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Testimony of Senator Mike Crapo

Veterans Health Administration Reform Act (S. 1279)
Senate Veterans Affairs Committee
July 11, 2017

Chairman Isakson, Ranking Member Tester, and Distinguished Members of the Committee:

Thank you for the opportunity to testify on S. 1279, the Veterans Health Administration Reform Act. This legislation is drawn from two statewide veterans surveys, hosting more than 200 town meetings, and reviewing official reports suggesting how veterans health care can be improved.

Idahoans use four Department of Veterans Affairs' medical centers (VAMCs) across two Veterans Integrated Services Networks (VISNs): Spokane VAMC, Walla Walla VAMC, Boise VAMC, and Salt Lake City VAMC. Some Idahoans use urban facilities; others use rural facilities. Having Idaho veterans fall within both urban and rural settings, as well as in two different VISNs, impacts the way I approach reforming the Veterans Choice Program and the other non-VA care programs.

We need accessible non-VA community care that is responsive to the needs of veterans in both communities with many resources and communities with fewer services and providers.

S. 1279 would improve veterans' access to care by consolidating the multiple and overlapping non- VA care programs, including the Veterans Choice Program, into one new program with veteran-centric eligibility criteria. The new Care in the Community program would allow the VA to send veterans to non-VA local care when facing one of the following important circumstances:

1) it is in the clinical best interest of the veteran to access care or services outside of the VA;
2) the veteran would experience an undue burden if he or she continued to seek care from the VA, which would include being forced to travel long distances because the local VA does not offer the particular service needed by the veteran; or
3) it is not economical for the VA to provide the veteran the care or services needed by the veteran.

It is important that veterans have access to this kind of care they need. For Idahoans, it is particularly important that care in the community is available when the services veterans need are not available at a VA facilities nearby.

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The Veterans Health Administration Reform Act would require the VA to pay providers in a timely fashion and to ensure providers have a streamlined way to submit claims and track payment. These provisions are critical to ensuring providers in local communities, particularly in smaller and rural areas, can afford to continue serving veterans. Long repayment times and lack of clarity in the claims process make it difficult for some providers to both serve veterans and continue to make ends meet.

The measure also would facilitate a formal partnership between the VA and the Centers for Medicare and Medicaid (CMS) share information on best practices. In 2015, the American Community Survey found that 11.3 million veterans out of 22.5 million veterans nationwide reported having health coverage through Medicare. About 6.4 million veterans reported having care through the Veterans Health Administration (VHA), and many veterans may be dual eligible under Medicare and the VA. CMS has significant experience modernizing its health care delivery. Instead of having the taxpayer continue to pay for studies, it is wise to have CMS share with the VA how it approached modernizing claims processing and how it developed auto-adjudication for claims.

Beyond the technical assistance CMS could provide, there is a lack of knowledge both among veterans and VA staff on how Medicare benefits interact with (and may be different from) VA benefits. Through casework, I have seen veterans decline Medicare Part B, have a non-service-connected emergency, and then discover that the VA will not pay the expenses when Medicare (or another insurance) would have. It is important to educate veterans and staff on how the two programs work together, particularly as a larger percentage of the veteran population becomes older than 65.

If a veteran wishes to see a specialist outside of the VA, the veteran should have the freedom to choose to use Medicare benefits to receive outside care. Some senior veterans I have talked with in Idaho like their primary care provider at the VA. They do not want to exclude their VA provider by using Medicare for a specialty care need in the community. Currently, there seems to be confusion on the VA's ability to have providers refer veterans into the community for care without incurring a financial obligation.

S. 1279 would require the VA to administer an education program that helps veterans know about their health care options. This program should inform the veteran of the services for which he or she might be eligible, more information about the VA's priority group system, and information about the veteran's co-pays or other financial obligations. The program should clearly explain to veterans how health insurance programs (private, Medicare, Medicaid, TRICARE, etc.) interact with the services provided by the VA. And the program should also inform the veteran of what to do with a complaint about health care received from the VA. The information must be accessible to veterans who do not have access to the internet. Education about the

health care options and limits through the VA is critical to ensuring that veterans are more satisfied with the VA and that they have the information to make wise health care decisions before an expensive emergency.

I thank the committee for its thoughtful consideration of this legislation and look forward to working together to come up with reforms that meaningfully impact the lives of servicemembers.

Thank you, Mr. Chairman.