Pending Health Care Legislation

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Statement of
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For the Record

Committee on Veterans' Affairs
United States Senate

With Respect To

"Pending Health Care Legislation"

WASHINGTON, D.C.

Chairman Isakson, Ranking Member Tester and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary,

I would like to thank you for the opportunity to testify on today's pending legislation.

S. 115, Veterans Transplant Coverage Act

This legislation would authorize the Department of Veterans Affairs (VA) to provide live donor transplants to veterans eligible for VA health care regardless of the live donor's eligibility for care at VA. Currently, VA provides care to non-veterans who fall under one or

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more of the eight categories in which they are authorized to provide medical coverage. These categories range from survivors and dependents of certain veterans, newborn children of women veterans and in cases of humanitarian care.

By authorizing VA to perform medical care on non-veteran live donors in situations of medically necessary transplants for veterans, more veterans will be able to obtain lifesaving surgery in a timelier manner. The VFW strongly supports this legislation.

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

This legislation would build on the success of the Intermediate Care Technician (ICT) pilot program. Launched in December 2012, the ICT pilot program recruited transitioning veterans who served as medics or corpsmen in the military to work in VA emergency departments as intermediate care technicians. The ICT program offered transitioning medics and corpsmen, who have extensive combat medicine experience and training, the opportunity to provide clinical support for VA health care providers without requiring them to undergo additional academic preparation

This legislation would go a step further by affording transitioning medics and corpsmen the opportunity to become physician assistants. With the continued drawdown of military personnel, more medics and corpsmen will be leaving military service and transitioning into the civilian workforce. The VFW strongly supports efforts to leverage their medical knowledge and experience to meet the health care needs of our nation's veterans.

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

This legislation would extend, for one year, the requirement for VA to provide nursing home care to certain veterans with service-connected disabilities.

As the veteran population continues to age, the need for nursing home care continues to rise. Nursing home care within VA is considered the "safety net" for their outpatient services such as residential care, respite care, hospital-based home care, adult day health care, homemaker/home health aide services and other extended care programs. Yet the eligibility requirements for nursing home care and inpatient hospital care are inconsistent with

standard medical practice and do not support continuity of care for veterans.

The VFW supports the intent of this legislation, but believes a standard for VA nursing home entitlement must be established for all veterans –– not just veterans with a disability rating of 70 percent or higher.

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

This legislation would expand health care and benefits from VA for veteran survivors of sexual trauma. While the VFW agrees with the intent of this legislation, there are concerns as well.

The VFW strongly supports the expansion of coverage to include survivors of cyber harassment. As technological capabilities have continued expanding and becoming more accessible, many have fallen victim to sexual harassment and assaults of a sexual nature on the Internet and by other technological means. Survivors of cyber harassment should not fall victim again by being pushed to the wayside due to legal definitions not being inclusive of them. Regardless if an individual is sexually harassed or assaulted in a physical nature, or by means of technology, they deserve the right to seek counseling and treatment.

Section 2 would also expand the population who can use VA for counseling and treatment beyond the current restriction of only those who were assaulted while serving on active duty. It is the duty of Congress and VA to take care of every veteran who served, regardless of their duty status.

The VFW supports codifying the standard of proof for sexual trauma, as current law only regulates combat veterans. Yet, there are concerns with some portions of this section. Some inconsistencies can be found throughout section 3, which begins by saying it is covering all veterans making a claim of “a covered mental health condition” either due to, or aggravated by, military sexual trauma (MST). While this term is later defined, further into section 3 there are inconsistencies where only post-traumatic stress disorder is referenced for the nonmilitary sources of evidence, as well as under the notice and opportunity to supply evidence portion.

The VFW has long advocated for nonmilitary sources of evidence to be able to be used by

veterans filing disability claims with VA. Particularly for MST claims, as survivors may not have felt comfortable talking with military law enforcement, medical personnel or their commands. By expanding what veterans can submit as evidence for MST claims, to include records for non-military law enforcement, rape crisis centers, physicians and statements from others, this would greatly reduce the barriers of proof for survivors seeking treatment through VA. Yet, the VFW is concerned that by saying the Secretary shall accept nonmilitary evidence, but also saying the Secretary may seek a credible opinion during the review of evidence, will contradict and further complicate the benefits of allowing outside evidence.

This legislation would also expand notifications of opportunity to supply evidence for disability claims. The VFW is concerned that by providing veterans submitting MST claims the opportunity to submit more evidence after a claim is submitted, and before the Secretary is able to deny the claim, will create a double standard. While the VFW supports improving the disability claims process for veterans claiming MST, providing them a benefit others do not have in their claims process would be unfair to other veterans. There should be equity for all veterans in not just health care, but in benefits and applications as well.

This legislation would also require reports on claims for disabilities incurred or aggravated by military sexual trauma. One of the reporting requirements would be a description of training that the Secretary provides to employees of the Veterans Benefits Administration. The VFW believes this reporting requirement should not be limited to strictly employees, but should also include contractors and affiliates of the Veterans Benefits Administration. This would include contract physicians' compensation and pension exams, as well as Veteran Service Organizations assisting in benefit claims.

The VFW supports section 4, which would ensure Sexual Assault Response Coordinators (SARCs) from the Department of Defense advise members of the armed forces reporting instances of sexual assault or harassment that they are eligible for services at Vet Centers. The VFW would like to see this section expand to ensure this information is provided during sexual assault awareness training as well as incorporated into training for the Sexual Assault Prevention Response Office.

S. 946, Veterans Treatment Court Improvement Act of 2017

The VFW supports this legislation, which would require VA to hire 50 additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved veterans. These specialists serve as an invaluable asset in ensuring the VJO program helps

veterans avoid unnecessary criminalization of mental illness and receive treatment in lieu of incarceration.

Outreach specialists for VJO make sure veterans within the program have access to VA services, provide outreach, and handle case management for justice-involved veterans. By requiring VA to not allow their number of employed VJO Specialists to go lower than the number currently within the system the day this legislation would go into effect, as well as increasing that number by 50, more veterans in need of assistance and guidance through this unique and live-saving program will have access to Veteran Treatment Courts.

S. 1153, Veterans ACCESS Act

This legislation would suspend or prohibit certain non-VA providers from providing community care health services to veterans. The VFW supports the intent of this legislation, but has concerns that must be addressed before passing.

The *Veterans ACCESS Act* has four factors which would result in the denial or revocation of eligibility of a health care provider to provide non-VA health care services to veterans. One of those factors categorized under section 2 of this legislation would authorize the Secretary to revoke eligibility of a medical provider who violated a law for which a term of imprisonment of more than one year may be imposed. This particular part of the legislation has nothing specifically to do with medical licensing and is incredibly vague. The VFW agrees if a crime results in a medical provider losing their license that they should not be able to practice medicine, but that is already covered in this legislation.

The VFW also has concerns with language stating that the Secretary may deny, revoke, or suspend the eligibility of health care providers under investigation by the medical licensing board of a state in which the provider is licensed or practices. This denies the providers their right to due process, as they are only under investigation and no verdict has been reached.

Lastly, this legislation provides no means for health care providers who may have their eligibility revoked, but want to come back as a community care provider for VA patients. Particularly in rural areas, these community providers are crucial in allowing veterans timely access to care. If health care providers are not able to provide care to veterans using VA, the department should be required to explain to them how long they are revoked or suspended. In instances where providers are revoked, they must be informed of what they

may do to provide community care again, as well as when they may reapply.

S. 1261, Veterans Emergency Room Relief Act

The VFW strongly supports expansion of emergency treatment and urgent care in the community. However, we oppose the requirement to have VA establish copayments for community urgent and emergent care that is different from copayments charged for VA care. This proposal also makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. Veterans currently exempted from co-payments should not be required to bear a cost-share for emergency and urgent care services.

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

S. 1279, Veterans Health Administration Reform Act of 2017

This legislation would, among other things, consolidate VA's community care authorities, expand VA's authority to provide emergency room and urgent care, and improve VA community care. The VFW supports this legislation and would like to offer suggestions to strengthen it.

The VFW strongly believes that veterans have earned and deserve timely access to high quality, comprehensive, and veteran-centric health care. In most instances, VA care is the best and preferred option, but we acknowledge that VA cannot provide timely access to all services to all veterans in all locations at all times; that is why VA must leverage private sector providers and other public health care systems to expand viable health care options

for veterans.

The VFW supports section 2, but would like to offer recommendations to strengthen it. This section would build on lessons learned from the Veterans Choice Program to reform the way veterans access community care. When the Choice Program was first implemented, the VA wait time standard required a veteran to wait at least 30 days beyond the date a veteran's provider deemed clinically necessary –– the clinically indicated date –– before being considered eligible for the Choice Program. This meant that a veteran who was told by a VA doctor that he or she needs to be seen within 60 days was only eligible for the Choice Program if he or she was scheduled for an appointment that was more than 90 days out, or more than 30 days after the doctor's recommendation.

After the VFW expressed concern that veterans' health may be at risk if they are not offered the ability to receive care within the timeframe their doctors deem necessary, Congress amended Public Law (PL) 113-146, the *Veterans Access, Choice, and Accountability Act of 2014,* to require VA to offer veterans the option to receive care through the Choice Program if VA is unable to provide an appointment before the clinically indicated date.

The VFW strongly believes that when and where veterans receive their health care is a clinical decision made by veterans and their doctors. This bill would rightfully base eligibility for the proposed Care in the Community Program on whether receiving care through community providers is in the clinical best interest of the veteran.

Another lesson learned from the Choice Program is that geographic accessibility is difficult to define because it means different things in different locations and changes depending on the health care needs of the veteran concerned. That is why the VFW supports basing access to community care on whether a veteran would experience an undue burden if the veteran seeks care from VA. However, the VFW believes it necessary to authorize VA and veterans to work together to define what is considered an undue burden instead of establishing systemwide definitions that do not account for local variances.

This bill would also require VA to place veterans on an electronic waiting list. Instead of placing veterans on electronic waiting lists, the VFW recommends VA provide veterans an appointment that is beyond the wait time standards of the department and offer veterans the opportunity to receive community care. When veterans accept an appointment in the community, their VA appointments must be cancelled to prevent no-shows. However, this would require VA to track community care appointments better than they have with the

Choice Program.

This bill would charge VA with scheduling and coordination of community care appointments and management of the community care networks. In so doing, it would also limit VA's ability to use a third party administrator for the proposed Care in the Community Program. The Choice Program has experienced many issues because VA elected to simply contract virtually every aspect of the community care process. However, not every issue that the Choice Program has faced is the fault of the third party administrators, and there is no guarantee that VA would not have experienced the same issues without a third party administrator. What is clear from the VFW's continued evaluation of the Choice Program is that the third party administrators have the capability to accomplish certain tasks more efficiently than VA. For example, the VFW does not believe VA has the capability to manage a network of hundreds of thousands of private sector health care providers.

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

The VFW supports section 3, which would establish a VA provider agreement authority. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not able to provide the care.

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

However, the VFW urges the committee to amend section 3 of the bill to make it clear that provider agreements may only be used if VA is unable to schedule an appointment at its medical facilities or through the Care in the Community Program. Authorizing local medical facilities to enter into provider agreements with providers who are in or are being perused to join the community care network would erode the networks, and could result in such networks failing to meet needed coverage and size requirements.

The VFW supports section 4, which would reform VA emergency and urgent care options for veterans. The VFW continues to hear from veterans that VA refuses to pay the cost of their emergency room visits, which may have saved their lives or was their only option for receiving the urgent care they needed. That is why the VFW supports this legislation's expansion of emergency and urgent community care. Specifically, the VFW is pleased to see that this legislation would ensure copayments associated with emergency and urgent community care would be equal to the copayments paid by veterans at VA medical facilities. This would ensure veterans are not punished for using community care.

However, this legislation would require veterans to have received VA care with the past 24-months in order to be eligible to receive reimbursement for the cost of community emergency and urgent care, which is similar to the eligibly requirements under VA's current emergency care reimbursement program. This barrier to access has caused undue hardship on veterans who enroll in VA health care, but have been denied access due to wait times, and subsequently require emergency services. VA is aware of this problem and has requested the authority to make an exemption to the 24-month requirement for veterans who find themselves in this situation. The VFW recommends that the committee amend this legislation to ensure veterans who face long appointment wait times are not precluded from seeking the emergent and urgent care they need.

The VFW strongly supports section 5, which would require VA and the Centers for Medicare and Medicaid (CMS) to enter into a memorandum of understanding. The VFW has long supported Medicare subvention, because our members see no logical reason VA lacks the ability to bill their Medicare plans for the cost of providing non-service-connected care. This section would require VA and CMS to do the next best thing –– coordinate referrals. By requiring Medicare providers to accept referrals from VA doctors, this section would enable veterans who want to use private sector doctors but maintain all their records and health care management at VA the ability to do so.

The VFW support sections 6 and 7, which would establish education programs to teach veterans, community care providers and VA employees about VA's community care programs. The VFW believes that community care providers must also have the opportunity to obtain military competency training and continuing medical education (CME) on how to provide veteran-centric care. That is why we recommend the committee expand section 7 by requiring VA to also provide CME on veteran-specific health care and military competency training.

S. 1325, Better Workforce for Veterans Act of 2017

The VFW strongly supports this bill and thanks the committee for including it in the agenda. If enacted, this bill would significantly improve VA recruitment and retention authorities. When the VFW asked veterans how they would improve the VA health care system in our latest survey of VA health care entitled "Our Care 2017," the most common suggestion was to hire more health care staff to reduce wait times.

The VFW thanks the committee for recognizing that VA's ability to hire and retain high quality employees is important. Considering that more than 30 percent of VA employees will be eligible for retirement by 2020, it is vital that Congress focuses on ways to improve VA's hiring and retention authorities to ensure veterans have timely access to the care they have earned.

Title I of this important bill would improve VA recruitment and hiring practices. It would improve authorities for quickly hiring students who complete their residency or internships at VA. With more than 70 percent of America's health care workforce receiving some or all of its training at VA, it should be easy for VA to develop a pipeline of students who become employees. However, VA's cumbersome human resources (HR) requirements limit its ability to recruit the students it trains. The VFW supports eliminating such HR barriers to ensure VA is able to quickly hire the high quality health care professionals it trains.

The VFW is also pleased this bill takes steps toward improving veterans preference to ensure veterans who served in the National Guard and Reserve are afforded the same hiring preferences as their active duty counterparts. Currently, veterans who served after September 11, 2001, are required to have served at least 180 consecutive days on active duty. Due to our all-volunteer military and the nature of the wars in Iraq and Afghanistan, the Guard and Reserve have been utilized much more than they have during past conflicts.

However, not all Guard and Reserve service members receive active duty orders for more than 180 days. Thus, many veterans that deployed into harm's way in support of the wars in Iraq and Afghanistan are not eligible for veterans hiring preferences. Changing the eligibility for veterans preference from "180 consecutive days" to "for a total of more than 180 days," ensures Guardsmen and Reservists are afforded the same opportunity to obtain meaningful civilian employment after military service as their active duty brothers and sisters.

This important bill also makes several administrative changes to VA's HR processes. The VFW strongly supports amending VA's reduction in force procedures to make certain VA ranks its employees based on performance instead of tenure. Doing so would ensure the highest quality employees would remain to care for our nation's veterans if VA is required to implement a reduction in force.

Discussion Draft, the Veterans Choice Act of 2017

This legislation would expand the Choice Program, establish VA provider agreements authority, require VA to assign each veteran a primary care provider, and establish demand capacity analyses, among other things. The VFW supports sections 4, 5, 6, 9, 10 and 11; supports the intent of section 7; has serious concerns with section 3; and takes no position on sections 8 and 12.

The VFW has serious concerns with section 3 as written and would be forced to oppose the underlying bill if changes are not made to the bill before it is advanced by the committee. While the Veterans Choice Program has made significant progress since it was implemented in November 2014, it has yet to achieve what Congress envisioned when it passed the *Veterans Access, Choice, and Accountability Act of 2014*. The purpose for this landmark program was to address the national access crisis that has plagued the VA health care system, where veterans wait too long or travel too far for the care they need. The VFW has made a concerted effort to ensure the program works as intended by evaluating what aspects of the program are working and identifying common sense solutions to aspects that are not working well. We have done this because we agree that VA must leverage its community care partners in order to fulfil its obligation to our nation's veterans. However, we firmly believe that community care must complement, not supplant or compete with, the high quality, comprehensive and veteran-centric care veterans receive from their VA health care system.

Section 3 would make any veteran enrolled in VA health care eligible for the Choice

Program. The VFW is seriously concerned that such a significant expansion of eligibility would result in veterans receiving disparate and uncoordinated care. Medical research has determined and the Commission on Care has reiterated that integrated and managed health care systems provide better health care outcomes than fee-for-service systems. That is why the majority of high performing health care systems, including VA, have implemented the patient-centered medical home model of delivering health care, which ensures patients receive the care they need when they need it.

While the idea that veterans should be free to choose between VA and community care providers whenever they want and every time they seek care sounds enticing, it is unsustainable because of the cost, and the VFW would vehemently oppose any future efforts to pass that cost onto veterans. The Commission on Care estimated that the cost of a proposal very similar to Choice Program eligibility proposed by section 2 would have ranged from $156 billion to $237 billion once fully implemented. The VFW is not concerned that veterans will flee VA medical facilities for private sector doctors. To the contrary, VFW health care surveys show that nearly 60 percent of veterans who use VA health care prefer it, despite having other health care options. Yet, the increased reliance on VA health care due to such a generous benefit and VA's inability to keep pace with the increase in demand would require Congress to shift already strained and insufficient appropriations from direct care to community care. Such a shift of resources would further limit VA's ability to update its aging infrastructure, hire needed health care professionals, compete with the private sector, and would lead to the gradual erosion of the VA health care system.

The VFW is also concerned that a "choose your own adventure" approach to health care would lead to veterans receiving fragmented health care that the Commission on Care found would lower health care outcomes and endanger patient safety. Veterans deserve the highest quality health care possible, not fragmented care that fails to meet their health care needs. The VFW urges the committee to amend this section by ensuring veterans who are unable to receive a VA appointment by a clinically indicated date, or within a distance an enrolled veteran and such veteran's health care provider agree is reasonable, are offered community care options.

The VFW supports provisions which authorize VA to enter into regional contracts to establish and manage networks of health care providers, schedule appointments, process claims and payments, and collect medical documentation. However, the VFW believes the specific processes that are completed by the contractor should be determined by VA in consultation with Veterans Service Organizations, the current third party administrators and entities interested in becoming a third party administrator.

VA has worked on this process for the past year, and has determined that it is best for VA community care staff to schedule Choice Program appointments when feasible, and to turn to the third party administrators when local facilities are unable to timely process appointments. While different parts of the country have experienced mixed results with the current third party administrators, the VFW does not believe it would be in the best interest of veterans for every aspect of the Choice Program to be managed by a third party administrator or VA. By evaluating issues the Choice Program has faced, and with increased communication and management of the current third party administrators, VA must strike the right balance between what is handled internally and what can be contracted out. The most important factor is that veterans must have a seamless transition from VA care to community care and vice versa.

This section would also prohibit VA from using tiered networks to direct veterans to specific providers. While the VFW agrees that veterans must not be forced to receive care from specific community care providers, VA must have the authority to recommend providers in higher tiers to incentivize network providers who show dedication to developing military competency and veteran-centric health care practices. The VFW recommends the committee amend this section to prohibit VA from requiring veterans to obtain care from specific doctors, but still make recommendations based on a provider's tier level.

The VFW supports the provision to authorize VA to collect reasonable charges from a veteran's other health care plans. Doing so would ensure VA is able to offset some of the costs of providing community care to veterans. Specifically, the VFW is glad this bill would not impose a financial penalty on veterans who may not be aware that their other health care coverage has changed. We do, however, recommend that the committee expand the definition of other health care coverage to include Medicare. VFW members who pay for Medicare coverage see no justifiable reason for VA to be treated differently than private sector providers when a Medicare- enrolled veteran receives non-service-connected care from a VA doctor. Doing so would further offset the cost of providing community care.

The VFW supports section 4, which would authorize VA to enter into provider agreements. Specifically, the VFW is glad this bill would require VA to provide care through its facilities or the Choice Program before considering provider agreements. This would ensure provider agreements do not impact the integrity of the Choice networks or VA's ability to provide direct care.

Section 7 would require VA to assign each enrolled veteran a primary care provider. It would also authorize veterans to freely choose a community primary care provider when such

veteran enrolls into the VA health care system. The VFW supports including community care options when veterans seek primary care and, to ensure continuation of care, veterans must be given the opportunity to receive all their primary care from their assigned community primary care provider. However, the VFW does not support giving veterans a list of providers and leaving them to fend for themselves to find a community primary care provider who is accepting new patients and is willing to see them. Instead, VA must work with every veteran who requests primary care to determine what option and doctors are best for each individual veteran.

Furthermore, the VFW recommends the committee require community primary care providers give VA the right of first refusal when referring veterans to specialty care. Under the current Choice Program, community care providers do not have they ability to refer veterans back to VA for specialty care or follow-up care. Doing so would ensure proper utilization of VA resources and strengthen the relationship between VA and local community care providers.

The VFW strongly supports section 9, which would require VA to conduct demand capacity analyses. The VFW believes that community care networks and VA's footprint must be tailored to each health care market. There are some areas in this country were wait time for private sector care is much greater than VA. In other areas, VA is duplicating services that are readily available in the private sector or through other public health care systems. By conducting periodic demand/capacity analyses, VA would be able to determine when it should leverage the capabilities of its community care partners and when it must expand internal access. Doing so would ensure VA devotes its finite resources to capabilities the community lacks.

Discussion Draft, Improving Veterans Access to Community Care Act of 2017

This legislation would consolidate VA's community care authorities and improve VA community care, among other things. The VFW supports sections 102, 103, 201, 202, 204 and 205; has concerns with section 101; and agrees with the intent of section 203.

The Choice Program has faced a number of challenges since it was implemented in November 2014. The VFW has made a concerted effort to evaluate what aspects of the program have worked and identify common sense solutions to aspects that have not worked as intended. That is why we are pleased to see that this legislation would incorporate many of the lessons learned from the implementation of the Choice Program and other

community care programs, such as consolidating all of VA's community care authorities to ensure veterans, VA employees and private sector providers understand how to navigate VA's community care program.

Section 101 would reconstitute and make a number of improvements to the Choice Program, to include ensuring a veteran's continuation of care is not interrupted by bureaucratic rules. The VFW supports provisions to allow veterans who receive authorized care from a community care provider to continue to see their community care provider or another community care provider to complete an episode of care, or enter into follow-up treatment without the need to request additional authorization.

The VFW is glad to see that this legislation includes recent improvements to the eligibility criteria in the proposed Veterans Community Care Program, such as the Secretary's authority to determine that there is a compelling reason for a veteran to use community care in lieu of VA care. However, the VFW is concerned that the bill continues the flawed 40-mile and 30-day eligibility criteria to determine when veterans are afforded the opportunity to access community care. The VFW believes that the distance a veteran is required to travel or how long a veteran is required to wait for health care must be a clinical decision made by the veteran and his or her health care provider.

Another lesson learned from the Veterans Choice Program is that VA provides health specialties that do not have a Medicare rate, including obstetrics and gynecological care. While the VFW understands the need to set limits on the amount VA is authorized to reimburse community care providers, the VFW believes that a consolidated community care program should authorize VA to provide community care options for every health care specialty it delivers. That is why we are glad to see the legislation would authorize VA to establish a fee schedule for services it provides that do not have a Medicare rate. It would also authorize VA to negotiate rates, which the VFW supports.

This section would also authorize VA to establish tiered networks to operate the Veterans Community Care Program. The VFW supports establishing tiered networks to incentivize community care providers to develop military competency and veteran-centric health care practices. However, a veteran's choice of community care provider should not be limited by a specific tier. Each veteran should be given the opportunity to work with VA to determine what community care options are best suited to the veteran's clinical needs and preferences.

The VFW supports section 102 which would require VA to comply with prompt payment

requirements. The VFW continues to hear from veterans that they have been billed for care that VA is responsible for paying simply because the community care provider VA sent them to was unable to collect payment from VA in a timely manner, so the provider elected to bill the veteran instead. Prompt payment is vitally important to ensuring VA's community care network is able to attract and maintain high quality private sector health care providers.

The VFW supports section 103, which would expand medical malpractice protections to veterans who use VA community care. Veterans who receive care at VA medial facilities are eligible for disability compensation and other benefits if they have been injured or negatively impacted by VA care. Veterans who use the Choice Program are not offered the same opportunity and are required to seek legal action in order to be compensated for malpractice.

The VFW agrees with the intent of section 203, which would authorize VA to transfer resources between its medical services and community care accounts. If veterans receive care from community care providers or VA, health care facilities must be determined at the local level by each veteran and his or her health care team, not by Congress or VA bureaucrats who favor one option over the other. That is why the VFW supports authorizing VA to transfer resources between its internal care and community care accounts based on demand. Instead of implementing this section, the VFW would recommend doing away with the community care appropriations account and simply require VA to report on the use and cost of community care, rather than continuing to fence off certain appropriations for community care.

The VFW supports section 204, which would authorize VA to obligate funds when care is approved, not when VA authorizes community care. If enacted, this provision would enable VA to better forecast community care expenditures and reduce the amount of resources it is required to deobligate, because it obligated more money than it was required to pay in an effort to prevent the department from violating anti-deficiency laws.

The Department of Veterans Affairs Quality Employment Act of 2017

The VFW strongly supports this legislation which would improve employment practices at VA. If VA is not able to quickly hire high quality employees, it will lack the staff needed to accomplish its mission. In its report, "Hurry Up and Wait," the VFW highlighted deficiencies in VA Human Resources practices. The VFW recommended Congress ease federal hiring protocols for VA health care professionals to ensure VA can compete with

private industry to hire and retain the best health care providers in a timely manner.

In their review of VA's scheduling system and software development as required by the *Veterans Access, Choice and Accountability Act of 2014*, the Northern Virginia Technology Council (NVTC) reinforced the VFW's concerns that VA's hiring process moves too slowly. NVTC suggested that for VA to be successful, it must aggressively redesign its human resources processes by prioritizing efforts to recruit, train, and retain clerical and support staff. This important bill would make many needed improvements to the way VA hires and retains high quality employees.

The VFW strongly supports the creation of an Executive Management Fellowship Program. This ideas was advocated by a VFW-Student Veterans of America fellow. In his proposal, *"*Connecting America's Best to Serve America's Best*,"* Karthik A. Venkatraj highlighted how a private-public partnership program such as the Executive Management Fellowship –– where VA leaders are detailed to a private sector company and vice versa –– can infuse private sector expertise and disciplines into VA governance and management. The proposed fellowship would also grant private, non-profit and academic institutions the ability to immerse its leadership in the highest levels of our nation's public policy to better understand how the public and private sector can learn from each other and work together to improve the lives of America's veterans.

This bill includes other ideas the VFW has suggested and supported in the past, such as expedited hiring authority for students enrolled in a VA residency or internship program and recent graduates who are being poached by private sector health care systems, because VA's hiring process is to too long and cumbersome. It also includes a requirement for VA to conduct and use exit surveys to determine why its medical professionals are leaving. Doing so would ensure VA is able to address retention issues, which is one of the biggest reasons behind VA staff shortages.