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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
MARCH 16, 2016***

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing, and to present our views on the bills under consideration. DAV is a congressionally chartered national veteran's service organization of 1.3 million wartime veterans, all of whom were injured or made ill while serving on behalf of this nation, and dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

We believe ill and injured veterans earned and deserve timely access to high-quality, comprehensive and veteran-centric health care designed to meet their unique circumstances and needs. Because numerous studies on the quality of care the VA health care system delivers as well as the studies mandated by P.L. 113-146, "the Veterans Access, Choice, and Accountability Act of 2014," show that while the VA has a numerous challenges and problems, it continues to outperform the rest of the U.S. health care sector on nearly every metric of quality. This unique accomplishment in the face of the access crisis must not be compromised.

**S. 2646, the Veterans Choice Improvement Act of 2016, and
S. 2633, the Improving Veterans Access to Care in the Community Act**

DAV deeply appreciates the commitment and work of the members and staff of this Committee and the Senators for sponsoring the two bills being considered in today's hearing. Both bills seek to improve veterans access to community care by, among other things, consolidating some of VA's purchased care authorities, ensure coordination of care and health information sharing, and improving emergency care. DAV is pleased both bills contain some of our recommendations to reform the VA health care system while preserving and strengthening it so that DAV members and all eligible veterans may continue to enjoy the unique benefits and vital services VA provides well into the future.

Over the past year, DAV and our Independent Budget (IB) partners developed a comprehensive framework to reform VA health care based on the principle that it is the responsibility of the federal government to ensure that disabled veterans have proper access to the full array of benefits, services and supports promised to them by a grateful Nation. In order to achieve this goal, our comprehensive framework has four pillars—Restructure, Redesign, Realign, and Reform. We offer our views on specific provisions of S. 2633 and S. 2646 that we believe fit within this framework and recommend it be part of the final legislation this Committee passes to reform VA health care.

- I. Restructure our nation's system for delivering health care to veterans, relying not just on a federal VA and a separate private sector, but instead creating local Veterans-Centered Integrated Health Care Networks that optimize the strengths of all health care resources to seamlessly integrate community care *into* the VA system to provide a full continuum of care for veterans.

Veterans-Centered Integrated Health Care Networks

To this end, we believe the health care network contemplated in S. 2633 would most likely yield the local Veterans-Centered Integrated Health Care Networks. Like private sector health care plans and larger provider systems that offer health coverage, the proposed Subsection 1730A(c)(3) of this measure will allow VA to create a tiered network that would best meet the expectations of veteran patients at that local level.

This kind of integrated network should provide veterans information they would need to make an informed decision. For example, information about the quality of the community providers in this network will give veterans the ability to discern between those community providers that are more knowledgeable about the veteran experience and unique needs, information about the satisfaction rating from other veterans who have seen that provider, and whether there is a good working relationship with the VA that facilitates care coordination.

This integrated network would create and preserve the kind of community-VA provider partnership that mirrors the care our members value most in the VA health care system. However, we believe S. 2646 offers an important provision that would prohibit VA from requiring veterans to receive care or services from an entity in a specific tier.¹

To ensure formation of the local Veterans-Centered Integrated Health Care Networks allows for the function of a high performing network, our framework places VA as the coordinator and principal provider of care, which we discuss immediately below. VA's primary care (medical home) model with integrated mental health care, is more likely to prevent and treat conditions unique to or more prevalent among veterans, particularly those with disabilities or chronic conditions.

¹ § 1703A(n)(2) as proposed in S. 2646.

- II. Redesign the systems and procedures by which veterans access their health care with the goal of expanding actual, high-quality, timely options; rather than just giving them hollow choices:

Care Coordination

We strongly urge the Committee to preserve the organizational model required in Section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note) in any future consolidation of VA’s purchased care authorities. Section 106 effectively created a “wall” that separated the financial and clinical operations of the current Choice program, which better insulated front-line clinicians, such as VA Community Health Nurse Coordinators, social workers, or other VA health care professionals against the fiscal pressures that have been known to sway clinical decisions and delay or deny community care to veterans.

DAV also strongly urges the Committee to discontinue the current arrangement under the Choice program that has effectively removed a critical part of the care coordination responsibility away from VA front-line clinicians. VA Community Health Nurse Coordinators are the veteran’s case manager and coordinators of care who work with the veteran's health care team to provide for the veteran patient's medical, nursing, emotional, social and rehabilitative needs as close to and/or in the veterans home.

While VA Community Health Nurse Coordinators are now better able to exercise their clinical authority due to the Section 106 reorganization, they are frustrated having lost their ability under the current Choice program to act as a liaison between community providers and VA and as an advocate for their veteran patients—who themselves have unsuccessfully tried to exercise their Choice option and asked for assistance from their VA nurse coordinator—to get the care they need in the community.

We strongly recommend the Committee ensure VA remains the coordinator of veterans care especially if that care is provided in the community and paid for by the Department.

Community Care Eligibility

For veteran patients, waiting for a health service begins when the veteran and the appropriate clinician agree to a service, and when the veteran is ready and available to receive it. We believe it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor – without bureaucrats, regulations or legislation getting in the way.

As both S. 2633 and S. 2646 proposes an additional hurdle for veterans to receive clinically necessary in the community, we stand ready to work with the Committee to ensure veterans, and especially service-connected veterans are not any more encumbered in receiving care in a reformed VA health care system. We applaud the veteran-centric approach in using a geographic distance around the veteran as described in Section 302 of S. 2633. Moreover, if clinical access to a primary care provider is to be used, we recommend language employed in

S. 2633 of a full-time primary care “provider” rather than “physician.” This would ensure uniformity with the private sector practice of using non-physician providers in primary care settings.

We also support the provisions in both S. 2633 and S. 2645 to make eligible to receive care in the community those veterans enrolled in Project ARCH so they do not experience a disruption in the care they have been receiving when the authority for the program is consolidated.

Veterans Care Agreements

Section 201 of both S. 2633 and S. 2644 would authorize the establishment of “Veterans Care Agreements,” and would prescribe the types of providers eligible for participation. We support the establishment of such agreements, but we are concerned that VA would be required to first exhaust other acquisition strategies before being allowed to pursue such agreements under S. 2646. In addition, different terms are used for paragraph (4) in both bills. We recommend the term “provider” be used rather than “health care provider” for consistency and ease of implementation of this section by the Department.

We agree with VA’s assessment regarding the need for this authority to be enacted into law without delay and applaud this Committee’s work to include similar language in S. 425; however, there are limitations in that measure that we believe will work against the consolidation of VA’s purchased care authorities as contemplated in the two bills under consideration today.

Mr. Chairman, there is one other note of concern as you consider legislation restructuring VA’s relationship with non-VA community providers. Both S. 2633 and S. 2646 have provisions authorizing provider agreements with community providers, but there is a provision in S. 2633 (Sec. 202) addressing State Veteran Home provider agreements which does not have a corresponding provision in S. 2646. When this Committee approved S. 425 on December 9, 2015, in addition to authorizing new provider agreement authority for VA, it also included a conforming amendment to protect existing provider agreements that VA has with all State Veterans Homes for the provision of skilled nursing care to severely disabled veterans rated 70 percent or higher. As you know, it took several years, two public laws (P.L. 109-461 & P.L. 112-154) and an Interim Final Rule (RIN 2900–AO57) to achieve Congress’ original intent of offering the most severely disabled veterans the option to receive extended care at State Veterans Homes. As the Committee and the Senate move forward, it is important to ensure that any legislation that addresses VA’s provider agreement authority with community providers does not modify, diminish, endanger or eliminate State Veterans Homes existing provider agreements authorizing them to provide these critical long term care services to thousands of severely injured and ill veterans.

Emergency and Urgent Care

DAV applauds the sponsors and cosponsors of S. 2633 for including our recommendations to make urgent care part of VA’s medical benefits package and to better integrate emergency and urgent care with the overall health care delivery system. DAV believes

a health care benefit package is incomplete without provision for both urgent and emergency care.

We support the proposal in both bills to address the eligibility and payment issues that veterans and community providers face. This Committee is aware of our organization's long standing position opposing any and all copayments imposed on veterans and support legislation reducing the copay amount. In light of the latter, we are pleased the legislation would limit the imposition of emergency and urgent care copayments had veterans sought this type of care at VA medical facilities.

However, DAV opposes the provision that would force veterans to pay copayments while their health insurance reimburses VA for emergency or urgent care. VA should be applauded and allowed to continue its current practice of offsetting a veteran's copayment debt with monies VA receives from billing the veteran's health insurance plan.

We also oppose the provision in S. 2633 that would require veterans to have received VA care within the last 24-months prior to receiving emergency care to be eligible for the emergency and urgent care benefit. This requirement unduly discriminates against otherwise healthy veterans who need not seek care at least once every 24 months, yet is required to make an otherwise unnecessary medical appointment in order to be eligible for payment or reimbursement for non-VA emergency treatment. We urge the Committee provide greater flexibility by including an exemption authority to the 24-month requirement for this and other unforeseen circumstances.

Emergency Care Defined

Carrying out the multiple and complex authorities² for VA to pay or reimburse emergency care under title 38 are a source of continuous complaints and can drive ill and injured veterans and their families to financial ruin.

According to VA, "In FY 2014, approximately 30 percent of the 2.9 million emergency treatment claims filed with VA were denied, amounting to \$2.6 billion in billed charges that reverted to Veterans and their [Other Health Insurance]. Many of these denials are the result of inconsistent application of the "prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care."

One of the by-products of Emergency Medical Treatment and Labor Act (EMTALA) was the prudent layperson standard in response to a critical payer issue of the day — payment denials for the lack of prior authorization. To address the inconsistent application of the prudent layperson standard, DAV recommended the "emergency condition" be defined using EMTALA, with a minor amendment to include behavioral conditions, so that the definition of an emergency condition for VA purposes would be:

² 38 U.S.C. §§ 1703, 1725 and 1728

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

Claims Processing and VA as Primary Payer

In addition, VA's processing of claims has been a significant weakness to the Department's community care programs resulting in costlier care, inappropriate billing of veterans and strained partnerships with community providers. Government Accountability Office reports throughout the years have consistently highlighted disturbing limitations in the Department's claims processing system as having unnecessary manual operations rather than automatically applying relevant information and criteria to determine whether claims are eligible for payment and notifying veterans and community providers about the results of the determination, payment, and appeal procedures.

Many veterans worry about claims that are not paid promptly or are left unpaid, and they are left in a difficult position of trying to get claims paid or be put into collections. These delays or denials create an environment where community providers are hesitant to partner with VA for fear they will not be paid for services provided. Hospitals and community providers have also expressed concern that prompt payment laws do not apply to care that is provided to veterans if they do not have a contract with VA. We have also heard complaints from veterans regarding section 101(e) of the current Choice program, which places on them greater financial burden and emotional stress while trying to recover from injuries and illnesses. We believe the responsibility of the government as first-payer and prompt payer for care and services should be reaffirmed.

Thus, DAV supports the required claims processing system in Section 103 of S. 2646, which would apply the prompt payment act to all services under the new Veterans Choice Program, govern claims management and payments to providers under the Choice Program, and would set a firm date after which VA would not accept claims in other than electronic form. This section would mandate the establishment of an electronic interface to enable private providers to submit electronic claims as required by the section. To further strengthen this proposal, we recommend adding certain provisions in S. 2633 requiring VA be primarily responsible for payment of services, an eligible provider to submit claims to VA within 180 days of furnishing care or services and how paper claims will be treated in the interim. These factors are critical elements in high performing Veterans-Centered Integrated Health Care Networks.

- III. Realign the provision and allocation of VA's resources so that they fully meet our national and sacred obligation to make whole those who have served.

We support the provisions in both S. 2633 and S. 2646 which would require the Administration to submit in its annual budget requests for advance appropriations for the Veterans Health Administration, Care in the Community program to begin in fiscal year 2017.

- IV. Reform VA's culture to ensure that there is sufficient transparency and accountability to the veterans this system is intended to serve.

In line with our recommendation to maintain the financial and clinical reorganization under Section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 U.S.C. 1701 note), we believe it is beneficial to require, rather than make discretionary, the transfer of funds and payment of services to the Chief Business Office of the Veterans Health Administration. This would help ensure transparency and accountability to a single entity when conducting oversight.

S. 2473 - Express Appeals Act of 2016

S. 2473, the Express Appeals Act of 2016, introduced by Senators Dan Sullivan (AK), Robert Casey (PA), Dean Heller (NV) and Jon Tester (MT) would establish a new pilot program to allow veterans to file “fully developed appeals” (FDA) which would receive expedited processing by the Veterans Benefits Administration (VBA) and the Board of Veterans Appeals (Board). An identical House bill (H.R. 800) was incorporated into an omnibus bill (H.R. 677) approved by the full House on February 9, 2016.

The FDA program was developed through a year-long collaborative effort among stakeholders that included DAV, VFW, The American Legion and other major veterans organizations, as well as leaders of both VBA and the Board. The FDA is modeled on the successful Fully Developed Claims (FDC) program in which veterans agree to undertake the development of private evidence necessary to substantiate their claims in exchange for expedited processing. Similarly, to participate in the FDA program, appellants would agree to develop and submit any private evidence necessary for the Board to make its decision, thus relieving both VBA and the Board of that development workload. The appellant would be required to submit all such new evidence, as well as any argument and other required certifications, at the time they submit their FDA.

In addition, the appellant would agree to an expedited process at VBA that eliminates the Statement of the Case (SOC), Form 9, any hearing before the VBA or the Board and the Form 8 certification process. The elimination of these processing steps alone could save some veterans up to 1,000 days or more waiting for their appeals to be transferred from VBA to the Board.

During stakeholder negotiations over the FDA it was agreed that the Board would retain its “duty to assist” in the development of any necessary federal records. If new federal records are obtained, or new exams or independent medical opinions ordered, the appellant would not

only be given copies of all such evidence, but would have 90 days to review it and submit additional argument and evidence in response, including private evidence.

A key attribute of the FDA program is that it is a voluntary program with the appellant retaining the absolute right to withdraw from the FDA program and revert their appeal back to the standard appeal processing model at any time prior to disposition by the Board. Such a reversion would then allow the appellant to submit any additional evidence, have their appeal heard by a Decision Review Officer (DRO) or request a hearing by the Board.

In accordance with DAV Resolution No. 091 to improve the claims and appeals process, DAV strongly supports the creation of a “fully developed appeals” pilot program through enactment of H.R. 2473. This innovative and pragmatic legislation would alleviate workload at the Board and VBA, provide some veterans with a new option to expedite their appeals by up to 1,000 days, while fully protecting the due process rights of veterans so that they can receive all the benefits they have earned through their service. H.R. 2473 has broad and bipartisan support and we urge the Committee to approve important legislation to improve the appeals process.

Discussion Draft on title 38, United States Code, appointment, compensation, performance management, and accountability system for senior executive leaders in the Department of Veterans Affairs.

Delegates to our most recent national convention passed two resolutions that may be relevant to this informal “discussion” proposal. DAV Resolution No. 126 calls for modernization of VA human resources management system to enable VA to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans. DAV Resolution No. 214 calls for meaningful accountability measures, but with due process, for employees of the Department of Veterans Affairs—by requiring that any legislation changing the existing employment protections in VA must strike a balance between holding civil servants accountable for their performance, while maintaining VA as an employer of choice for the best and brightest.

The discussion draft would apply personnel laws for Senior Executive Service (SES) members now working under title 5, United States Code, which covers most civil servants, to title 38, which allows greater pay flexibility to provide more competitive wages. Hiring under title 38 would also give the Secretary more authority to expedite hiring. These are key issues when competing against other federal agencies and the private sector for top talent. DAV supports the intent of these provisions.

However, there may be some issues when hiring individuals under title 38, which is generally reserved for personnel in health related fields, and applying those standards to those who would lead the Veterans Benefits Administration, National Cemetery Administration, and VA staff offices. In addition, while the proposed reform would allow expedited SES hiring, DAV asks the Committee to carefully consider whether the proposed executive compensation, which would still lag far behind that of chief executives in private sector health care, is nearly sufficient to offset the new risks being created by other parts of this proposal.

In the final analysis, these individuals would serve at the pleasure of the VA Secretary with little protection that is now available under current law to guarantee their status under title 5 to appropriately protect their due process rights and provide them retreat rights to lower-level assignments and to insulate them from politically motivated decisions—all hallmarks of the origins of the SES as envisioned in the Civil Service Reform Act of 1978. That act established the SES, the Merit Systems Protection Board, and created an array of procedures and requirements that govern the entirety of the SES program and many other aspects of federal personnel law.

Mr. Chairman, DAV and our members urge serious reform of the VA health care system to address access problems while preserving the strengths of the system and its unique model of care. We appreciate this Committee's hard work and are pleased that many of our recommendations have been incorporated into the measures under consideration today so that veterans will have more options to receive timely, high-quality care closer to home.

Thank you for inviting DAV to submit this testimony. We would be pleased to further discuss any of the issues raised by this statement, to provide the Committee additional views, or to respond to specific questions from you or other Members.