facility, and Medicare be authorized to reimburse VA for such medical care and services; and, be it finally

RESOLVED, That The American Legion remain open to further discussion on the possibility of expanding and improving VA's health-care services."²

HEALTH CARE SYSTEM

This is the voice of more than 3 million voters who comprise The American Legion family.

As Congress is now discovering and as The American Legion has previously testified, costs are skyrocketing beyond all budget predictions as the quest to provide "choice" has overtaken common sense governing. False narratives instigated by po-

¹ Resolution No. 46 (2012): *Department of Veterans Affairs (VA) Non-VA Care Programs*

² Resolution No. 372 (2016): *Oppose Closing or Privatization of Department of Veterans Affairs*

litical interests trashed the department in 2015 and 2016 and continued to feed the media's insatiable appetite for scandal by spotlighting as many isolated incidents of malfeasance as they could find. Transparency is important and exposing criminal behavior is essential to good governance, but taken out of context this biased coverage fails to tell the more accurate story of an agency that serves millions of veterans every day with expert care. Hundreds of thousands of caring, well trained, and highly competitive professionals stream through the doors of VA medical centers throughout this Nation day in and day out for one purpose, and one purpose only—to care for those who have borne the battle—and overall, they do an excellent job.

According to an initial report published in the *Journal of the American Medical Association* published online April 17, 2017:

Initial Public Reporting of Quality at Veterans Affairs vs. Non-Veterans Affairs Hospitals

Recently, the Centers for Medicare and Medicaid (CMS) announced the inclusion of Veterans Affairs (VA) hospital performance data on its Hospital Compare website. Prior to this release, comparisons of quality at VA vs non-VA hospitals were inconclusive and had methodological limitations. Given longstanding concerns about care at VA hospitals, our objective was to compare available outcome, patient experience, and behavioral health measures between VA and non-VA hospitals.

Results—Veterans Affairs hospitals had better outcomes than non-VA hospitals for 6 of 9 PSIs. There were no significant differences for the other 3 PSIs. In addition, VA hospitals had better outcomes for all the mortality and readmissions metrics. However, on the patient experience measures, non-VA hospitals scored better overall than VA hospitals for nursing and physician communication, responsiveness, quietness, pain management, and on whether the patient would recommend the hospital to others. For behavioral health measures, non-VA hospitals did better on 4 of 9 measures, while VA hospitals did better on 1 of 9 measures.

Following the Phoenix scandal, Congress appropriated \$10 billion to help VA address any and all veterans who ended up on off-the-books waitlists³ that schedulers had developed, in an attempt to juggle the overwhelming requests they were receiving for VA care. This behavior was inexcusable and resulted in managers being improperly enriched with bonuses and incentives for a standard they had little control over meeting. The waitlist debacle began because schedulers were forbidden from using the official VA scheduling system once wait times started to exceed 14 days. Medical center executives' performance ratings were being directly tied to ensuring veterans were being seen within the, then Secretary of Veterans Affairs (SECVA) Eric Shinseki's directive of 14 days. This unrealistic goal soon became an example of the antithesis of performance management⁴ which led to the next SECVA focusing heavily on customer satisfaction and organizational management.

Secretary McDonald instituted veteran-centric principles and programs while attempting to reprogram staff and midlevel leadership with his iconic I CARE⁵ core values; Integrity, Care, Advocacy, Respect, and Excellence. At the same time, Secretary McDonald was struggling to integrate the Choice directives into the VA's community care model despite the spending restrictions imposed by Congress on how the money was to be spent. The Choice program is a textbook example of how well intended overregulating can turn into troublesome unintended consequences.

By committing \$10 billion to this new procurement vehicle, Congress ignored all of the established contracting control measures used in VA's other community care programs. Choice instituted third party administrators, additional eligibility criteria, higher and inconsistent reimbursement rates, and a disconnected billing authority. In addition, the Choice Act mandated VA to issue paper Choice cards to every enrolled veteran that were essentially worthless, wasting millions and millions of dollars on designing, procuring, and mailing millions of these cards in 90 days or less.

As part of the Choice legislation, Congress called for comprehensive studies into the VA's wait time issues. The VA found that the widespread assumption that these problems are worse in the VA than elsewhere is simply untrue. Based on a study by the independent RAND Corporation at the end of 2015, they found that "wait times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector." Overall, the report con-

³April 2010 Schoenhard memo addressing gaming the system

⁴Performance Mismanagement: How an Unrealistic Goal Fueled VA Scandal

⁵<https://www.va.gov/icare/>

cluded that VA wait times “do not seem to be substantially worse than non-VA waits.”⁶

The one thing the Choice Act effectively did was expose VA’s practice of managing to budget as opposed to managing to need. While the Choice Act set a restrictive access boundary of 30 days of wait time, and 40 driving distance miles by presenting it as increasing access, the truth is, VA already had the authority to contract patients out to community care. They just rarely used the authority because their budget could serve twice as many veterans if redirected toward organic campus care or already negotiated and established community care contracts.

Every year VA would send their budget request to the Office of Management and Budget (OMB) as calculated by the number of veterans they projected would require medical care from VA in the upcoming fiscal year, and every year OMB would recommend less money than VA had requested for the president’s annual budget request. To Congress’ credit, each year Congress would fund VA at an amount greater than what the president would request, but still lower than what VA had predicted their needs being. This budgetary tug-of-war continued for years while returning injured veterans became new patients of the VA, aging Vietnam and Korean War veterans consumed more medical services, and Congress opened free access to all returning combat vets regardless of whether or not they had a service-connected disability. Additionally, the Affordable Healthcare Act pushed veterans into VA who were eligible for VA care but never used the VA because they had access to private care, but who’s private care didn’t qualify for Obamacare. It was this combination of events in tandem with the national shortage of primary care doctors that was the foundation of the backlog of patients that finally erupted in 2014.

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

On October 30, 2015, VA delivered to Congress the department’s Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan sought to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other Federal health care providers, academic affiliates, and community providers. It promised to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care. That legislation was never enacted.

The American Legion commends this Committee for recognizing the need to fix the Choice program. The American Legion supported passage of the Veterans Access, Choice, and Accountability Act of 2014 as a temporary fix to help veterans get the health care they need, regardless of distance from VA facilities or appointment scheduling pressure. As Congress now recognizes a long-term solution requires consolidating all of VA’s authorities for outside care, including Choice, PC3, Project ARCH and others, under one authority to help veterans only when and where VA cannot meet demand. **The American Legion supports a strong VA that relies on outside care as little as possible and only when medically necessary,** rather than a move toward vouchers and privatization.

While many veterans initially clamored for “more Choice” as a solution to scheduling problems within the VA healthcare system, once this program was implemented, most have not found it to be a solution. Instead, they have found it to create as many problems as it solves. The American Legion operates our System Worth Saving program, which travels the Nation annually examining the delivery of healthcare to veterans. What we have found over the past decade, directly interacting with veterans, is that many of the problems veterans encountered with scheduling appointments in VA are mirrored in the civilian community outside VA. The solutions in many areas may not be out in the private sector, and opening unfettered access to that civilian health care system may create more problems than it solves. National Public Radio recently noted, “Thousands of veterans referred to the Choice program are returning to VA for care—sometimes because the program

⁶A Product of the CMS Alliance to Modernize Healthcare federally Funded Research and Development Center Centers for Medicare & Medicaid Services (CMS) At the Request of: Veterans Access, Choice, and Accountability Act of 2014 Section 201

couldn't find a doctor for them" or "because the private doctor they were told to see was too far away."⁷

As predicted by The American Legion, sending patients off VA campuses to community providers absent of well-crafted contracts, such as those used for Project ARCH and PC3, has led to inadequate compliance by local physicians. Their inability to return treatment records to VA following care provided by Choice led to uncoordinated care and putting veterans at serious risk for medical complications. When the Choice legislation was being developed, The American Legion insisted that any doctor treating a referred veteran have access to the veteran's medical records so that doctors would have a complete history of the veteran's medical history and be able to provide a diagnosis based on a holistic understanding of the patient's medical profile. This is important for a litany of reasons, not the least of which includes the risk of harmful drug interaction, possible overmedication, and a better understanding of the patient's previous military history—all important factors in wellness.

Also, The American Legion was adamant that any treating physician contracted through Choice have a responsibility to return treatment records promptly to be included in the patients' VA medical file so that VA could maintain a complete and up-to-date medical record on their patients. We believed then, as we do now, that safeguarding of the veterans' medical records was so important, that we helped craft a provision that was included in the language that prevented VA from paying physicians until they turned over the treatment records to VA. Sadly The American Legion was forced to acquiesce our position in favor of paying doctors whether they turned over the medical records or not, because doctors weren't sending the records—it just wasn't that important to them—and when VA refused to pay based on the failure of docs to turn their medical records over to VA, the doctors blamed VA for not paying them in a timely manner, ultimately billing the veterans directly, and refusing to see any more VA-referred patients until they got paid. Since it was more important that veterans had access to sufficient medical care and not have their credit damaged, The American Legion supported repealing that provision.

This, among other reasons including unsustainable cost, is why Choice is not the answer. The equation is simple; a dramatic increase in cost is guaranteed to result in an increased financial burden to veterans using VA care that will include higher co-pays, premiums, deductions, and other out-of-pocket expenses currently suffered by non-VA health care programs.

The American Legion has worked with this Committee to ensure veterans receive the care and benefits they have earned, and we look forward to our continued work with this Congress and administration to better this program for veterans as well as taxpayers. We can start by:

1. Open VA to more patients—volume decreases costs per patient and increases access.
2. Make VA more competitive and allow them to accept ALL forms of insurance including Medicare, Medicaid, and etcetera.
3. Make VA a destination employer by offering physicians rotations in research, emergency preparedness, and education areas.
4. Call on VA to stand up a medical school. It fits within their statutory mission, they have the real estate, they have the expertise, they have the reputation, and they have resources. Think Service Academies.
5. Insist VA engage in public-private partnerships with community hospitals across the country by renting wings of existing hospitals.

That said—the first thing that needs to happen is that VA needs to start being treated equitably by congressional leaders and the media. The American Legion calls on Congress and the American people to treat VA with fair and balanced criticism as well as praise. Stop taking cheap shots at our healthcare system. It's hurting veterans, it's hurting morale, and it's killing VA's recruiting efforts. If anyone thinks that killing VA will save taxpayer dollars, they are either woefully misinformed, delusional, or lying. Cost shifting to veterans has already begun, and proposals that will require veterans to pay for care to treat service-connected disabilities are already being discussed. This is immoral and unacceptable.

VA can be more competitive if allowed to be, and the only outcry you will hear will be coming from the private hospitals in the country who will accuse the government of unfair competition. Medical care provided organically at VA is the best investment and greatest assurance the United States of America has to give our veteran community guaranteed healthcare sustainability, continuity of care, and ensure that our veterans continue to receive, the best care anywhere.

⁷ NPR—May 17, 2016

The American Legion thanks this Committee for the opportunity to explain the position of the more than 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Jeff Steele at The American Legion's Legislative Division at (202) 861-2700 or jsteele@legion.org.

Chairman ISAKSON. Thank you, Mr. Steele.
Mr. Atizado?

**STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL
LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS**

Mr. ATIZADO. Thank you, Chairman Isakson, Ranking Member Tester, Senator Sanders, and distinguished Members of the Committee. First, I want to thank you for inviting DAV to testify at this critical hearing about Veterans Choice Program and the future of community care for veterans.

Today's hearing is critically important to the 1.3 million members of the Disabled American Veterans. Our members, sir, rely quite heavily on the VA.

In response to the 2014 access crisis, DAV supported the intent of the temporary Choice Program, but it has never really quite fully met congressional intent nor veterans' expectation.

While referrals of veterans to Choice providers continue to increase, we continue to receive complaints from veterans in Choice providers, and I see Members on this Committee as well have heard those complaints. The underlying law has been amended twice, the original contract modified over 70 times, and over 20 letters of corrections have been issued.

It is clear to DAV, the temporary Choice Program is not the long-term strategic solution. It fails to address the disconnect and the alignment of demand, resources, and authorities that the VA has pointed out and the Care Commission—Commission on Care. Even the Commission on Care, charged by Congress to evaluate and make recommendations to reform VA, found that the design and execution of the Choice Program are flawed.

Now, in 2015, DAV and our independent budget partners developed a proposal called the Framework for Veterans Health Care Reform, based around four main pillars, and it is to serve as a guide, sir, a guide in developing the future of VA community care for veterans. That future requires a long-term solution, a comprehensive plan, if you will, to build an integrated high-performing network around a modernized VA health care system.

Now, because even the Choice Program in place and the plethora of authorities, albeit cumbersome as has been alluded to, that VA is using to purchase care in the community, the vast majority of veterans still choose to rely on VA, a system created to meet their unique needs, and this Committee, Congress, and the Administration must honor this clear and overwhelming preference.

To pay respect to the millions of veterans who choose VA year over year, our written testimony outlines some of the necessary improvements that Congress and VA must address to ensure the VA health care system itself becomes a high-performing integrated network. A central piece of a high-performing health system is its ability to empower its patients, to make important decisions to protect their health and their quality-of-life. DAV calls on Congress and the VA to focus on that goal of ensuring a veteran and their doctor,

not some bean counter or some bureaucrat, chooses when a veteran should receive care in the community. That VA clinician, that clinician must help veterans identify, not dictate, their most appropriate and effective care.

To this end, we are supportive of VA's approach of moving away from using arbitrary wait times and geographic distances toward shared decisionmaking. This leverages the relationship between a veteran and their doctor. It uses business intelligence about clinical performance and quality of care. We believe this new focus is more likely to be sustainable, cost effective, and garner higher patient satisfaction.

In light of the high-performing network, community and Federal health care providers as partners must also meet certain standards to ensure veterans will have the best experience possible through timely, high-quality, and veteran-centric care.

As we move forward, it is critical that every legislative action to increase access to care must simultaneously include a commensurate increase in resources. As evidenced in the Choice Program, we are all witnessing today that increased care in the community also increases demand for care in the VA. DAV disagrees with the proposed budgetary approach to use both discretionary and mandatory funds to provide medical care to veterans, and we vehemently oppose any budgetary approach to cut veterans' earned compensation as a means to fund the Choice Program or any community care program. This cost must be borne by the Federal Government, not by disabled veterans who have already paid more than their fair share.

Mr. Chairman, building an integrated, high-performing network is a fundamental change culturally and operationally in how VA treats veterans today. It will take time and patience. The Commission on Care made clear that this is a significant undertaking that will take a decade or more to accomplish. You have DAV's commitment to work with this Committee and Congress, as we are doing with VA, on the next evolution for VA health care.

This concludes my statement. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE
DIRECTOR, DISABLED AMERICAN VETERANS

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, DISTINGUISHED MEMBERS OF THE COMMITTEE: Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing to examine the Department of Veterans Affairs (VA) Veterans Choice program and the future of care in the community.

As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Today's hearing is critically important to DAV as most of our members choose and rely heavily or entirely on VA health care.

In the VA health care system, too many veterans are experiencing uneven and delayed access to quality veteran-centered care because of a "disconnect in the alignment of demand, resources and authorities" for VA health care.¹ Even before the Veterans Choice program was established as authorized by the Veterans Access,

¹Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare (operated by MITRE Corporation). "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume I: Integrated Report." https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf

Choice, and Accountability Act of 2014 (Public Law 113–146), VA facilities had limitations on the services it could offer due to a variety of factors, including changing veteran demographics, aging facilities and the types of providers that could be recruited and retained at different regions of the country. VA’s legacy purchased care programs, such as fee basis, were generally used to address a VA facility’s limited availability of clinical services, the distance that veterans would have to travel to receive care at a VA facility, and the amount of time veterans had to wait for an appointment.

Additionally, the manner in which VA historically referred veterans to community care was fragmented. VA did not track how long it took for veterans to be seen when referred to a community provider, the quality of care they received in the community, how it impacted veterans’ health outcomes, or veterans’ satisfaction. We frequently heard complaints that due to limited resources, VA providers were not allowed to send veterans to the community resulting in delayed access to needed care.

Yet these issues persisted. Born out of the waiting list scandals and access crisis that culminated in the spring of 2014, the Choice program was authorized and implemented but has never fully met Congress’ or veterans’ expectations.

Despite a difficult and complex national rollout mandated in just 90 days, VA quadrupled the number of Choice authorizations from fiscal year (FY) 2015 to FY 2016. Veterans received more than 2.5 million Choice program appointments, and VA is poised to provide even more care in the community in FY 2017.

We applaud Congress’ work with VA to enact Public Law 115–26, which extended the Choice program until all of the remaining choice funds have been spent and to ensure continuity for veterans who access care through this program. As this Committee is aware, DAV supported this law as a short-term and temporary measure to ensure that veterans using the Choice program do not fall through the cracks while waiting for realistic and meaningful reforms to be enacted and implemented.

DAV believes the current Choice program should continue to be used as a short-term solution, but only for as long as necessary to enact and implement a long-term solution based on a comprehensive plan to build an integrated, high performing network with a modernized VA health care system seamlessly working with other Federal and community providers.

As this Committee is aware, problems remain in the Choice program and we continue to receive complaints from veterans and community providers. The Commission on Care also found, “[t]he design and execution of the *Choice Program* are flawed.”² As such, DAV does not believe the Choice program should be expanded to new categories of veterans. Absent a high-performing integrated network, putting more veterans into the Choice program could result in less coordination of care, increased fragmentation of services, lower quality and ultimately worse health outcomes for more veterans. In addition, even a limited expansion of the current eligibility for the Choice program would add significant fiscal costs at a time when demand for VA health care is already rising faster than resources provided by Congress.

While the Choice program relieves some of the demand for VA medical care, it does not have the necessary elements to serve as a solid foundation for the future of community care. The underlying law has been fundamentally amended twice, the original contract has been modified over 70 times, 23 letters of correction have been issued to the contractors, and there are a number of pending and draft bills to amend the Choice program—yet necessary improvements to the overall VA health care system remain largely unaddressed.

Thus, if the Choice program ends without an effective, comprehensive replacement, there would be tremendous dislocation and hardship for hundreds of thousands of veterans who would find themselves unable to access timely care in an already overburdened VA health care system.

BEYOND THE CHOICE PROGRAM

Over the past year, DAV, along with our partners in the *Independent Budget (IB)* (Paralyzed Veterans of America and Veterans of Foreign Wars), other major veterans service organizations (VSOs), VA Secretary Shulkin, the Commission on Care and many Members of the House and Senate, have discussed, debated and ultimately coalesced around a common long-term vision for reforming the veterans health care system. All support the concept of developing an integrated network that combines the strength of the VA health care system with the best of community care to offer seamless access for enrolled veterans.

² Commission on Care. “Final Report” June 30, 2016. <https://commissiononcare.sites.usa.gov/>

Yet there is a continued push by some for unfettered and unlimited choice. In our opinion, such pursuit of this unrealistic and narrow goal to expand access to care without a plan for containing costs and ensuring quality is unwise and unsustainable. Access to care without a focus on quality should not be the objective, nor should reducing cost at the expense of quality be acceptable. The pyrrhic goal of unfettered and unlimited choice also carries with it the potential to delay and distort realistic plans to move forward with implementing the shared vision of the veterans community and most active users of the VA health care system. We must not let this generational opportunity to reform VA health care to be encumbered by lack of a clear strategy toward an overarching goal to build an integrated, high performing network with a modernized VA health care system seamlessly working with other Federal and community providers.

Veterans should not have to wait any longer to move forward with true and meaningful reform that keeps VA as the coordinator and primary provider of care. Even with the additional options of the Choice program, veterans in general overwhelmingly prefer to use VA.³ DAV strongly urges this Committee, Congress, and the Administration to honor the clear preference of the vast majority of veterans who choose to use the VA health care system—a system created to meet their unique needs.

In 2015, DAV and our *IB* partners developed our proposed Framework for Veterans Health Care Reform based around four main pillars. First, we proposed restructuring the veterans health care delivery system by creating local integrated veteran-centric networks to ensure that all enrollees have timely access to high quality medical care. VA would remain the coordinator and primary provider for most veterans. We also called for establishing a veteran-managed community care program to ensure that veterans living in rural and remote areas have a realistic option to receive veteran-centric, coordinated care wherever they may live. This would require local communities to work with VA's Office of Rural Care to develop relationships with local providers, as well as increased flexibility in reimbursement rates to attract and retain community partners.

Our second pillar for reform called for redesigning the systems and procedures that facilitate access to health care by creating a new urgent care benefit and taking other actions to expand access to care, such as extended hours in evenings and on weekends, as well as increased use of telehealth. We recommended that as the new integrated networks are fully phased in, decisions about providing veterans access to community network providers should be based on clinical determinations and veteran preferences, rather than arbitrary time or distance standards that exist in the current Choice program.

Third, we proposed realigning the provision and allocation of VA's resources to better reflect its mission by making structural changes to the way Federal funds are appropriated, distributed and audited. Our plan calls for strengthening VA's budget and strategic planning process by establishing a Quadrennial Veterans Review, similar to the Quadrennial Defense Review currently used by the Department of Defense.

The fourth and final pillar of our framework called for reforming VA's culture with transparency and accountability. In this regard, we strongly support the *MyVA* initiative, which has already resulted in good progress in making system-wide changes putting veterans in the center of VA's planning and operations, so that their needs and preferences are paramount.

A HIGH PERFORMING HEALTH CARE SYSTEM

To address salient questions about how expanding access to and options for veterans health care will affect overall costs, it must be considered in terms of being cost effective while achieving the best outcomes and quality of life for veterans. Private sector providers and regional health organizations have been working more rapidly in recent years from volume and profitability of services toward providing holistic, patient-centered and coordinated care—the kind of care that VA strives to provide to all veteran patients. DAV believes that to provide holistic, veteran-centric and coordinated care while increasing access in a cost-effective manner, VA must remain the coordinator and primary provider of care in a high performing network, with Federal and community partners providing additional expertise and access whenever and wherever necessary.

³Of the over 1.2 million veterans who have received some community care in the Choice program, only about 5,000 veterans used the Choice program as their sole health care provider. United States. Cong. House. Committee on Veterans' Affairs. Hearings, Mar. 7, 2017. 115th Cong. 1st sess. Washington: GPO, 2017.

Coordination of care between VA and community providers is critical because studies have continually shown that lack of coordination increases the risk of unfavorable health outcomes for veterans. For example, a lack of care coordination may lead to unnecessary duplication of services, which is not only costly, but may also pose health risks to veterans who may receive and pay for care that is not needed. Moreover, the quality of care may be adversely affected if important clinical information is not promptly and clearly communicated between VA, Federal and community providers.

In order to serve veterans effectively in a seamless integrated network as the coordinator and primary provider of care, VA itself must first be modernized and strengthened to address known gaps and deficiencies. Congress must therefore act to resolve a number of known legislative, policy and budgetary matters, including:

- Consolidating the plethora of statutory authorities and at least nine distinct programs with different administrative and clinical processes to purchase community care for veterans;⁴
- The widening salary gap between private sector and VA to allow the Department to hire and pay the best and brightest;
- Improving VA's infrastructure to align with veterans' needs—beginning with VA leases, which have not been authorized since 2012;
- Gaps in VA's medical care benefits package such as access to urgent care in the community, and differing eligibility for dental care and vision care;⁵
- The inadequate clinical grievance and appeals process available to veterans when there is a difference of opinion between the patient and provider;
- A permanent Provider Agreement authority for VA to purchase such things as in-home and community care for the most severely ill and injured veterans;
- Authority that would allow veterans greater access to telemedicine;
- Modernize its IT system—beginning with a new less cumbersome scheduling system, which allows veterans to self-schedule, allows meaningful health information sharing, simpler authorization and referral, and improved community provider payment systems.

A central piece of a high-performing health system is its ability to empower its patients to make important decisions to protect their health and quality of life. One of the most common sources of patient dissatisfaction is not feeling properly informed about, and involved in, their treatment or in the developing their treatment plan. Shared decisionmaking—where patients are involved as active partners with the clinician in treatment decisions, to clarify acceptable medical options and choose appropriate treatments. While not all patients want to play an active role in choosing a treatment, most want clinicians to inform them and take their preferences into account.

DAV calls on Congress and the VA to focus on the goal of ensuring a veteran and their doctor—not government bureaucrats—choose when a veteran should receive care in the community. VA must use evidence-based patient decision aids and improve the communications skills of all their health care providers to assist veterans in making informed decisions about their care, improve their knowledge and understanding of different treatment options, and give veterans a more accurate perception of risk, to help veterans identify—not dictate—the most appropriate treatments.

We are supportive of VA's approach of moving away from using arbitrary wait times and geographic distances in determining when veterans should be given the option to receive care in the community. Through shared decisionmaking leveraging the relationship between a veteran and their doctor, and using business intelligence about clinical performance and quality of care, this new focus will strike a better balance in using community care to fill gaps in service than unfettered choice. This approach is more likely to be sustainable, a hallmark of good governance and garner higher patient satisfaction.

However, this new approach, much like building an integrated, high performing network with community providers, is a fundamental change culturally and oper-

⁴ 38 U.S.C. §§ 1701 note (Veterans Choice Program), 1703 (Contract Care in the Community), 1703 note (Project Access Received Closer to Home), 1720 (Community Nursing Home Care), 1720C (Home and Community Based Care), 1725 (Emergency Care for Nonservice-connected Conditions), 1728 (Emergency Care for Certain Veterans with Service-Connected Conditions), 1741 (State Nursing Home Care), 1745 (State Nursing Home Medication) 8111 (Health Resource Sharing of VA and Department of Defense), 8153 (Enhanced Sharing Authority, Patient-Centered Community Care), and 25 U.S.C. § 1645 (Indian Health Service/Tribal Health Program)

⁵ VA provides audiology and eye care services (including preventive services and routine vision testing) for all enrolled veterans, but eyeglasses and hearing aids are provided only to veterans meeting certain criteria (See 38 U.S.C. § 1707). Eligibility for VA dental care is limited by law and differs significantly from eligibility for medical care (See 38 U.S.C. § 1712).

ationally in how VA provides care to our Nation’s veterans. It will take time and patience and will require collaborative work between Congress, VA, and VSOs.

COMMUNITY PARTNERS

VA continues to be challenged in fostering its relationship with community providers. Previous studies by the Government Accountability Office—including its most recent June 2015 report—demonstrate that its claims processing remains largely reliant on staff rather than leveraging IT solutions, resulting in frequent inappropriate actions such as non-payment, delayed payment or incorrect payment amounts. VA must act now to become a trusted and collaborative partner with community providers in order to rebuild lost or damaged relationships, enhance good relationships, and foster new ones.

The Commission on Care also pointed out that community partners must undergo a thorough credentialing process to ensure that all providers have, “...appropriate education, training, and experience, provide veteran access that meets [Veterans Health Administration (VHA)] standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.” That is why the Commission on Care recommended that “[n]etworks be built out in a well-planned, phased approach...”

DAV calls on Congress and the new Administration to begin taking actions necessary for the next evolution of veterans health care to begin. VA health care must become an integrated, high-performing system first before it can serve as the foundation for a larger integrated network with other Federal and community providers, one in which all enrolled veterans will have the best experience possible through timely access to comprehensive, high-quality and veteran-focused care.

RESOURCES

As Congress and VA move forward, it is critical that every legislative action to increase access to care must simultaneously include a commensurate increase in resources. As evidenced in the Choice program, VA saw both increased access to care in the community and increased demand for care in VA, putting a strain on VA’s budget.

Last year, then-VA Secretary McDonald indicated the cost implication of increasing demand on VA stating, “[J]ust a one percent increase in Veteran reliance on VA health care will increase costs by \$1.4 billion.”⁶ This year’s budget request for VA notes the impact of the Choice Act with an increase of 1.89 percent in reliance on VA versus their other health care options,⁷ a roughly a \$2.65 billion increase in needed resources.

Moreover, DAV disagrees with the proposed budgetary approach to use both discretionary and mandatory funds to provide medical care to veterans. VA’s community care program must be allowed to compete with other VA medical care programs such as long-term care, mental health and gender-specific care for the same finite resources. Moreover, we vehemently oppose the reduction of veterans compensation as a means to fund the Choice program. Increases in veterans’ health care should be paid for by the Federal Government, not by disabled veterans.

DAV and out *IB* partners have consistently testified about VA’s inadequate resources to purchase community care, cumbersome and confusing purchase care authorities, inadequate IT systems for scheduling, financial and business processing, as well as insufficient resources and ineffective tools to address constrained and aging infrastructure that all hindered VA’s ability to meet veterans health care needs on a timely basis. Of these concerns, none has a more direct impact on a veteran’s ability to receive care in the community than limited funds provided to local VA facilities, which too often forced them to choose between meeting internal clinical needs or expanding access to community care.

When Congress authorized the creation of the Choice program, they also authorized an “independent assessment” of VA health care to study the causes of and offer solutions for the access problems, resulting in a report by the MITRE Corporation, the Rand Corporation, and others in September 2015. As previously noted, the independent assessment’s first finding was that there was a “disconnect in the alignment of demand, resources and authorities” for VA health care. Its first recommendation was that VA must “address the misalignment of demand with available re-

⁶United States. Cong. House. Committee on Veterans’ Affairs. Hearings, Feb. 10, 2017. 115th Cong. 1st sess. Washington: GPO, 2017.

⁷Department of Veterans Affairs Volume II Medical Programs and Information Technology Programs Congressional Submission FY 2018 Funding and FY 2019 Advance Appropriations, pages VHA-364, 366

sources both overall and locally.” In terms of access to care, it found that “increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years.”

The findings of this assessment confirmed what *IB* veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet its comprehensive mission of care for veterans. While there are many factors that contributed to the access crisis, when there are not enough doctors, nurses, and other clinical professionals or enough usable treatment space to meet the rising demand for care by enrolled veterans, the result will inevitably be rationing of care, waiting lists and access problems. Further proof that demand was greater than VA capacity can be seen in the fact that even as care in the community increased dramatically over the last two years, care inside VA health care facilities still continued to increase, and according to VA 16 percent of its primary care clinics are over capacity today.

If it is not already evident in this testimony, DAV and our *IB* partners have not suggested that simply increasing funding by itself—without making significant reforms in VA—will lead to better health outcomes for veterans over the next 20 years. However, history shows that no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true demand for services. With more and more veterans seeking VA care as it improves access, Congress will have to continue investing resources to allow VA to keep up with rising demand, or make difficult decisions to restrict enrollment or propose increased fees or copayments for veterans’ care.

MIND THE GAP

We are cognizant Choice funds are projected to run out by the end of this year or early next year, and that any legislation enacted by Congress—even if enacted before the end of this fiscal year—will require more than 90 days to implement as clearly evidenced by the recent experience with the Choice program roll-out. Moreover, existing VA community care authorities and programs are not sufficient to serve as a seamless bridge toward a long-term solution of a high performing integrated network combining VA with other Federal and community providers. To provide a short-term bridge, we believe VA needs to move forward expeditiously with its Request for Proposal (RFP) that was drafted and issued late last year. The RFP developed by VA in consultation and collaboration with a number of stakeholders, including DAV, would be a natural progression toward the future high performing integrated health care system we all envision.

While continuing to appropriately fulfill its oversight responsibilities, DAV urges Congress to support the Department’s efforts to move the RFP process forward so VA can enter into contracts with appropriate national providers before the end of this year to ensure veterans continuity of care so that no one falls through the gap.

REALISTIC EXPECTATIONS

Finally, we urge Congress to work with VA to set realistic expectations for the implementation of these much needed long-term reforms. Many of the supporting systems and technologies necessary to promote a truly seamless integrated network capable of delivering consistently high-quality, veteran-centric and timely care will need to be developed, optimized and customized for VA before full implementation of the new system. Also, while we support the goal of eliminating all access limitations on community care, including the current 40-mile and 30-day choice standards, these limitations can only be phased out as the integrated network becomes fully operational to avoid unintended negative fiscal and clinical outcomes.

The Commission on Care was charged to develop plans to strengthen the VA health care system over the next 20 years. In its report, the Commission makes clear that this is a significant undertaking that will likely take a decade or more to accomplish. The report states: “[t]he fruits of the transformation... will not be realized over the course of a single Congress or a single 4-year administration.” Considering the magnitude and importance of this transformation, it is not only imperative that Congress and VA have the patience and vision for the long haul, but that they begin moving forward now.

Mr. Chairman, after more than three years of spirited and passionate debate in Congress over the future of veterans health care, there is now remarkable consensus on how best to strengthen, reform and sustain the VA health care system. Veterans and their representative organizations, independent experts, VA leaders and many Members of Congress agree that the best veterans health care system would consist of integrated networks that combine the strength of VA with the best of community care to offer veterans real choices for quality and timely care. However, in order to

build a truly high-performing network, VA must first modernize its own infrastructure, IT and operations before it can begin to integrate with qualified and credentialed community partners.

We look forward to working with you to help fill in the details of such a plan for the next evolution of VA health care and we urge you and your colleagues in the 115th Congress to start implementing this shared vision so that ill and injured veterans can get the care they have earned and deserve, whenever and wherever they need it.

That concludes my testimony and I would be pleased to answer any questions that the Committee may have.

Chairman ISAKSON. Thank you for your testimony.
Mr. Fuentes.

**STATEMENT OF CARLOS FUENTES, DIRECTOR, NATIONAL
LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF
THE UNITED STATES**

Mr. FUENTES. Chairman Isakson, Ranking Member Tester, Members of the Committee, on behalf of the men and women of the VFW, I would like to thank you for the opportunity to present our views on VA community care.

In the past 3 years, the VFW has assisted more than 2,000 veterans who needed help obtaining VA health care and has heard directly from more than 20,000 veterans on their VA health care experiences. Through this work, the VFW has identified a number of issues, has proposed more than 15 common-sense recommendations to improve the Veterans Choice Program.

The VFW would like to thank this Committee for your leadership in addressing many of the issues that we have identified, such as making VA the primary payer for Choice Program care, removing restrictions when VA is able to share medical records, making clinical necessity an eligibility criteria, and recalculating how mileage is measured to account for how humans drive, not how birds fly.

The Choice Program has come a long way since it was first created, but it continues to face several challenges that must be addressed. The biggest concern that the VFW continues to hear from veterans is regarding the breakdown of communication between VA, the third-party administrators, doctors and veterans. This breakdown has a significant impact on the care veterans receive, and it often leads to veterans having to put the pieces together in order to receive the care they need.

For example, a veteran from Missoula, Montana, told us it took him 3 months, numerous phone calls, faxes, and emails to finally get the treatment he required. This issue has even led to veterans being sent to the wrong doctors because VA, the contractors, cannot figure out how to get them to the specialist who can provide the care they need.

VA has taken a number of steps to address this breakdown and a number of other issues the VFW has identified. It has worked with TriWest and Health Net to have contractors colocated with VA Community Care staff to address issues in person instead of requiring VA staff to spend hours on the Choice hotline to have their questions answered.

The VFW has received positive feedback from VA employees and veterans at colocated facilities. We urge VA to expand this best

practice and incorporate it in any future Community Care Program.

As the VFW has highlighted in our numerous Choice Program reports, which can be found at vfw.org/VAwatch, the eligibility criteria for the Choice Program must be reformed.

While the VFW agrees that using clinical need to determine when veterans must be referred to community care is the right approach, we do not believe Congress or VA should dictate how long veterans must wait before being referred to community care providers. Arbitrary thresholds such as 30 days or 40 miles do not reflect the health care landscape of our country.

When and where veterans must be seen is a clinical decision between a veteran and his or her doctor. Overall, Congress and VA must take the lessons learned and create a single, sustainable program.

The VFW also urges Congress to swiftly pass provider agreement legislation authorizing VA to enter into non-FAR-based agreements with private-sector doctors which would ensure veterans can quickly receive care that cannot be provided at VA or through its community care programs.

The VA health care system delivers high-quality care and has consistently outperformed the private sector in independent assessments. The VFW six health care surveys have also validated the veterans who use VA health care are satisfied with the care they receive.

Veterans deserve reduced wait times and shorter commutes to their medical appointments. This means turning to the private sector when needed, but community care is only part of the solution. Congress must make certain VA has the resources and authorities to quickly recruit and adequately compensate a high-performing workforce, properly train its employees, hold wrongdoers accountable—and thank you for your leadership in taking steps to accomplish that goal yesterday—update its aging infrastructure, which includes VA being able to quickly lease facilities without requiring an Act of Congress.

I would also like to mention that the VFW largely supports the proposal that VA has sent to Congress yesterday; however, we are concerned that it includes certain pilots, as Senator Murray identified earlier, that we are very concerned with and we oppose, and we would really, truly like the opportunity to discuss those. We oppose turning VA into an insurance pilot—an insurance program or turning VA into Amtrak, and we would really like to discuss those proposals moving forward.

This concludes my testimony, and thank you for the opportunity. [The prepared statement of Mr. Fuentes follows:]

PREPARED STATEMENT OF CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

CHAIRMAN ISAKSON, RANKING MEMBER TESTER AND MEMBERS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS, On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our views on the Choice Program and how to consolidate and improve the Department of Veterans Affairs' (VA) community care.

In the past three years, the VFW has assisted hundreds of veterans who have faced delays receiving care through the Choice Program, and has surveyed more than 8,000 veterans specifically on their experiences using VA community care.

Through this work, the VFW has identified a number of issues and has proposed more than 15 common sense recommendations on how to improve this important program. The VFW would like to thank the Committee for its leadership in addressing many of the issues the VFW has identified, such as making VA the primary payer for Choice Program care, removing restrictions on when VA is able to share medical records with Choice providers, making clinical necessity the trigger for community care, and recalculating how mileage is measured to account for how humans drive, not how birds fly.

The VFW must also commend VA and the third party administrators for their willingness to work with us to address issues veterans encounter when obtaining care through the Choice Program. VA has made more than 70 modifications to the Choice Program's contract to address many of the pitfalls that have plagued the program, such as allowing the contractors to conduct outbound calls when they have the proper authorization to begin the scheduling process.

However, the Choice Program continues to face several challenges that must be addressed. That is why the VFW is very concerned that the Administration has requested to make the Choice Program a permanent mandatory program. The VFW believes this program must be improved and consolidated with other VA community care programs, but we oppose making it a continuing it as a mandatory program. VA's medical care accounts are under discretionary spending and subject to sequestration budget caps. Having the Choice Program as the only VA health care program not subject to spending caps could lead to a gradual erosion of the VA health care system.

The biggest issue that the VFW hears from veterans who use the program is the breakdown of communication between VA, the third party administrators, Choice providers and veterans. This breakdown has a significant impact on the care veterans receive. The VFW has heard from too many veterans that they were sent to the wrong doctor because VA and the contractor could not figure out how to make certain the veteran sees the specialist that can provide the care the veteran needs. For example, veterans who need to receive the recently developed cure for Hepatitis C have been sent to hepatologists who cannot provide them the lifesaving medications they need.

The VFW has also heard from veterans that the breakdown in communication between VA, contractors and Choice providers often delays their care because their Choice doctors do not receive authorization to provide needed treatments. What is concerning is that veterans are left to piece together the entire story or else they do not receive the care they need; or they are left to pay for the care out of pocket because their Choice doctors performed treatments that are beyond the scope of the Choice authorization.

VA has taken a number of steps to address this breakdown in communication. It is in the process of implementing a new authorization management system to eliminate the confusion regarding which provider veterans need to see. It has also worked with TriWest Healthcare Alliance and Health Net, Inc. to have contractors co-located with VA community care staff at VA medical facilities to address and issues in approving secondary authorizations or ensuring veterans are sent to the right doctors. The VFW has received good feedback from VA employees and veterans at facilities with co-located VA and contract staff.

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

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

As the VFW has highlighted in our two Choice Program reports, which can be found on our VA health care watch website, www.vfw.org/vawatch, the eligibility criteria for the Choice Program must also be reformed. The VFW firmly believes that VA must reevaluate how it measures wait times. In the VFW's most recent VA

health care report, only 67 percent of veterans indicated they had obtained a VA appointment within 30 days, which is significantly less than the 93 percent VA reported in its most recent access report. This is because the way VA measures wait times is not aligned with the realities of scheduling a health care appointment.

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

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

A recent independent assessment on VA access standards by the Institute of Medicine (IOM) was unable to find a national standard for access similar to the Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. That is why Congress should not dictate eligibility for community care with arbitrary or federally regulated access standards, such as 30-days or 40-miles. When and where a veteran needs to be seen is a clinical decision made between a veteran and his or her doctor.

Several ideas have been proposed to replace the 30-day and 40-mile eligibility criteria for the Choice Program. Several Members of Congress have suggested that veterans should be free to choose between VA and community care providers whenever they want and every time they seek care. While this proposal may sound enticing, it is unsustainable because of cost and the VFW would vehemently oppose any proposal to pass that cost onto veterans. This choose your own adventure approach to health care also leads to veterans receiving fragmented health care that the Commission on Care determined leads to lower health care outcomes and endangers patient safety. Veterans deserve the highest quality health care possible, not fragmented care that fails to meet their health care needs.

Other proposals have focused on allowing a certain segment of the veteran population or veterans who are in certain circumstances to openly choose whether to receive care from VA or community care providers. The VFW believes what is important is that veterans receive the care that fits their clinical needs and care that accommodates their preferences. This is best achieved by empowering veterans to have a discussion with their care teams every time they need an appointment.

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

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

Overall, Congress and VA must take the lessons learned from the Choice Program and other community care programs such as Project ARCH, Project HERO, and PC3, to create a single, sustainable community care program. The VFW and our Independent Budget partners have proposed a veteran centric framework for how to integrate community care into the VA health care system, which can be found at www.vfw.org/vawatch. VA has outlined its vision for consolidating its community care programs in a report it was required to send Congress under Public Law 114–

41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. It is time for Congress to act to ensure VA is able to transform the way it provides community care.

In its consolidation report, VA requested authority to develop a nationwide system of urgent care at existing VA medical facilities, and to reimburse veterans for urgent care they receive from smaller urgent care clinics around the country to fill the gap between emergency care and traditional appointment-based outpatient care. Doing so would ensure veterans with acute medical conditions that require urgent attention, such as the flu, infections, or non-life threatening injuries, do not wait days or weeks for a primary care appointment. Establishing urgent care would also curb the reliance on emergency rooms for non-emergent care, which is more expensive for veterans and VA. The VFW urges Congress to consider and swiftly pass legislation authorizing VA to reimburse veterans for using community urgent care clinics.

The VFW also urges Congress to swiftly pass provider agreement legislation. Authorizing VA to enter into non-Federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not able to provide the care.

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

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

VA has made significant strides since the access crisis erupted in 2014 when whistleblowers across the country exposed how long veterans were waiting for the care they have earned and deserve. However, VA still has a lot of work to do to ensure all veterans have timely access to high quality and veteran-centric care. Veterans deserve reduced wait times and shorter commutes to their medical appointments. This means turning to community care when needed, but also means improving VA's ability to provide direct care.

The VFW thanks Congress for its commitment to improving VA's community care authorities and programs. VA also needs the resources and authorities to quickly recruit and properly compensate a high performing health care workforce, properly train its employees, hold wrongdoers accountable, and update its aging capital infrastructure. Community care must continue to supplement direct VA health care. This means VA and Congress must continue to invest in VA to ensure it remains a premier health care system.

Mr. Chairman, this concludes my testimony. I will happy to answer any questions you or the Committee members may have.

Chairman ISAKSON. Thank you for your testimony too.
Mr. Stultz?

STATEMENT OF GABRIEL STULTZ, LEGISLATIVE COUNSEL, PARALYZED VETERANS OF AMERICA

Mr. STULTZ. Chairman Isakson, Ranking Member Tester, and Members of the Committee, Paralyzed Veterans of America appreciates the opportunity to be here today to discuss the evolution of the Choice Program.

Our experience tells us that veterans prefer to receive their care from VA. We recognize, though, that VA cannot provide all types

of services at all times in all locations. Care delivered in the community must remain a viable solution.

As the Department continues the trend toward greater utilization of community care, Congress and the Administration must remain cognizant of the impact decisions will have on veterans who rely on VA the most.

Choice cannot be viewed as a solution to all VA's problems. For veterans with spinal cord injuries who rely on VA's specialized services, the community is not always an option. Many times, there are no comparable services within a reasonable distance, and where it is available, the choice is often still clear for our members: VA remains the best option.

Expanding care in the community has dominated the conversation over the last 2 years, but our members would be the first to tell you that this is only half the equation. VA's own services must improve side by side with the Community Care Program. The Secretary wants VA to become lean and competitive. He wants to modernize VA's IT and infrastructure. He wants to develop an integrated network that capitalizes on the vast Federal health care infrastructure, longstanding academic partnerships, and local providers to more effectively deliver care.

We have consistently supported these efforts. A high-performing network ensures the sustainability of VA, and by extension, quality, accountable health care for future veterans. More importantly, it ensures the viability of VA's crown jewels: specialized services.

Effective care coordination, convenient scheduling, and fluid exchange of health care records will not come without substantial investment. It also requires providing VA with the flexibility to deal with the legitimate obstacles like the aging infrastructure that it drags around like an expensive ball and chain.

The Secretary's monumental announcement Monday that VA will purchase a new electronic health care record system was decisive and should greatly increase the probability of success.

We also applaud his leadership in moving the Department away from the current 30-day, 40-mile eligibility standards in favor of a case-by-case clinical determination. Shifting the mindset of the Department away from arbitrary metrics to a focus on clinical outcomes is a worthwhile endeavor.

One serious concern that continues to be overlooked is that when veterans receive treatment at a VA medical center or from a VA doctor, they are covered in the event of medical malpractice, but this protection does not follow the veteran into the community. The veteran must pursue standard legal remedies instead of VA's non-adversarial process.

Adding insult to literal injury, veterans who prevail are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38. The disparity in outcomes and the different processes by which they are achieved are unacceptable. Ultimately, legislation designed to reform VA health care must incorporate the attributes that make its specialized services strong. External accreditation and comprehensive policies in VA's handbook govern the system. The outcome-based standards of care across the spinal cord injury system allows PVA to go into facilities and scrutinize the quality of care provided.

When individual facilities are lagging behind, the evidence is not just anecdotal. We need a plan to ensure care in the community is held to the same standards for veterans.

I will close by emphasizing that while much of the focus is key to addressing smooth integration of community care, access issues plaguing VA continue to be exacerbated by staffing shortages. The nurse shortage within the SCID system of care has reduced available beds and forced centers to limit the number of veterans they admit. The subsequent average daily census suggests there is a lack of demand in the system, when in reality veterans who want access are being turned away because those centers lack the staff to man available beds.

At our urging, the Secretary took a big step a few days ago and agreed to immediately implement the new staffing methodology we have been calling for. This is what PVA is looking forward to seeing as we go forward. It demonstrates an intent to not only increase access to the majority of veterans, but to strengthen VA's own capacity to care for veterans who exist in far fewer numbers but have the greatest and most complex needs.

PVA is here to see VA become successful in the long run. To get there, it needs to first modernize and develop a solid foundation, and we need to exercise a level of measured patience and support. We have to take the harder road here instead of gratifying ourselves with short-term successes.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you have.

[The prepared statement of Mr. Stultz follows:]

PREPARED STATEMENT OF GABRIEL STULTZ, LEGISLATIVE COUNSEL,
PARALYZED VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER TESTER, AND MEMBERS OF THE COMMITTEE, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to offer our views on consolidating and improving the Department of Veterans Affairs' (VA) delivery of community care. The impact that veterans health care reform will have on present and future generations of veterans cannot be overstated, and we are pleased to be part of this important discussion.

PVA's historical experience and extensive interaction with veterans around the country leads us to confidently conclude that veterans prefer to receive their care from VA. We recognize, however, that while VA remains the best and preferred option for most enrolled veterans, it cannot provide all types of services, in all locations, at all times. Care in the community must remain a viable option. But it also cannot be considered the failsafe for every situation. Few would give credence to the idea that the private health care system has excess capacity ready to absorb VA's excess patient load. More importantly, specialized services, such as spinal cord injury care, do not always have comparable services in the community. When access issues affect these systems of care, the veteran's "choice" is often simply to wait.

Specialized services are part of the core mission and responsibility of VA. As the Department continues the trend toward greater utilization of community care, Congress and the Administration must be cognizant of the impact those decisions will have on veterans who need the level of complex care that, more often than not, only VA can deliver. This includes VA's decision to continue concentrating all its energy on expanding the Choice Program without demonstrating how it plans to make its own services more competitive with the private sector—a key component of the proposed high-performing network. We stand behind any effort to improve health care for all veterans, which is why we support in principle what VA is trying to accomplish. But the plans we are seeing evolve fall woefully short of improving health care for the most vulnerable populations, such as those with spinal cord dysfunction and polytrauma. Sidelining these concerns while everyone focuses acutely on the next iteration of Choice is insulting and demoralizing to our members.

A few recent proposals warrant our attention at the outset. We do not, nor will we, support billing a veteran's third party health insurance for service-connected care received in a VA facility. This amounts to a wholesale abandonment of this country's responsibility to its wounded veterans. Using this tactic as a revenue generator would simply alleviate pressure on Congress to find the resources necessary to meet this sacred obligation. Congressional staff notified the Veteran Service Organization (VSO) community and attributed this proposal to VA officials.

This idea has since been retracted, but replaced with an equally disturbing funding offset—the elimination of Individual Unemployability (IU) benefits for veterans eligible to collect social security benefits. It is beyond comprehension that the Administration would propose such a benefit reduction in order to pay for a program that sometimes provides health care for non-service-connected veterans. Does this Committee really believe that veterans with disability ratings between sixty and ninety percent should be the source of funding for the Choice Program? Eliminating IU benefits for veterans over the age of 62 provokes numerous questions for us. Will veterans who have statutorily protected evaluations (the 20-year rule) also be subject to reduction? Will those dependents using Chapter 35 education benefits based on their sponsor's IU rating be forced to drop out of school? Will those veterans on IU who are covered by Service-Disabled Life Insurance (a.k.a. RH insurance) at no premium be forced to now pay premiums in order to keep coverage? What about state benefits, such as property tax exemptions or state education benefits that are based on 100% VA disability ratings? How will this proposal affect efforts to combat veteran suicide and homelessness? We hope this idea will be rejected in the strongest terms.

These off-the-cuff ideas only serve to reinforce our belief that VA's community care team should continue to engage with VSO's as it plans for the future. For over two years, trust has grown through strong engagement at the policy level. We encourage the Secretary to make further engagement a priority.

Any legislation designed to reform VA health care must incorporate or match the attributes that make VA's specialized services strong. For example, VA utilizes outcome-based standards of care across the spinal cord injury or disorder (SCI/D) system, which, in turn, allows us to measure and scrutinize the quality of care provided. The system is governed by comprehensive policies laid out in Veterans Health Administration (VHA) Directive 1176 and the corresponding handbook governing procedures. These authorities require VA to track the SCI/D population in a variety of ways, specifically capturing data on outcomes. When individual facilities are lagging behind, the evidence is not just anecdotal. VA's facilities are also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission. When the entire system is questioned, Congress can commission an independent assessment, similar to the one carried out as part of the original Choice legislation. VA officials can also be called to testify about the conditions of care in VHA facilities. Congress should examine more closely how VA will monitor the quality of care veterans are receiving in the community. This question goes beyond a plan for care coordination. If VA is unprepared to retain ownership of responsibility for care delivered in the private sector, Congress will be helpless in conducting adequate oversight.

Many advocates for greater access to care in the community also minimize, or ignore altogether, the impact that pushing more veterans into the community would have on the larger VA health care system, and by extension the specialized health services that rely upon the larger system. We cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. The SCI/D system of care and other specialized services in VA do not operate in a vacuum. If these services decline, then specialized care is also diminished. Veterans with catastrophic disabilities rely almost exclusively upon VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers. Making VA's own facilities lean and competitive must not be taken for granted; it must be a significant part of the conversation about expanding access to care in the community.

PVA, along with our Independent Budget (*IB*) partners, Disabled American Veterans (DAV) and Veterans of Foreign Wars (VFW), developed and previously presented to this Committee a framework for VA health care reform. It includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high-quality, veteran-centered health care system. Our framework stands on four pillars: 1) restructuring the veterans health care system; 2) redesigning the systems and procedures that facilitate access to health care; 3) realigning the provision and allocation of VA's resources to reflect the mission; and 4) reforming VA's culture with workforce innova-

tions and real accountability. With this perspective, we offer our views on consolidating and strengthening the delivery of care in the community.

I. RESTRUCTURING THE SYSTEM IN A WAY THAT ESTABLISHES INTEGRATED HEALTH CARE NETWORKS DESIGNED TO LEVERAGE THE CAPABILITIES AND STRENGTHS OF EXISTING LOCAL RESOURCES IN ORDER TO PROVIDE MORE EFFICIENT, HIGHER QUALITY AND BETTER COORDINATED CARE.

PVA strongly supports the concept of developing a high-performing network that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. This approach is gaining consensus among stakeholders, including the most recent and current VA Secretaries, the *IB*, most major VSO's, the Commission on Care, and congressional leadership. As stakeholders coalesce around this concept, though, the dynamics that govern the boundaries of this network need to be thoroughly explored.

PVA believes, like many stakeholders and Members of Congress have stated, that the definition of an integrated VA network is one that utilizes private providers to supplement, not supplant, the VA health care system. Unfettered choice of provider granted to all veterans is not a realistic or financially viable basis for a healthy VA health care system capable of sustaining critical, veteran-centric, specialized services. It is cost-prohibitive and, in many cases, leads to fractured care as veterans attempt to navigate the private health care system without managed care coordination. We believe that the design and development of VA's network must be locally driven using national guidance, and it must reflect the demographics and availability of resources within that area. VA has taken the first steps toward this goal by conducting test run analyses using three individual VHA facilities and their surrounding health care markets. A solicitation for information was also issued to help VA develop its acquisition strategy to procure this analysis nationwide on a continual basis. We look forward to seeing this process develop.

VA will be able to make greater strides, especially in rural areas, if given the ability to bring more community providers into the fold with flexible provider agreements. The current requirement that providers enter into agreements with VA governed by the Federal acquisition regulation (FAR) system has suffocated VA's attempts to expand access to care in a timely manner. Smaller health care provider organizations otherwise disposed to serve the veteran population are especially resistant to engaging in the laborious FAR process. And yet they remain vital to filling the gaps in health care services in certain areas.

The same flexibility should be applied to VA's ability to manage its capital infrastructure. The recent report issued by the U.S. Government Accountability Office (GAO) entitled "VA Real Property" highlights the variety of challenges VA faces in trying to keep up with the ever-evolving broader health care system.¹ Whether it is adjusting capacity to reflect migration patterns of aging veterans or dealing with underutilized facilities that cannot be demolished due to a historical designation, VA must be afforded the appropriate tools to respond to changes in its operating environment. It is unfortunate that the Secretary's comments related to "closing 1,100 facilities" were met with widespread panic instead of a realization of how hard it is for VA to dispose of underutilized infrastructure and reinvest the proceeds where the money is needed.

Care coordination is another piece that has a direct correlation with quality health care outcomes. This is one of VA's strengths, and it must continue to own the responsibility for care coordination for veterans. VA's proposed Plan to Consolidate Community Care Programs revolved around the patient's circumstances, specifically the intensity of coordination needed and whether the non-VA care was being provided based on a wait time or geographical distance.² In light of VA's push toward removing the 30-day/40-mile standards for determining eligibility for community care, this feature should be revisited to accommodate the next iteration of governing criteria. We will continue to support a policy that includes VA's direct involvement in care coordination for complex cases being handled by community care providers.

PVA has another serious concern that has consistently been overlooked in the expansion of community care access. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability or health

¹ U.S. Government Accountability Office. (April 2017). VA Real Property—VA Should Improve Its Efforts to Align Facilities with Veterans' Needs. (Publication No. GAO-17-349). Retrieved from <https://www.gao.gov/assets/690/683938.pdf> on May 6, 2017.

² Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, pp. 21-24, http://www.va.gov/opa/publications/va_community_care_report_11_03_2015.pdf.

problem is incurred. Under 38 U.S.C. § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility or as a result of care delivered by a VA provider. When PVA questioned VA as to whether these protections are conferred to veterans being treated in the community, VA officials confirmed in writing that this protection, as a matter of law, does not attach to a veteran receiving care in the community. If medical malpractice occurs during outsourced care, the veteran must pursue standard legal remedies instead of VA's non-adversarial process. Adding insult to literal injury, veterans who prevail in a private action are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. These include treating the resulting injuries as service-connected conditions, such as a botched spinal surgery resulting in paralysis where the veteran did not provide adequately-informed consent. It also includes access to adaptive housing and adaptive automobile equipment benefits should the veteran require these features. Furthermore, the limits on these monetary damages vary from state to state leading to disparate results for similarly-situated veterans. The disparity in outcomes and the different processes by which they are achieved are unacceptable. Congress must ensure that veterans are treated equally and that these protections follow the veteran into the community.

II. REDESIGNING THE SYSTEMS AND PROCEDURES THAT FACILITATE ACCESS TO CARE IN A WAY THAT PROVIDES INFORMED AND MEANINGFUL CHOICES.

PVA supports the Secretary's leadership in moving the Department away from the current 30-day/40-mile eligibility standards in favor of a case-by-case clinical determination. Access decisions dictated by arbitrary wait times and geographic distances have no comparable industry practices in the private sector. This change would shift the organizational mindset and focus of VA to clinical outcomes instead of catering to arbitrary metrics governing access to care in the community. We have consistently advocated for this proposition before Congress and the administration, stating that eligibility and access to care in the community should be a clinically-based decision made between a veteran and his or her doctor.

This approach requires us to confront the difficult question of how a decision is reached in the absence of arbitrary, but clear, delineations for eligibility. As the Commission on Care's report demonstrated, variations in how liberally access is granted to community care providers can have a drastic impact on cost.³ In the most expansive scenario, where VA maintains a loosely-managed network of providers and veterans have an unmitigated choice to receive care in the community, the Commission's economists found that the cost would be more than \$1.0 trillion over a decade.⁴ It is impossible to rationalize this outcome as sustainable or consistent with good governance.

An objective starting point is to allow veterans to go outside VA when a particular medical service is not provided in that facility. When VA does provide the needed service, though, the decision should be made by the doctor in consultation with the veteran. Providers should be able to sit down with a veteran and consider things such as access and availability of services and the urgency of that veteran's situation. The veteran should also have the opportunity to voice concerns over how a certain care plan will adversely or inadvertently impact him or her. Access to transportation, geographic distance and travel time can often present unreasonable obstacles to care for veterans. For example, a thirty-mile trip to a VA facility might seem reasonable on paper, but a doctor administering a treatment plan that requires the veteran to commute three times per week may have good grounds to object to that determination.

Providers should have the ability to help educate veterans and make decisions in the context of the patient's specific circumstances. They should be able to take action when it is clear that VA offers a needed service, but a particular veteran's situation requires a higher level of expertise than what that doctor or facility can offer. Arbitrary standards should not prevent a doctor from sending a veteran out to the community when the need is urgent and VA is not prepared to administer the care in a timely fashion.

Some veterans might have reservations about their provider, i.e. VA, having the final say in whether they are eligible to utilize the Choice Program, but it is a marked improvement over the current process where bean-counting bureaucrats make decisions behind closed doors for veterans who appear to be just another number in the queue. A more pointed concern is the past institutional bias exhibited by

³ Commission on Care, Final Report, June 30, 2016, Appendix A, p. 171–190.

⁴ Id.

VA employees for administering care directly in VA at all costs. VA has long had authority to contract for care, but in prior years employees demonstrated a reluctance to utilize this tool to the point that it eventually prevented timely access to care for many veterans. This behavior, though, was largely attributed to mid-level bureaucrats making decisions driven by how the funding was administered. The current funding arrangement under the Choice Program produced a welcome side-effect of removing the incentive to avoid contracting care out to the community. Over the last two years, VA's institutional behavior has been modified to a degree, and it has become more comfortable with contracting for care when the need exists.

Once the clinical parameters are determined, eligible veterans will have meaningful choices among the options developed within the high-performing network and the ability to schedule appointments that are most convenient for them. When you pair this decisionmaking process with a well-managed, integrated network and the structural flexibilities discussed above, it becomes possible for VA to be a competitive and sustainable enterprise. Of course, we must point out the obvious fact: none of this is possible unless we are able to get veterans out of the waiting rooms and in with the doctor to have this discussion.

PVA and our fellow IBVSO's also continue to advocate for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care. This is consistent with current health care trends, and greater utilization could provide a relief valve to VA emergency services, the Choice Program, and the system as a whole. VA previously proposed in its Plan to Consolidate Community Care Programs a more common sense determination of what constitutes reimbursable emergency and urgent care, thereby expanding access, but it came with the imposition of cost-sharing for otherwise exempt veterans. We strongly oppose co-payments for veterans who are currently exempt. Using co-payments as a means to discourage inappropriate use of emergency care by service-connected veterans is not an acceptable method of incentivizing behavior.

The Secretary was previously weighing the idea of allowing enrolled veterans to utilize urgent care in the community at the veteran's discretion. Instead of using co-payments to control costs, there would be a limit of two authorized urgent care visits per year. We supported this and encouraged the Secretary to explore the concept further. Unfortunately, the proposal has evolved to provide access to "community walk-in care clinics within the community care network." It remains unclear whether this is a departure from urgent care in favor of retail minute clinics, and whether it has also curtailed the number of eligible providers to those who are "within the community care network." Given the disparity in quality and scope of care provided between urgent care and retail minute clinics, we would encourage this Committee to seek further clarification from VA.

III. REALIGNING THE PROVISION AND ALLOCATION OF VA'S RESOURCES TO REFLECT THE MISSION.

We stated in the beginning of this testimony that VA cannot provide every type of service in every locality, nor should it. In the broader health care system, patients in some hospitals face greater risk of death and complications because the surgical team conducts too few procedures. The doctors, and the members of their team, are unable to maintain their skills. The same is true for VA. Some medical centers successfully continue to expand the services they offer. Others follow suit but fail to recognize their limitations or true demand levels, and it directly impacts the quality of care throughout the entire facility. Right-sizing facilities and developing a balanced network of community providers has a direct impact on risks and health care outcomes. VA should have the ability to aggressively deal with these failures. Before condemning an entire medical center or clinic, though, it should break down its analysis to the service line level and determine where it should make adjustments or cuts, as well as where it should be growing.

While much of the focus is keyed to addressing smooth integration of community care, we reiterate that the access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system. PVA is proud to have been an integral part of the efforts that led to reinstating the capacity reporting requirement for VA's specialized services during the last Congress. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of veterans' health care demand and utilization measured against VA's staffing, funding, and infrastructure. However, VA's capacity metrics fail to properly account for the true demand on its system. The metrics are based on deflated utilization numbers that have been suppressed through census caps and limited patient admission.

The nurse shortage within the SCI/D system of care has precluded these centers from fully utilizing available bed space and forced centers to reduce the amount of

veterans they admit. A decrease in the daily average census at some centers naturally follows, suggesting that there is a lack of demand in the system. In reality, veterans who want to access care are turned away because those centers lack the staff to man available beds.

A reduction in capacity to provide services is the immediate effect of staffing shortages. But second and third order effects follow and create a negative feedback loop that is detrimental to the entire SCI/D system of care. As staffing thins and those remaining behind attempt to cover more responsibility, individual patients receive less attention and staff burn out. It impacts morale and eventually erodes the overall quality of care. As this cycle takes hold, demand for care in these facilities shrinks. When VA calculates demand under these conditions, the new demand metrics have been artificially depressed and tend to justify reduced staff, further perpetuating the downward spiral.

By our estimates, VA needs an additional 1,000 SCI/D nurses. These estimates are not abstract; they are drawn from the regular, in-depth site audits our medical services staff conduct across the VHA system. At the SCI/D leadership meeting held in December 2016, nearly every chief and nurse executive answered in the affirmative when asked if empty beds would be filled if more nursing staff were hired. In May 2017, PVA leadership met with the heads of Nursing and SCI/D services. Both individuals stated that their own projections called for an additional 920 SCI/D nurses. The Secretary himself admitted the need and announced at our annual convention that VA would be hiring an additional 800 SCI/D nurses. Actions, though, speak louder than words.

The pathway to proper staffing begins with the revision and recertification of VHA Directive 2008–085, Spinal Cord Injury Center Staffing and Beds, which required updating in December 2013. Despite our constant advocacy, it remains antiquated. A modernized nurse staffing methodology is available. It was developed and field tested in order to address clinician understaffing at virtually every SCI/D facility. It factors in the increasing medical needs of an aging population and wait times for inpatient annual physical exams and extended care. If VA truly intends to strengthen its “foundational” services, this is where it needs to start. It should be part and parcel of building a new Choice framework, not an afterthought.

We note that VA ventured down this road unsuccessfully in the past. A GAO report in October 2014 revealed that VA utterly failed to address staffing shortages after years of trying to implement a nationally standardized methodology for determining an adequate and qualified nurse workforce.⁵ Specifically the report found a lack of oversight and a failure to ensure preparedness for implementing the staffing methodology, including the necessary technical support and resources. Simply put, PVA is not persuaded that these obstacles cannot be overcome. This Committee should not be either.

With the capacity reporting requirement reinstated, Congress now has the means to conduct effective oversight and ensure VA stays ahead of the curve in determining where shortages exist and what gaps must be filled. Congress should start immediately by determining how VA plans to abide by the newly reinstated reporting requirement. This Committee might also inquire as to why VHA Directive 1176, VHA Handbook 1176.01 and VHA Handbook 1176.02 all remain expired.⁶

Without strong Congressional oversight and the provision of adequate resources, history will repeat itself. These types of issues are not new, and the Independent Assessment’s report in September 2015 repeated findings similar to those in a report from a bipartisan Presidential task force back in 2003: there is a disconnect in alignment of demand, resources and authorities. Beyond simply providing more and more funds, though, PVA supports certain changes being requested by VA that would impact how those funds are spent.

One change would increase efficiency and accuracy in funding by allowing VA to record non-VA care obligations at the time of payment instead of when the care is authorized. The current practice requiring VA to project obligations at the time of authorization incentivizes over-obligation to avoid violating the Anti-Deficiency Act and ultimately results in forgoing funds previously provided by Congress—money which could otherwise be spent on medical care.

⁵ U.S. Government Accountability Office. (October 2014). VA Health Care—Actions Needed to Ensure Adequate and Qualified Nurse Staffing. (Publication No. GAO–15–61). Retrieved from www.gao.gov/assets/670/666538.pdf on March 2, 2017.

⁶ VHA Directive 1176, defining policy for the Spinal Cord Injury and Disorders System of Care, expired in October 2015; VHA Handbook 1176.01, defining procedures for the Spinal Cord Injury and Disorders System of Care, expired in February 2016; VHA Handbook 1176.02, defining procedures for Spinal Cord Injury and Disorders Extended Care Services, expired in June 2012.

The second change we support is giving VA the flexibility to allocate funds in a way that accommodates shifts in demand for health care services. While consolidation of community care programs might obviate the need to lift restrictions on using Choice Program funds to reimburse community providers operating under Patient-Centered Community Care (PC3), any consolidation effort should permit VA to develop internal capacity if utilization patterns demonstrate increasing demand for care in VA facilities.

With this in mind, we believe that Congress must also reject continued funding of the Choice program through a mandatory account and place it in line with all other community care funded through the discretionary Community Care account established previously. This will eliminate competing sources of funding for delivery of health care services in the community, while maintaining visibility on spending through the Choice program.

IV. REFORMING VA'S CULTURE WITH TRANSPARENCY AND ACCOUNTABILITY.

It is no secret that VA's administrative bureaucracy has ballooned in recent years. Arguably, resources devoted to expanding administrative staff have significantly jeopardized the clinical operations of VA. We believe serious consideration needs to be given to rightsizing the administrative functions of VA to free critical resources and dedicate them to building clinical capacity.

Additionally, VA has struggled with the notion of accountability. Too often, VA staff who should be terminated are "removed," but not in the way the ordinary citizen in the workforce would envision that action. VA has allowed too many VA employees who have compromised the public's trust to collect a full paycheck while under reassignment in a position that is neatly tucked away from public view, or to simply retire with full benefits, in some cases only to become VA contractors who make even more money with far less accountability. The public has grown tired of this happening. So have America's veterans. We implore Congress to provide the new VA secretary whatever authority he needs to prevent this from continuing.

PVA believes that substantial reform in health care can be achieved, and the time is ripe to accomplish this task. Our organization represents veterans with some of the most complex issues, and we cannot stress enough that moving forward should not be done at the expense of the most vulnerable among them. We must remain vigilant and appreciate the benefits of bringing together the variety of stakeholders who are participating and bringing different perspectives and viewpoints—it is a healthy development process that ensures veterans remain the focus. Thank you for the opportunity to present our views on these issues.

Chairman ISAKSON. Well, thanks to all of you for your input and your outstanding testimony, and we appreciate your compliments about the work of the Congress yesterday and the Senate by passing accountability, and hope to continue that record of achievement throughout this year.

Mr. Fuentes, have you seen the movie "Hidden Figures"?

Mr. FUENTES. I have.

Chairman ISAKSON. Have you seen it, Mr. Atizado?

Mr. ATIZADO. Yes, sir.

Chairman ISAKSON. Have you seen it, Mr. Steele?

Mr. STEELE. No, sir.

Chairman ISAKSON. I am going to buy you a ticket.

Have you seen it, Mr. Stultz?

Mr. STULTZ. No, sir.

Chairman ISAKSON. You will get a second ticket. You all can go together.

Mr. STULTZ. Sounds good. [Laughter.]

Chairman ISAKSON. I really enjoyed the testimony.

When Senator Murray started her testimony—and I am sorry she is not here now—questioned pilot projects as maybe being a stalking horse for privatization or taking stuff out of the VA, it made me think of the movie "Hidden Figures." "Hidden Figures" is a true story about three African American women who worked for the Redstone Rocket Program in Alabama in the 1960s on the per-

formance of the rocket that took John Glenn into outer space and brought him home again. They kept trying and trying and trying to get all the mathematicians, the white male mathematicians, to come up with the right formula to bring that Redstone safely to home, and they just could not do it.

These three African American women who worked in the same department but were segregated in their work were very good mathematicians, and one of the people in frustration—in fact, Kevin Costner, played the director of the project—said, “Why don’t we give them a chance to see if they can do it?”—another word for a pilot program.

In a few short weeks, those three women figured out the answer to how you get John Glenn from Cape Canaveral into space and back home safely again. It was through the assignment of a responsibility to a pilot group within the organization who had been victims of prejudice and fear of the past, not the opportunity of the future.

So, I just want to say this. When I read the testimony of Secretary Shulkin and the use of the word “pilot,” I did not see a boogeyman. I did not see a problem. I saw an opportunity.

We have an opportunity in this Choice bill to learn from the experiences we have had within the VA and learn from the experiences outside the VA to how we can better deliver health care to every veteran who is eligible for it in the ways of the 21st century, and the 21st century hospitals are doing it a lot differently than they were in the 20th century. VA is going to have to be the same way.

So, do not let the term “pilot project” be a ruse or a stalking horse for something that you fear. It is an opportunity to solve a problem that you want to get rid of, and I want us to be open minded enough as they were in Alabama in the early 1960s at the Redstone Rocket Factory to figure out and to look outside of the box, to get over their prejudice, and find a solution within their own midst through what was then, admittedly, a pilot project. I just wanted to make that observation.

The second observation I want to make, when I got elected, the Ranking Member originally was Richard Blumenthal, and he is a great American, but there’s none better than Jon Tester. Jon, I know how to bread and butter my bread, and I am going to bread it right now so he gets all the credit he can get. Jon Tester is great one. We have got a lot of challenges ahead of us that we have got to do.

But, the first problem I inherited was the problem of the hospital in Denver. If you remember, it had a cost overrun of \$800 million. It was a hospital that was supposed to cost \$600 million, and it was going to cost \$1.4 billion. It is now being finished at a significant overrun but not as big as it was going to be, and what happened is, when Richard and I took the reins, the first thing we did was get on an airplane, flew to Denver to look at the problem firsthand, and come back and ask ourselves rhetorically what can we do to get out of this—we got to finish it; it has started—and how can we deliver the best—have what we finish deliver the best services to our veterans.

I am proud to say the hospital, I think, is on its way to being completed with some pretty significant savings because we made some good decisions on what we did not let the VA do in the future and what the VA is now doing now. My only point for saying that is there is no problem too big that cannot be solved if people who are willing to solve it sit down together and work together to do it.

I am sure, because of what we did on the accountability bill, what we are going to do in terms of speeding up and getting rid of the problems that we have had in terms of appeals, I am sure we are going to be able to do the same thing on Choice. I pledge to all of you and the VSOs that Jon and I will be soldiers in your army to see to it that we do not fear pilot projects, but we learn the lessons of pilots to make the VA perform even better for you without being a threat to destroy your VA, but to make your VA better in the future.

I did not mean to make a speech, but I thought that was a pretty good example.

And if you want to go to the movie, Mr. Stultz, Mr. Steele, I will be glad to buy your ticket because it is a damn good movie; let me tell you.

Jon Tester—I am sorry—Bernie Sanders.

Senator SANDERS. Thanks, Mr. Chairman. You are right.

Chairman ISAKSON. Congratulations on your new book, by the way.

Senator SANDERS. Thank you. Not only will we get these guys tickets to the movie, we will get them copies of the book as well. You will pay for that—

Chairman ISAKSON. Right. [Laughter.]

Senator SANDERS. Let me kind of ask you. You see, I think, Mr. Chairman, I am a former mayor, and I believe in pilot projects. I am a former mayor. We did it. You learn a lot from them. Sometimes they work; sometimes they do not. But, at the end of the day, you have got to know what your goals are and what you want to achieve. You cannot do a pilot project without having a goal in mind.

I think what I think the veterans community fears very much, Mr. Chairman, is not unrealistic. We have seen over the last many years, efforts to privatize Social Security. We have seen efforts to voucherize Medicare. The President's budget calls for an \$800 billion cut in Medicaid. There have been efforts to privatize part or all of the U.S. Postal Service.

So, if these guys come before us and they say, "Hey, we are a little bit nervous about some efforts to privatize the VA, the largest, what is essentially a socialized health care system, government-run health care system," they are not paranoid about this. They have legitimate concerns.

But, let me start off by asking you a question that I always do at hearings. The bottom line here is that in a country which has massive health care problems—got 28 million people who have no health insurance. We have more people who are underinsured; we have people who cannot afford prescription drugs. Every day, hundreds of people are dying in private hospitals because of inadequate—mistakes being made, et cetera, et cetera.

Let me start with The American Legion, Mr. Steele, and go down the line. For your members who walk into the VA—and I understand the problem of timeliness, getting people in when they need to be. It is something we all agree on, and we are all working on. We want people to get in when they should. Once they get in, how do they feel about the quality of care in the VA?

Mr. STEELE. I have spoken to many of our members, and almost uniformly, they speak highly of the VA care, and they love their VA. It is just that simple.

Mr. ATIZADO. I could not have said it any better than that, sir.

Senator SANDERS. Mr. Fuentes?

Mr. FUENTES. Senator, from our surveys, 75 percent of veterans who use VA health care system report being satisfied with that care. It is not absolutely perfect. There are ways to improve it, but overwhelmingly, veterans like the care that they receive.

Senator SANDERS. Mr. Stultz?

Mr. STULTZ. Senator, our members rely on VA more than any other population of veterans, and I think that is proof of how they feel.

Senator SANDERS. All right. I think, Mr. Chairman, what these guys have just said is enormously important. Look, no hospital in America does not have problems. Correct? Every day, there are problems. We know that. VA is the largest integrated health care system in the United States. They have got problems every single day, but it is very important to hear from people who use the facility to say that, by and large, when people get into the system, they enjoy it, and they feel that the system is working well for them.

Our job is to improve what already works reasonably well and not to dismember it, which is a fear that I think many service organizations have, and it is a fear that I share.

Second question. In Vermont, I talked to a lot of veterans who have serious oral health problems. All right. The VA covers service-connected oral health issues. If you get your teeth knocked out, VA does a pretty good job. But, if you do not have service-connected oral health problems and your teeth are rotting, VA does not provide services. Is that an area where you think VA could be expanding and that would meet the need of many veterans?

Mr. ATIZADO. Senator Sanders, thank you for raising that issue.

Our members have spoken on this issue quite clearly. We have a very specific resolution about dental care. I cannot speak to the history of why it is such a fragmented, cumbersome, administratively burdensome, and quite frankly, antithetical to VA's philosophy of holistic care, but that is what it is today. It needs to get fixed.

Mr. FUENTES. Dental care is an integral part of health care and must be treated as such within the VA health care system.

Importantly, I would want to point out that the proposal to cutoff IU at retirement age, one of the largest concerns that we have received from those veterans who are, frankly, scared that their benefits are going to be taken away, is that they are going to lose dental.

Senator SANDERS. OK. So, what I am hearing from you—I do not want to put words in your mouth—is that I agree with Mr. Fuentes that when we talk about health care, we talk about dental care. I

mean, dental care is part of health care. Am I hearing from you correctly that everything being equal, you would like to see dental care be expanded as a benefit within the VA? Is that a fair statement?

Mr. STULTZ. Senator, I would just chime in and say that we would have to look at it a little bit closer to see if that is where we want VA to start allocating resources.

I mean, we advocate that specialized services be taken care of with the highest priority, notwithstanding the importance of oral health care.

Senator SANDERS. All right. Your concern is that we take from Peter to pay Paul?

Mr. STULTZ. Essentially.

Senator SANDERS. Yes.

Mr. STULTZ. It always is, almost.

Senator SANDERS. All right. But, some of us believe that when people put their lives on the line to defend this country, it should not be just taking from Peter to pay Paul. That we can take care of Peter and Paul, and in this case, we can provide health care, general health care benefits to all of our veterans.

Thank you very much, Johnny.

Chairman ISAKSON. Thank you, Senator Sanders.

Senator TESTER.

Senator TESTER. Take it from Peter and Paul, give it to Peter and Paul from Sam. [Laughter.]

Look, I want to ask—first of all, thank you. I thank every one of you for your testimony today. I thought it was very insightful.

As we said when we had the joint hearings with the House Veterans' Affairs Committee, we should be taking our direction from you. So, I very much appreciate your testimony.

I want to quote Secretary Shulkin from the first panel. Jerry Moran had asked him a question. Senator Moran had asked him a question, and this was Secretary Shulkin's response. I want to know your opinion of the response, if you agree with it, disagree with it, and why, either way. I quote, "At some point in the future, if you design a system right, giving veterans complete choice, I believe in principle is the direction we should be headed in but not in 2017." What is your belief in that?

Mr. STEELE. Well, I can certainly see how that could be seen two different ways. I think the good-faith way would be he—Secretary Shulkin along with this Committee, Congress, and the VSOs need to modernize VA so that when veterans are presented with a choice, they will prefer VA. If the VA is set up to succeed like that, the Secretary succeeds, then there would be no problem with that.

To speak to Chairman Isakson's, we would not have to fear that because there would be no hidden agendas. It would just be the veteran preferring VA. That is it.

Senator TESTER. Anybody else like to comment?

Mr. FUENTES. The VFW is absolutely confident that Secretary Shulkin is committed to improving the VA health care system and its ability to provide direct care. If that is accomplished, if you have a strong, robust VA health care system—

Senator TESTER. Yes.

Mr. FUENTES [continuing]. That is not going to be a concern whatsoever.

Even now, about 50 percent of veterans who meet the 30-day or 40-mile criteria still prefer to go to VA. So, even now, you see that veterans are wanting to and continue to choose VA over the private sector. But, if you have a robust VA health care system, which I am sure is exactly what Secretary Shulkin wants to create, having this unfettered choice is not going to be a concern.

Senator TESTER. Mr. Stultz, would you like to comment?

Mr. STULTZ. Thank you, Senator.

My first thought goes to the fact that the Secretary wants to move toward a high-performing network that closely integrates with the community, and I think when we realize that goal—let us say the Commission on Care's estimate of 10 years to reach that point where we have got a solid network. By the time we realize that goal, I think veterans are going to have a meaningful choice: "I have private health care insurance, and I have VA insurance. I have meaningful choices, although I cannot just pick up and go to any doctor I want." I think that is where we reach the point where veterans are satisfied.

Senator TESTER. Good.

I talked about the budget a little bit with Secretary Shulkin, and I am sure you guys are aware that in the budget, 33 percent goes to community care, I think 1.3 percent to VA care. What would you want to tell the President right now through the Secretary about that budget as organizations, by the way, that represent a vast swath of veterans in this country?

Mr. ATIZADO. Thank you for that question, Senator Tester.

I think the first thing I would say to the President is, first and foremost, thank you for giving the VA the increase compared to the other agencies in the budget that did not fare very well. I think that sends a very strong message of this President's commitment to veterans and the Department of Veterans Affairs.

But, I would urge him to relook some proposals that we believe could be strengthened, whether it be this reduction in compensation to pay for community care or the bifurcation of the funding resources for community care, one being discretionary and one being mandatory. For those around the room who have been around for a while—can appreciate the finer points of the long-term impacts that this may have—and hope that those be reconsidered.

Senator TESTER. Anybody else like to comment? You do not have to if you do not want to. That is fine.

You are itching, Mr. Fuentes.

Mr. FUENTES. We have said to the President that we are very thankful for increased funding for VA health care and support his focus on mental health care, veterans suicide, homelessness, and a number of other issues. We do not support—and actually, we oppose—requiring veterans to pay for improvements.

Senator TESTER. OK. Last question, if I might. I want to go the same route as Rounds and Blumenthal.

Tell me what happens—any one of you or all of you, whatever you want—tell me what happens when a veteran receives care in a VA facility and something goes wrong.

Mr. STULTZ. I will take that one, Senator. Chapter 38, Section 1151 allows you to file a medical malpractice claim, like any other disability claim that you present to VA. With that comes a non-adversarial process, which obviously is a benefit in and of itself.

You not only are compensated for that injury, but it is treated as a service-connected injury, so you pull health care benefits related to that injury for the rest of your life as well as any disability compensation.

Senator TESTER. Do you have any idea about how often that happens in the course of time, where something goes wrong within the VA? Is it more often? Basically, I am looking to see if it is more often or less often than the private sector.

Mr. STULTZ. Actually, I cannot answer that. I am sorry.

Senator TESTER. I have got staff that will check that out.

Now can you tell me what happens when a veteran goes out in the community and something goes wrong?

Mr. STULTZ. They are left to—I will put it bluntly— fend for themselves like any other citizen. The result is that you have a disparity in process and results when you have similarly situated veterans, same injury, same procedure. One gets monetary damages, and that can be capped, depending on what State they are suing in, so—

Senator TESTER. Though you may not know the answer to this, because I do not know that we have been doing this long enough for an answer, but maybe we have. If something goes wrong, is it treated like a service-connected injury by the VA if it is done in the private sector?

Mr. STULTZ. No, it is not.

Senator TESTER. It is not.

Mr. STULTZ. We have specifically—we have analyzed the statute. We have looked at case law, and then we have presented VBA—not VHA, VBA makes those decisions, and they confirmed our—

Senator TESTER. Well, I just want to close by saying the first panel was very, very good, and I want to thank Dr. Shulkin because he is still here. I want to thank you for staying here, Dr. Shulkin, with your team. I think it is really, really important.

I really want to thank the VSOs. I did not serve. The Chairman has; I did not. So, I really depend upon you to tell us what your members are saying, which you have today. I appreciate that a lot.

I look forward to working with the Chairman and this entire Committee to developing a bill that makes the VA stronger and allows the VA to have limited amount of red tape, not only for you guys, but for the providers to be able to fill in the gaps. Hopefully, we will get there. With your help, we will.

Thank you all, and thank you, Mr. Chairman.

Chairman ISAKSON. Well, thank you, Senator Tester. I want to thank Secretary Shulkin again for his being here and staying through the testimony of the VSOs. That is a compliment to the VSOs, but it is a real tribute to the Secretary. We appreciate you doing it.

To the VSOs, thank you. I agree exactly with what Senator Tester said. Your information is of immense value to us in making the decisions we have to make. I may have served, but that has now been 40 years ago. So, I would much rather be knowing what is

going on today in the field than what was going on 40 years ago, so you are a blessing to me as well.

Thanks to all of you for being here today. Thanks to the men and women, who serve us, in harm's way.

Let us not forget yesterday was the 73rd anniversary of D-Day, which was the beginning of the great victory in Europe. We owe everything to our veterans, and most importantly, we know that.

Thank all of you very much, and this meeting is now adjourned. [Whereupon, at 4:41 p.m., the Committee was adjourned.]

[The posthearing responses follow:]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The program VA has described is a drastic change from the current program. The program described would not only get rid of the 30-day and 40-mile eligibility rules, but also includes adopting industry standards, providing access to urgent care clinics, and gives Veterans a choice if the VA medical center or clinic doesn't offer the service.

a. Under the current Choice Program, VA relies on a Third-Party Administrator—or TPA—to administer the program. What role would a TPA provide in the program described?

b. Specifically, what would the contractor's duties be and how would that differ from the current program?

Response. Under the new program, the role of the contractors would be to establish and maintain a network of qualified healthcare providers, as well as complete claims processing, provider payments, and data reporting for the care provided within the network. The contractors would use an industry-standard credentialing process for network healthcare providers.

Question 2. By moving toward a clinical needs, convenience, and quality of care model, it is clear the VA wants to build the Doctor-Patient relationship back in to the decisionmaking process.

a. How will VA ensure that consistent guidance is sent out to all VA providers?

Response. The VA Office of Community Care (OCC) uses, and will continue to use, regular conference calls and a SharePoint site to communicate guidance and information about procedures to the field leadership, including VHA Chiefs of Staff, and staff. This information includes but is not limited to clinical business processes, contractor performance, data analysis, financial updates, and network issues. This regular communication furthers education, promotes discussion, and provides an opportunity to resolve questions.

Additionally, to promote consistency, the Office of Clinical Integration actively collaborates and partners with all Clinical Program offices to incorporate their feedback into guidance regarding clinical business processes. VHA Chiefs of Staff will be asked to distribute the guidance and educate their providers. Also, providers will be required to document requests for community care in a standardized manner that includes their clinical rationale for requesting care in the community.

b. In the past VA has issued guidance to the field but never followed up on how it is implemented. How will you guarantee the proper oversight is conducted to ensure the guidance issued is implemented correctly?

Response. OCC has developed solutions that will enable it to better monitor utilization of tools and clinical business processes. This will include collection of data to evaluate the timeliness with which staff performs key steps in these processes. The Consult Tool Box and One Consult Model reporting tool assist with tracking and analyzing performance data from across the organization. OCC will work closely with the field to review results, adjust tools and other clinical business process as needed, and thus improve our service to our Veterans, VA and community providers and other VA staff.

Question 3. VA's testimony states if a VA facility doesn't offer the service then the Veteran (in consultation with the provider) would be offered community care. However, VA has a long history of looking to provide that service at another VA facility before sending a Veteran to the community.

a. Would the proposed change VA intends to make change this practice of first looking for another VA facility to provide the care?

Response. VHA continues to increase accessibility to medical care at all VHA facilities and VHA's practice of considering other VA facilities will continue when doing so is consistent with applicable eligibility criteria for community care.

b. If so, how would you ensure this is implemented at the facility level?

Response. Each VHA facility will review individual requests for medical care and make appropriate clinical determinations, based on each Veteran's medical condition and the nature of the care required, about the most appropriate way to furnish the care. The determination whether to furnish care within VA or in the community will take into consideration such factors as distance, the frequency of the needed procedure, and VA's ability to provide the care.

Question 4. In testimony provided by the Paralyzed Veterans of America (PVA) states, "A more pointed concern is the past institutional bias exhibited by VA employees for administering care directly in VA at all costs." He goes on to state that this behavior has been "modified to a degree" and VA employees have become more comfortable with using care in the community. What will VA do to ensure the cultural changes noted in PVA's testimony continue to make sure more VA employees embrace the use of care in the community?

Response. VHA continues to develop guidance and communicate with staff about the benefits of and need for community care. The principles underlying the new community care program would be quality, Veteran's preference, and access. VHA emphasizes these principles in communications to employees. These principles would also be incorporated into the referral system VA providers use to request community care. In addition, VHA will continue to foster positive relationships between VA providers and community providers; this will create open communication and promote a better understanding of the benefits of providing community care as part of an integrated healthcare system.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DAN SULLIVAN TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 5. Secretary Shulkin, you recently came out with a list of buildings the VA considered "vacant or underutilized" and it included a domiciliary in Anchorage, Alaska. I believe it was wrongly added because it's neither vacant nor underutilized, in fact this domiciliary is usually full, with 48-50 of 50 beds filled. If closed, it would devastate the local VA's ability to provide residential substance abuse treatment for Alaskan Veterans and there's not another facility available as an option. Are consultations made with the state VA prior to making these determinations, to ensure that the assessment is accurate?

Response. The Domiciliary at the Anchorage, AK VA campus, also identified as Building 3001, is in use to treat Veterans, and VA has no current plans to close or dispose of this building. VA maintains a list, updated annually, of buildings that have been identified as vacant or underutilized using square footage data from VA's Capital Asset Inventory database. Based on this data, Building 3001 has been identified as underutilized. Building 3001 was identified as underutilized based upon its utilization ratio. The utilization ratio is a mathematical calculation determined by evaluating the required square footage needed to deliver the functions divided by the actual size of the building. In Anchorage, the total Domiciliary program (including Building 3001) is 51,340 square feet, whereas the square footage needed to deliver the functions as determined by workload data would be 25,200 square feet, resulting in a utilization ratio of 49.08%. This utilization ratio is barely below the 50% utilization threshold VA uses to declare a building underutilized and therefore Building 3001 is included in the list of underutilized buildings. However, inclusion on this list does not indicate that VA has made plans to, or is considering, closing Building 3001. As stated above, VA currently has no plans to close or dispose of Building 3001. VA will continue to evaluate if additional efficiencies can be gained in the building to improve space utilization, either through reconfiguration of space or possible consolidation of additional functions into the space.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 6. The goal of the Choice program was to fill an immediate gap and give VA time to determine where best to buildup its capacity. As part of the Choice Act, \$5 billion was included for increased staffing and clinics. Currently, all but \$595 million of that \$5 billion has been expended, yet there are still some 45,000 vacancies remaining, with 36,000 of those representing "front-line" care, that is doctors

and nurses and other medical professionals. Clearly that \$5 billion has not been sufficient to deal with the problem. To what do you attribute to the difficulty in filling these vacancies? What steps is the VA taking in order to fill these vacancies? Given the number of vacancies at VHA, why does the Administration's budget direct billions outside the VA?

Response. The 30,000+ vacancies cited in QFR6 are actually continuous—that is, most of those original vacancies have long since been filled, while new ones have emerged. With 325,000 employees, VHA has one of the largest workforces in the Federal Government. For years, VHA has consistently averaged a turnover rate of approximately 9%, which corresponds to a vacancy rate of approximately 33,000 positions at any given point in time. VHA typically hires approximately 35,000–40,000 employees in a given fiscal year. As fast as VHA fills existing vacancies, new vacancies emerge through employee lifecycle events such as retirements, resignations, and transfers to other Federal agencies. (Based on analysis of BLS reports for comparable institutions in the private sector, VHA's 9% turnover rate is less than half that of what is observed in the private sector.) Even with the 9% loss each year, VHA continues to successfully hire for these vacancies. This success is evidenced by VHA's workforce having increased by an average of 3.5% employees and 3.6% FTE annually over the last five years. VHA continues to promote an aggressive National recruiting program; partnering with facility leadership; utilizing innovative marketing strategies, leveraging of Title 38 direct hire and pay setting options; and related actions at all levels.

Question 7. Of the \$5 billion authorized in the Choice Act for hiring healthcare professionals:

a. How many physicians have been hired by VHA?

Response. As of May 31, 2017, 1,692 physicians have been hired by VHA.

b. How many specialists focusing on Traumatic Brain Injury, spinal cord injury, amputee/prosthetics have been hired?

Response. As of May 31, 2017, 265 occupation and physician specialties related to Traumatic Brain Injury, spinal cord injury and amputee/prosthetics have been hired by VHA.

c. How many registered nurses and nurse practitioners have been hired?

Response. As of May 31, 2017, 2,912 registered nurses and nurse practitioners have been hired by VHA.

d. How many mental health professionals have been hired?

Response. As of June 2017, 1,908 mental health professionals were hired under the VACAA hiring initiative.

e. How many staff have been hired to treat survivors of sexual assault?

Response. Military sexual trauma (MST) is the term used by VA to refer to sexual assault or repeated, threatening sexual harassment experienced by a Servicemember during military service. MST is an experience, not a diagnosis or a condition in and of itself, and Veterans may react in a wide variety of ways. Because MST is associated with a range of mental health and physical health conditions, numerous types of providers and clinics throughout VA provide MST-related treatment. Therefore, when treating "survivors of sexual assault," VA is treating survivors that have a wide variety of health conditions that emerge as the result of the sexual assault (i.e. there is not "sexual assault treatment" per se). Additionally, most providers who deliver MST-related mental health care do so in the context of broader mental health programs (e.g. general mental health clinics, mood and anxiety disorder clinics, PTSD clinical team, etc.) where they treat both patients who have experienced MST and patients who have not; as such, MST-related mental health care represents only a portion of the total care they provide. Given these factors, it is not possible to provide a precise number of providers who have been hired (either in the past or newly) to provide care to survivors of MST.

However, VA does track care that is related to MST, and from fiscal year (FY) 2014 to FY 2016, there was an increase of 29% in the total number of MST-related mental health encounters provided to Veterans. There was also an increase of 14.2% in the number of unique providers providing MST-related mental health care during this same period (FY 2014 to FY16). It should be noted, however, that it is not known whether the increase in unique providers providing MST-related care is related to new hires or existing providers.

Question 8. Please provide a breakdown of the current vacancies by position at VHA which are considered "frontline care." Please provide an analysis of the vacancies in underserved areas.

Response. VA currently does not have an information system that can identify a specific number of vacancies per facility or occupation. Secretary Shulkin recently announced the establishment of a fully functioning Manpower Management Office

by December of this year, which will be a critical step in establishing a Position Management system. While the manpower management process will determine and fund personnel needs, VA's new human capital management system, HR-Smart, in conjunction with other new H.R. IT systems, will enable the ground-level implementation of structural changes and filling of positions. Last, the new Human Capital Operating Plan will track progress on strategies to onboard, train and retain a workforce matching VA's objectives.

- VA's Manpower Management Office is scheduled to be stood up by December 2017, and forthcoming manpower management policies will guide much of this work.

- HRSmart's Manager Self-Service functionality is scheduled to go live June 2018 and is planned to be fully implemented by January, 2019.

- The draft FY18–19 Human Capital Operating Plan is scheduled to be delivered to OPM by late September, 2017, and the final version delivered to OPM in February, 2018.

Question 9. The number of Veterans needing care is expected to continue rising over the next several years. I strongly agree that we need to find short term fixes to the problem of long wait times, but our long term goal must be to strengthen the VA healthcare system itself. Why are we not putting another \$5 billion into the VA to strengthen VA's healthcare delivery system, a promise made by the President on the campaign trail? Instead, the budget's emphasis is on directing resources outside the VA, something VSOs are have rightly raised concerns about. If we're increasing support for community care by around 30%, but increasing support for hiring and retention by under 2%, that doesn't seem to me to reflect a commitment to strengthen the VA healthcare system. How do you justify a budget that is clearly at odds with the promises made by the Administration to Veterans?

Response. In the FY 2018 budget, total resources for VA facility care are increasing by 7.1% from FY 2017 to FY 2018, while total resources for community care are increasing by 8.3%. Our budget request supports the Administration's priority of delivering high quality healthcare to our Nation's Veterans.

For FY 2018 and FY 2019, VA has five sources of funds for its Medical Care accounts:

1. Annual Congressional Appropriations (Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities) net of any Congressional rescissions and transfers to other appropriations
2. The Medical Care Collections Fund (Medical Services and Medical Community Care)
3. Mandatory Appropriations from the Veterans Access, Choice and Accountability Act (VACAA)
4. Unobligated balance carryover amounts from the previous year (all four Medical Care accounts)
5. Reimbursements from other agencies for services provided (Medical Services, Medical Support and Compliance and Medical Facilities).

Amounts from these five sources combine to create the total Obligation Authority for VA Medical Care in a specific fiscal year. The easiest way to compare year-to-year "Purchasing Power" in the VA Medical Care Budget is to look at the "Obligations by Object" tables. These tables compare estimated total obligations by fiscal year for the period reported in the President's Budget.

The following table is extracted from the detailed Obligations by Object tables in the FY 2018 President's Budget.

Obligations by Object

Dollars in Thousands

Description	FY 2017	FY 2018	FY 2019	Change		VA Medical Care
				FY 17-18	FY 18-19	Budget Volume Reference
Medical Services 1/.....	\$47,799,641	\$50,540,898	\$52,142,267	\$2,741,257	\$1,601,369	VHA-389
Medical Support & Compliance 1/.....	\$6,525,573	\$6,994,534	\$7,235,663	\$468,961	\$241,129	VHA-391
Medical Facilities 1/.....	\$5,438,770	\$6,503,705	\$5,894,165	\$1,064,935	(\$609,540)	VHA-393
Subtotal.....	\$59,763,984	\$64,039,137	\$65,272,095	\$4,275,153	\$1,232,958	
Medical Community Care 2/.....	\$11,677,418	\$12,642,854	\$12,870,245	\$965,436	\$227,391	VHA-395
Total Medical Care Obligations.....	\$71,441,402	\$76,681,991	\$78,142,340	\$5,240,589	\$1,460,349	VHA-395

1/ Includes VACAA Section 801 funds.

2/ Includes VACAA Section 802 funds and new Mandatory Choice funds.

The information above shows an increase of \$4.3 billion in VA care funding from FY 2017 to FY 2018 as opposed to an increase of \$965 million in Medical Community Care funding. As the “Personnel Compensation & Benefits, and FTE” table indicates, in FY 2018 over \$36.7 billion will be obligated supporting nearly 315,000 FTE of which 7,000 will be new hires. In FY 2019, \$38.4 billion will be obligated to support over 317,000 FTE of which nearly 3,000 are new hires.

Personnel Compensation & Benefits, and FTE

Dollars in Thousands

Description	2017	2018	2019	Change		VA Medical Care
	Estimate	Estimate	Estimate	FY 17-18	FY 18-19	Budget Volume Reference
Personnel Compensation & Benefits						
Medical Services 1/.....	\$27,899,884	\$29,609,614	\$31,044,968	\$1,709,730	\$1,435,354	VHA-388
Medical Support & Compliance 1/.....	\$4,993,414	\$5,210,037	\$5,396,419	\$216,623	\$186,382	VHA-390
Medical Facilities 1/.....	\$1,812,087	\$1,884,931	\$1,957,212	\$72,844	\$72,281	VHA-392
Total Personnel Services Obligations.....	\$34,705,385	\$36,704,582	\$38,398,599	\$1,999,197	\$1,694,017	

FTE

Medical Services 1/.....	230,838	236,540	238,956	5,702	2,416	VHA-31,36, & 41
Medical Support & Compliance 1/.....	52,222	53,099	53,352	877	253	VHA-31,36, & 41
Medical Facilities 1/.....	24,743	25,189	25,477	446	288	VHA-31,36, & 41
Total Personnel Services FTE.....	307,803	314,828	317,785	7,025	2,957	

1/ Includes VACAA Section 801 funds.

Question 10. Looking at the “Community Care Redesign,” it seems to me that it sends a message to people already working in the VA that their work is not really valued, thereby making hiring and retention even more difficult. As I’m sure you’re aware, it has been pretty consistently shown that, by almost every measure, VA healthcare is as good, or better, than care in the private sector. For just one recent example, in an extensive 2016 study examining the VA’s performance in healthcare procedures versus its private sector counterparts, the Rand Corporation found that

“in a tally of 83 different measures covering a variety of types of care, including safety and effectiveness of treatment, the quality of VA healthcare exceeded that of non-VA care.” How does the President’s budget seek to strengthen VA’s health delivery system, and empower the agency to expand the areas of care where it excels?

Response. VA is committed to providing high-quality care within VA and in the community and is driving performance excellence through continual comparison with the community on metrics that matter to the Veteran. In this sense, the Veteran is empowered with a choice for their healthcare and VA is motivated at all levels of the organization to ensure that we continue to exceed those expectations. It also serves as an accountability function- VA hospital directors are incentivized to focus on quality in particular service lines to remain consistent with regional performance averages.

With that as the accountability function, VHA is moving toward a new Quality Governance Model as a support function for facilities to improve if they are at or near quality thresholds for particular services. This model encourages improvement at the local VA healthcare facility unit level on quality, safety, access and satisfaction metrics most important to the Veteran. The clinical care team is empowered to make process changes to achieve better outcomes and patient satisfaction. The governance model promotes the opportunity to share experiences and practices across the organization, thus driving overall care to higher levels.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

CVS Minute Clinics Pilot—Dr. Shulkin, last year the Palo Alto VA began a pilot with CVS to provide care for Veterans at 14 CVS Minute Clinics in the San Francisco Bay Area and Sacramento and was recently expanded to Phoenix.

Question 11. Can you share with the Committee your thoughts on the pilot?

Response. The CVS Minute Clinic Pilot, which is also called the Convenient Care Referral program, is a very promising proof of concept initiative that is still being refined and evaluated for expansion to other locations in the new fiscal year.

Question 12. Would you consider expanding it to Hawaii? We have many CVS locations under the Longs Drugs brand across the state that would provide Hawaii Veterans a more convenient option for routine care?

Response. VA is evaluating the success of the current initiative, and if successful, VA would support expansion of this initiative.

NATIVE HAWAIIAN HEALTH CARE CENTERS

Recently, my staff coordinated a call with representatives from TriWest and the Native Hawaiian Health Care Centers on their experience with the Choice program. During the conversation, a few issues regarding outreach as well as reimbursement for specific services were brought up.

Question 13. One of the key provisions in the Choice Act I worked to get included was the inclusion of NHHCC as providers eligible for reimbursable services. However, utilization to date has been low for a variety of reasons including outreach. Dr. Shulkin, does the VA have ways in which they assist Choice providers around the country with outreach? If so, can I get a commitment that the VA will work with the NHHCCs to strengthen outreach initiatives?

Response. VHA’s Office of Community Care (OCC) and its contractors maintain public websites with information regarding provider eligibility to participate in the Choice Program and how to register as a Choice provider. OCC also engages with hospital and trade organizations to provide outreach to providers and healthcare systems regarding the Choice Program and community care as a whole. The contractors work closely with VA medical centers to provide outreach to local providers such as NHHCCs based on the needs of Veterans locally.

VA REIMBURSEMENT OF NATIVE HAWAIIAN MEDICINE

Regarding reimbursement under Choice, I understand from the NHHCCs that lomilomi, which is a massage technique and just one part of traditional Native Hawaiian Healthcare Centers have been seeking. I’m aware that reimbursement for such a specific service is contingent upon the proper authorization, claims submission, and appropriate coding.

Question 14. Dr. Shulkin, could I receive a commitment from you that the VA, along with TRiWest will continue working with the Native Healthcare Centers in developing a way so they may be reimbursed for the lomilomi service?

Response. Lomilomi is a form of massage therapy. It is not currently included in the VA medical benefits package and so is not available under the Choice Program. VHA has a process for determining whether a service should be included in the medical benefits package that takes into account recommendations from the field if they meet certain criteria.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOE MANCHIN III TO HON. DAVID J. SHULKIN, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 15. How, if at all, do you see the repeal of the Affordable Care Act affecting VA Healthcare? For example, do you expect to see an uptick in enrollment?

Response. Any impacts on Veterans or VA would depend on the specific legislative changes enacted by Congress.

Question 16. Will the new non-VA care system you proposed utilize third party administrators for scheduling? If not, do you believe you have the workforce and other resources to handle non-VA care referrals and scheduling?

Response. VA will take the lead for scheduling locally and it will be supported by the third-party administrators when VA issues the optional task for Appointment Scheduling and Comprehensive Care Coordination. The Community Care Network Request for Proposal includes an optional task for support from the third-party administrators for these functions if VA medical facilities require additional support for them.

Question 17. The VA plan for community care does not address Emergency Care. Why doesn't the plan address emergency care and can we expect a plan on this soon?

Response. VA has existing reimbursement authority for emergency treatment furnished by non-VA providers, 38 U.S.C. 1725 and 1728.

Question 18. In the new VA plan, you shift metrics from mileage and appointment time to services and quality of services offered. Can you further explain how you make sure every Veteran, regardless of where they live, will have access to the very best care—VA or non-VA?

Response. Under the proposed Veteran CARE program, eligibility for community care would be based on factors that include a Veteran's individual clinical need, determined in consultation with their provider, and VA's ability to timely provide the service. In addition, Veterans will be eligible to receive community care through an innovative program if local service lines are performing below community standards. This program will be initially conducted with a limited number of clinical services, and no VA medical center will have more than five service lines subject to this program. Finally, eligible Veterans would have access to community walk-in clinics for minor medical needs.

Question 19. In July 2016, the Department for Health and Human Services made a decision to remove the HCAHPS survey questions regarding pain management from the hospital payment scoring calculation. This was all in an effort to eliminate any perception that hospitals may not receive full Medicare payments because they did not prescribe opioid pain medications to patients. If you use HCAHPS scores to grade VA medical centers level of care, will you be using pain management questions in your calculation?

Response. VA does use the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) in tracking Veteran Experience at our hospitals, but the item on Pain Management is not currently used for scoring facility performance in our Strategic Analytics for Improvement and Learning (SAIL) report. The only item from HCAHPS that is scored in SAIL for FY 2017 is the Overall Rating of the Hospital, which is scored as the percent of Veterans who give the hospital a 9 or 10 on a 0 to 10 point scale.

POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO JEFF STEELE, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE DIVISION, THE AMERICAN LEGION

Question 1. You testified that the Choice Act effectively exposed VA's practice of managing to budget as opposed to managing to need. Can you speak more about this issue and provide examples?

Question 2. You indicated that the American Legion supports an open and more competitive VA. What recommendations would you make to achieve this goal?

[Responses were not received within the Committee's timeframe for publication.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO
ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN
VETERANS

Question 1. Mr. Atizado, you testified that timely and cost effective access to needed health care services is essential and that a lack of coordination of care between VA and community providers exists. Can you provide examples of how a lack of care coordination has critically impacted services and what actions are needed for improvement?

Response. Coordinated health care is care provided in a planned way that meets the needs and preferences of the patient. When care is well coordinated, the veteran patient, family, caregivers, and the clinical team communicate with each other so that everyone has the information they need, and they all know who is responsible for providing various aspects of the veteran's care.

Problems with scheduling care, sharing pertinent health information, and communication between the veteran patient, family caregiver and health care teams leads to fragmentation of medical care and duplication of services often resulting in higher costs, lower quality, and may threaten patient safety. There is higher risk of adverse consequences due to fragmented care for veteran patients in the VA health care system because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.

Veterans who receive all their care from VA can generally expect to receive well-coordinated care compared to the private sector, yet care is often highly fragmented among those combining care secured through private health plans, Medicare, TRICARE, and VA. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.¹

The most recent addition to VA's authority to purchase care in the community through the Veterans Choice Program has yielded numerous complaints from individual patients specifically regarding care coordination including: Scheduling, such as blind scheduling where an appointment is made without discussing with the veteran and their family caregiver if they are able to make the appointment; Inappropriate health information sharing, such as sharing information not pertinent to the care for which the veteran is being referred or too much information requiring the provider to spend unnecessary time to search for pertinent or meaningful medical information; Adequacy and sufficiency issues of the referral network, such as providers listed in the network when they are no longer part of the network or the only available network providers are not closer to the veteran than VA.

We believe the immediate solution to ensure proper care coordination is for VA to fully resume its role as the coordinator and primary provider of care. The long-term solution to ensure veterans care is properly coordinated is to reform VA medical care into a high-performing integrated health care system using other Federal and community providers to deliver care when necessary.

Question 2. You stated that DAV does not believe that the Choice Program should be expanded to new categories of veterans for clinical and fiscal reasons. Can you expand on that statement and offer some guidelines on potential collaborative efforts going forward?

Response. In addition to care coordination issues highlighted in our response to the previous question, our primary clinical concern related to the Choice Program is the quality of care veterans receive. Oversight of the quality of care the VA health care system directly provides to veterans includes many important perspectives such as the work by the Government Accountability Office, VA Office of Inspector General, Veterans Service Organizations and Congress. Yet there has been barely equivalent oversight of the quality of care veterans receive through the Choice Program.

Unlike the Choice Program, the VA is an integrated health care system. Integrated health care systems have several features that lead to the delivery of less expensive or higher quality care than non-integrated providers: Comprehensive medical records are accessible to all providers and in all care locations, providing better information on which to make clinical decisions and making it easier to avoid delivering duplicative or potentially conflicting services; Collaboration among doctors and coordination of care among locations should be easier for both doctors and patients when the care is all provided "under one roof," and; Doctors' performance can be measured (and correspondingly rewarded) using factors that contribute to the

¹"The Impact of the Affordable Care Act on VA's Dual Eligible Population." Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016; "Veterans and the Affordable Care Act," Journal of the American Medical Association, 307, no. 8, (2012): 789-790, accessed June 20, 2016

overall health and improvement of patients, such as timely provision of care and adherence to treatment guidelines.²

According to a 2016 RAND Corporation study reviewing published scientific literature examining the quality of care provided at VA compared to other facilities and systems found that the VA health care system generally performs better than or similar to other health care systems on providing safe and effective care to patients.³

We believe there may be an erroneous assumption that credentialed network clinicians are equivalent to cost-effective, quality care. While there is a higher likelihood that certified/licensed/credentialed clinicians provide cost-effective quality care, there has been no study indicating care received in the Choice Program is the same as or better than the veteran-centric evidenced based care VA provides.

Our primary fiscal concern is due to the amount of funds for both the Choice Program and for the VA health care system. Currently, VA projects funding available for the Choice Program will be extinguished by mid-August this year. In addition, this year's budget request for VA notes the impact of the Choice Act with an increase of 1.89 percent in reliance on VA versus their other health care options,⁴ a roughly a \$2.65 billion increase in needed resources.

Because there is no concrete long-term viable solution to ensure a smooth transition from the current state of VA community care to the future state of a high performing integrated VA health care system comprised of other Federal and community providers, even a limited expansion of the Choice program would add significant fiscal costs, at a time when both the amount of requirements placed on the VA health care system as well as the growing demand for VA care is greater than resources provided by Congress.

To serve as a guide in developing the future of VA Community Care for veterans, DAV and our Independent Budget partner organizations developed our proposed Framework for Veterans Health Care Reform.⁵ To care for millions of veterans who use and rely on VA for health care benefits and services, the Department must be empowered to implement realistic, long-term reforms by creating an integrated high performing system based on a modernized VA health care system. This will require Congress, VA, and Veteran Services Organizations to agree on the end goal of VA Community Care for veterans, and to work together to set realistic expectations to achieve them.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Question 1. Mr. Fuentes, you stated that the VFW hears from veterans regarding issues they would like to see addressed. One area described was the VA's wait time measurement. Can you provide some of the feedback received on the VA's current role in determining how long a veteran must wait before receiving care?

Response. The VFW's health care surveys have identified a misalignment between the amount of time veterans perceive they wait for care and the amount of time VA reports veterans have waited for their appointments. In a survey from October 2017, nearly 70 percent of veterans reported waiting less than 30 days for a VA appointment. However, VA data showed that 93 percent of appointments being scheduled within 30 days. The difference is between what veterans perceive their wait times to be and how VA measures wait times.

VA uses the preferred date metric to report wait time. While this metric has improved since the access crisis erupted in 2014, it still remained flawed and susceptible to data manipulation. VA records the number of days that laps between the day a veterans says he or she wants to be seen (preferred date) or when a doctor determines a veteran must be seen (clinically indicated date) and the date the veteran is seen. Thus, a veteran who calls to make an appointment on the first of the month who says he or she wants to be seen with seven days, but isn't seen until the 14th

²"Effects of Integrated Delivery System on Cost and Quality," American Journal of Managed Care, vol. 19, no. 5 (May 2013)

³"Comparing VA and Non-VA Quality of Care: A Systematic Review," Journal of General Internal Medicine, 2016.

⁴Department of Veterans Affairs Volume II Medical Programs and Information Technology Programs Congressional Submission FY 2018 Funding and FY 2019 Advance Appropriations, pages VHA-364, 366

⁵<https://www.dav.org/learn-more/news/2015/setting-a-new-framework-for-reforming-va-health-care/>

has a VA recorded wait time of seven days, instead of the 14 days that the veteran perceives he or she has waited.

What is important to VFW members is that they get the care they need when they need it. That is why we have advocated for the elimination of the 30 day wait time eligibility determination for the Choice Program and asked the Congress make Choice Program eligibility based on the needs and preferences of individual veterans in consultation with their care teams. VFW members have also asked the VA hire more doctors and expand internal capacity so they can have the option of receiving timely care at VA—their preferred option—rather than having to receive care through the Choice Program.

Question 2. You recommended that there be an objective starting point in allowing veterans to go outside the VA when particular medical service is not provided in that facility. What are some of the scenarios where these decisions should be made?

Response. The VFW firmly believes that when and where veterans receive care must be determined through a discussion between veterans and their health care team. Arbitrary eligibility metrics like 30 days and 40 miles do not accurately reflect the nature of seeking health care. In many instances 30 days may be too long, like a veterans who has chest pain and needs to get an MRI. For other veterans, waiting more than 30 days for a routine checkup may not be a concern.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO
GABRIEL J. STULTZ, LEGISLATIVE COUNSEL, PARALYZED VETERANS OF AMERICA

Question 1. You testified that PVA strongly supports the concept of developing a high-performing network that would seamlessly combine the capabilities of both public and private health care providers. Can you provide examples of this approach? And are there efforts underway to coalesce around the concept?

Response. Much of the health care delivered in the United States is facilitated through managed care networks and other payer models separate from the provider functions, the goal being to ensure that members within a plan have the full spectrum of care available to them. VA is unique in that it is both payer and provider, and it is one of the few public entities charged with providing direct health care services. For these reasons, and because of VA's mandate to provide direct care to veterans spread across the country, it is difficult to draw direct comparisons or find examples within the industry.

The evolution of the Choice Program itself demonstrates the concept to a degree if one considers the interaction between VA and the third-party administrators who employ a network of providers to facilitate access to care in the community where gaps in service exist. A critical distinction, however, is that the proposal to develop a high-performing integrated network contemplates a prospective process that analyzes both VA's capacity, its service priorities and local market resources to determine the network's makeup. The current process is more reactionary, with third-party administrators filling gaps as veterans unable to access care within VA are presented.

VA must employ a network comprised of both public and private resources in order to keep up and effectively navigate a complex and ever-changing health care environment. Stakeholders have generally coalesced around this concept at this point in time. Over the last two years, VA's community care team has incorporated the veteran service organizations (VSO) into its planning efforts, collecting valuable feedback and gaining trust from stakeholders. Throughout this process VA and the VSO community have demonstrated to Congress a desire to move VA in a direction that integrates aspects of the community to better align resources and fill gaps in service. Members of Congress have likewise indicated support for this concept, often reiterating that utilization of private providers should supplement, not supplant, the VA health care system. Our interaction with the community care team has waned slightly with the change in administration. We believe firmly that robust and frequent collaboration should be restored at the policy level to ensure that the network developed reflects the true priorities and mission of VA.

Question 2. You recommended that there be an objective starting point in allowing veterans to go outside the VA when a particular medical service is not provided in that facility. What are some of the scenarios where these decisions should be made?

Response. VA's latest planning iteration contemplates eligibility determinations based on three categories. The first is a clinical determination made on a case-by-case basis. The second is focused on the quality of care being delivered within VA, specifically at the service line level. The third category focuses on offering convenient options for certain low-intensity types of care, such as the administration of immunizations. My comments related to rendering veterans eligible when a particular

service is not available in their local facility fall under the first category—clinical determinations. If a veteran seeks care from his or her facility, and the care team determines that the particular service the veteran needs is not offered at that facility, VA cannot simply abrogate its duty to provide that service. VA must supplement its own resources by engaging with a private provider to serve that veteran. The scenarios, therefore, are limitless. If, for example, VA does not provide urology services, and the veteran has a urinary disorder, the veteran would be authorized to seek care in the community. VA's tentative proposal contemplates two other considerations under the clinical determination category: 1. access, which deems a veteran eligible if the service cannot be provided within a clinically-appropriate timeframe, and 2. feasibility, which considers the full picture of the veterans treatment needs and whether care within a VA facility is feasible and will lead to the best outcome for the veteran.

A P P E N D I X

PREPARED STATEMENT OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES



Statement

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On

Examining the Veterans Choice Program and the Future of Care in the Community

Presented to the

Committee on Veterans Affairs
United States Senate

By

Association of American Medical Colleges

June 7, 2017

Thank you for this opportunity to submit comments on behalf of the Association of American Medical Colleges (AAMC) regarding the Department of Veterans Affairs (VA) community care and VA's relationships with U.S. medical schools and teaching hospitals for the benefit of our nation's Veterans. The AAMC looks forward to working with Congress and the Administration to ensure that the long-standing and critical partnerships between VA and these academic affiliates are preserved and enhanced. We share the VA's commitment to caring for our nation's Veterans through our joint missions of patient care, research, and education to improve access and quality of care for Veterans, both inside and outside the VA system.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 VA medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The unique relationship between the VA and academic medicine dates to the end of World War II when the VA faced a severe shortage of physicians as nearly 16 million men and women returned from overseas, many with injuries and illnesses that would require health care for the rest of their lives. At the same time, many physicians were returning from the war without having completed residency training.

The solution was VA-academic affiliations established under VA Policy Memorandum No. 2, making the VA an integral part of residency training for the nation's physicians. In return, the VA improved access and quality of care for our nation's Veterans. What started as a simple idea in a time of great need has developed into an unprecedented private-public partnership. Today, the VA has over 500 academic affiliations, and 127 VA facilities have affiliation agreements for physician education training with 135 U.S. medical schools. The AAMC encourages Congress and the Administration to build upon this past success to improve access and quality of care for the military service members who have bravely served our country.

THE ROLE OF ACADEMIC AFFILIATES IN CARING FOR VETERANS

Many Veterans who use VA services face complex health care conditions, ranging from chronic diseases associated with aging, treatment and rehabilitation from polytrauma injuries and complications, and neuropsychiatric and behavioral disorders associated with traumatic brain injuries, post-traumatic stress (PTS), depression and the tragic risk of suicide. These conditions not only affect individual Veterans but they also impact their families and the communities in which they reside. It is heartbreaking to hear the stories of Veterans and their families who have suffered; who have not received responsive and timely care; and who appear to have been left behind as the nation continues to move forward. Our collective responsibility and moral obligation as a nation is to address these challenges directly and with empathic urgency.

U.S. medical schools and teaching hospitals are committed to mobilizing the resources necessary to partner with the VA to solve the 21st century problems of Veterans and their families. The

AAMC as the membership organization for academic medicine would like to offer recommendations to ensure that we effectively partner with the VA to ensure that our nation's Veterans have access to the highest quality care, and to hold forth the promise that the next generation of physicians and health professionals will have the necessary competencies to care for Veterans, and all patients, across the care continuum.

Access to Complex Clinical Care

Veterans require the entire spectrum of clinical care services: preventive services, primary care, and highly-specialized clinical treatment. The VA's ability to directly contract with academic affiliates allows for planning, staffing, and maintaining infrastructure for complex clinical care services that are scarcely available elsewhere. In this way, the AAMC supports the proposed VA Core Network that retains academic affiliates as an immediate extension of VA. Further, when well-functioning contractual relationships exist between these institutions, there are better outcomes for Veterans and more efficient and cost effective use of health care resources.

Medical Education and Training

The VA is an irreplaceable component of the U.S. medical education system. Each year, the VA helps train more than 20,000 individual medical students and more than 40,000 individual medical residents within its walls. As a system, the VA represents the largest training site for physicians, and funds approximately 10 percent of national graduate medical education (GME) costs annually. The GME relationship between the VA and academic affiliates does more than benefit learners and training programs. Under the supervision of faculty, many of whom have been jointly recruited by the medical school and the VA, residents and fellows provide substantial and invaluable direct patient care. The VA patient-learner dyad is also a cultural anchor for many young physicians who have never served in the nation's armed forces. Thus, their VA rotations expand their empathic understanding of what it means to "serve and sacrifice" for the nation. Without this GME partnership, care for Veterans inside and outside the VA system would be diminished.

Innovation from Veteran-Centric Research

The combination of education, research, and patient care that occurs because of the close relationship and proximity among VA medical centers (VAMCs) and academic medical centers (AMCs) cultivates a culture of research curiosity and innovation. Medical faculty must be skilled in the latest clinical innovations to train the next generation physicians that will care for Veterans. State-of-the-art technology and groundbreaking treatments jump quickly from the research bench to the bedside to the care delivery system. The VA's intramural research program serves as a recruitment tool and sponsors numerous projects in areas that specifically benefit Veterans and the unique challenges they face — research that might otherwise be neglected in the private sector. Ultimately, we all benefit from breakthroughs at the VA, which have led to the cardiac pacemaker, CAT scans, kidney and liver transplantation, the nicotine patch, and numerous prosthetic developments.

IMPROVING VETERANS' ACCESS TO CARE AT ACADEMIC AFFILIATES

The nation's major teaching hospitals — frequently with regional campuses and co-located near VAMCs — provide around-the-clock, onsite, and fully-staffed standby services for critically-ill and injured patients, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services. While on paper there may be appeal to increasing Veteran's access to civilian health care services through fee-basis mechanisms like the Veterans Choice Program, this also has the potential to dilute Veterans' access to the very best care available.

The rationale is quite simple. For highly specialized complex clinical care, for example cardiac by-pass surgery, we know that heart centers that do high volumes of cardiac by-pass procedures have better outcomes than those who have less volumes. AMCs around the country make tremendous investments in their cardiovascular service lines, including capital equipment, human capital investment and protocol management to ensure topflight care. Many regional VAMCs neither have the budgetary strength, patient volumes or human capital to invest in these types of services in order to have comparable outcomes observed in civilian programs. Like with commercial and managed care organizations who preferentially contract with AMCs to ensure that their beneficiaries receive top line care, these same principles should be encouraged and embraced by the VA.

The VA's 2015 Plan to Consolidate Community Care Improves the Current System

The Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41) required the VA to “develop a plan to consolidate all non-Department provider programs by establishing a new, single program to be known as the ‘Veterans Choice Program’ to furnish hospital care and medical services to Veterans enrolled in the system of patient enrollment established under section 1705(a) of title 38, United States Code, at non-Department facilities.”

As proposed in the VA's 2015 plan, the AAMC supports a tiered network of providers in order to improve Veterans access to care at academic affiliates. The proposed VA Core Network would include federal and academic partners, and would be treated as a direct extension of VA care. The External Network would include a Standard Tier as well as a Preferred Tier for providers that demonstrate quality and value.

Under the plan, AMCs would be able to continue contracting directly with the local VA Medical Center to provide clinical services. This contracting would be streamlined with national templates, but allow for local flexibility. Importantly, medical schools and teaching hospitals would also be eligible for fee-basis care under the new External Network that is reimbursed at Medicare rates with customized fee schedules for selected areas and scarce specialty services.

The VA would be responsible for case management and referrals instead of third party administrators. Additionally, VA would accept academic affiliates' credentialing, with a new VA oversight committee to audit compliance with credentialing standards. The VA also plans to streamline referrals and health information sharing by automating these processes. The plan also calls for greater monitoring of outcomes and quality metrics for non-VA providers. VA is expected to utilize existing metrics, such as those under the Centers for Medicare and Medicaid (CMS) Hospital Value-Based Purchasing (VBP) program.

Improving VA Sole-Source Contracting with Affiliates

As was stated earlier, today's AMCs are sites where quaternary and complex clinical care can be best delivered to Veterans who are in need of those services. Improving the contractual processes between AMCs and regional VAs or VISNs would greatly relieve the administrative burdens for all parties, and thereby enhance the coordination and continuity of care for Veterans who require complex care.

While it is important to have performance standards and data, they will only confirm what we already know: the process for long-term, high value sole-source affiliate contracts (SSACs) is arduous, resulting in short-term SSACs as a fallback. In other words, the problem is the process itself, not the oversight of the process. The most frequently identified barrier is the additional review of contracts greater than \$500,000 by the VA Office of Inspector General (OIG). To apply similar review to short-term contracts under \$500,000 would only create the same problems we've seen with long-term, high-value SSACs.

Short-term agreements are executed as services are about to expire and leave Veterans in a lurch. AAMC members frequently report that short-term contracts are used as placeholders for long-term, high-value contracts. Both VA medical centers and their affiliates would prefer long-term, high-value SSACs, but the process and OIG oversight prevents or significantly delays agreements. As such, the focus should be on improving the process of long-term, high-value SSACs, rather than imposing similar arduous oversight on short-term SSACs.

In addition to improving turnaround for SSAC development and approval, the contracting rules for the VA are not designed with clinical services in mind. The size of clinical services contracts varies greatly, but AAMC members report that virtually all 5-year contracts with the VA are between \$2 million and \$10 million, far exceeding the current \$500,000 threshold for additional review. As an example, the AAMC estimates that contracts for the following clinical services would surpass \$500,000 and trigger additional review:

- 10 uncomplicated cardiac surgeries
- 4 burn cases
- 5 intensive care unit cases
- 10 outpatient radiation cases
- 10 esophageal cancer surgery cases

The AAMC understands the need for federal oversight, but often the administrative bodies designed to review and enforce this oversight have a less than full understanding of the value in contracts with academic affiliates. This value is why VA Directive 1663 states, "Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the service contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete."

However, by VA's own estimation, once the decision to contract out care has been made, VA sole-source contracting with trusted academic affiliates takes longer than the formal competitive solicitation process — officially between 17-28 weeks compared to 14-18 weeks, respectively, according to VA Directive 1663. Sole-source contracts over \$500,000 go through an additional

10-11 weeks of review (23-25 weeks total) compared to contracts under \$500,000. Contracts over \$5 million require an additional 3 weeks (26-28 weeks total). AAMC members report additional delays of up to 18 months as a result of the VA OIG pre-award audit for sole-source contracts that exceed \$500,000.

As a result of approval delays, it is necessary to execute a series of extensions or short-term contracts to continue to be paid for services. This requires a great deal of time and effort on the part of both the VA and the academic affiliate. In some cases, payment is delayed as a result of this process. In the long term, it makes it difficult for departments to recruit faculty for the VA because there is no commitment for future funding.

Establishing Joint Ventures With Academic Affiliates

To better align the VA and the nation's medical schools and teaching hospitals, the AAMC supports the Enhanced Veterans Healthcare Act of 2017 (H.R. 2312). The VA and academic medicine have enjoyed over a 70-year history of affiliations to help care for those who have served this nation.

This shared mission can be strengthened through joint ventures in research, education, and patient care. Already our institutions and medical faculty collaborate in these areas, but often VA lacks the administrative mechanisms to cooperatively increase medical personnel, services, equipment, infrastructure, and research capacity.

Current authority for VA to coordinate health care resources with affiliates has been narrowly interpreted by VA Office of General Counsel and the OIG. VA can occupy and use non-VA space for limited purposes, but only under 6-month sharing agreements, 6-month revocable licenses, or 5-year leasing agreements — all of which have failed in practice.

AAMC Recommendations

1. VA Core Network with Affiliates: AAMC supports implementation of the VA's 2015 plan to consolidate community care and create a tiered network that facilitates provider participation, but importantly does not dictate how Veterans will use the network. For academic affiliates who do not yet participate in the VA Choice Program, the Core Network will enable VA to sustain and strengthen relationships with affiliates and allow Veterans access to the high quality, timely care these affiliates deliver.
2. Contracting Process Improvements: Sole-source contracting with trusted academic affiliates should not take longer than the competitive bid process. The AAMC recommends exempting sole-source contracting with academic affiliates from additional OIG review triggered by the \$500,000 threshold, or raising the trigger to at least \$2.5 million for 5-year contracts.
3. Pre-Approved Templates and Rates: As referenced in the VA's consolidation plan, the AAMC appreciates VA's willingness to develop pre-approved template contracts that reimburse certain services with at least Medicare rates. Additionally, we have discussed the development of standardized facilities and administrative rates to eliminate unnecessary negotiations and contract delays.
4. Joint Ventures with Academic Affiliates: The Enhanced Veterans Healthcare Act of 2017 (H.R.2312) would direct the VA to enter into agreements for health care resources (including space) with schools of medicine and dentistry, university health science centers, and teaching hospitals to deliver care to our Veterans to meet the growing demand for Veteran health care services.

CONCLUSION

Mr. Chairman and Members of the Committee, thank you for the opportunity to submit this statement on these important issues. The VA is at a crossroads. VA GME, research, joint ventures, and the proposed Core Network of the Veterans Choice Program can strengthen the 70-year history of VA-academic affiliations and prepare our country for the next chapter of VA health care. The AAMC and our member institutions will continue to work with the Congress and the VA to address the challenges and opportunities to ultimately improve care for Veterans and all Americans.

PREPARED STATEMENT OF DAVID STACY, GOVERNMENT AFFAIRS DIRECTOR,
HUMAN RIGHTS CAMPAIGN

Mr. Chairman and Members of the Committee:

My name is David Stacy, and I am the Government Affairs Director for the Human Rights Campaign, America's largest civil rights organization working to achieve lesbian, gay, bisexual, transgender, and queer (LGBTQ) equality. On behalf of our 1.5 million members and supporters nationwide, I appreciate the opportunity to submit this statement into the record. We commend the Committee for taking significant steps to ensure that veterans receive the quality, comprehensive health care they deserve. Unfortunately, the current Veterans Choice Program exempts eligible health care providers from complying with critical nondiscrimination policies and regulations designed to promote fair and equitable workplaces, including protections for LGBTQ workers. This exemption undermines the civil rights protections these policies enforce, and it undermines the creation of inclusive, culturally competent facilities.

In July 2014, President Obama signed an Executive Order amending Executive Order 11,246 issued by President Johnson, adding sexual orientation and gender identity to the list of characteristics protected from employment discrimination by federal contractors. The Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor is charged with enforcing this executive order and holding federal contractors accountable for compliance. Executive Order 11,246 prohibits companies that contract with the federal government from discriminating in employment based on sexual orientation and gender identity. Federal contractors employ more than 20 percent of the American workforce—28 million workers—and collect around \$500 billion in federal contracts every year. This Executive Order protects 11

million more American workers from discrimination based on sexual orientation and up to 14 million more workers based on gender identity.¹

Despite recent advances in equality, LGBTQ workers across the country still face discrimination on the job simply because of who they are. Currently, fewer than half of states offer explicit protections from discrimination on the basis of sexual orientation and gender identity. In the absence of uniform, nation-wide protections, many LGBTQ people who experience discrimination are left with little recourse. The OFCCP policies and regulations not only provide much needed protection for LGBTQ people working for federal contractors and subcontractors, they also set an important example of fair and effective personnel policies for private employers.

Unfortunately, the Veterans Choice Program exempts participating providers from being treated as a contractor by OFCCP.² This exemption allows for eligible providers engaging in federal contracting to avoid compliance with all civil rights policies and regulations enforced by OFCCP, including Executive Order 11,246. The implementing regulations for the executive order prescribe specific affirmative action obligations,³ data collection requirements,⁴ and posting standards designed to ensure that providers receiving federal funds are not engaging in unlawful discrimination.⁵

The exemption for eligible providers from complying with employment nondiscrimination rules applicable to federal contractors not only has a detrimental impact on the workforces affected, but sends a disturbing message that ensuring fair treatment for LGBTQ employees—as well as women, people of color, veterans, and people with disabilities—is unnecessary and inconsequential. It sets a precedent for future exemptions and represents a step backward for equal opportunity.

¹ See the Williams Institute, *Executive Order Will Protect 34 Million Federal Contractor Employees from Sexual Orientation and Gender Identity Discrimination*, (July 8, 2014), available at <https://williamsinstitute.law.ucla.edu/press/press-releases/18-july-2014/>.

² See Veterans Access, Choice, and Accountability Act, § 101(d)(3)(A).

³ 41 C.F.R. § 60-1.40 (2017).

⁴ *Id.* at § 60-1.12.

⁵ *Id.* at 60-1.42.

Any continuation or future version of the Veterans Choice Program must recognize and empower OFCCP's enforcement jurisdiction and applicability of related civil rights regulations and policies for participating providers.

I appreciate the opportunity to offer this testimony today.

