Nurses Organization of Veterans Affairs*
Association of VA Psychologist Leaders*
Association of VA Social Workers*
Veterans Healthcare Action Campaign
(*An independent organization, not representing the Department of Veterans Affairs)

STATEMENT FOR THE RECORD
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO DRAFT LEGISLATION
TO ESTABLISH A PERMANENT VETERANS CHOICE PROGRAM

WASHINGTON, D.C. October 24, 2017

Chairman Roe, Ranking Member Walz and Members of the Committee:

On behalf of our organizations, we would like to thank you for the opportunity to submit a statement for the record on the Veterans Choice Program redesign. We appreciate your leadership on this issue and for the strong bipartisan spirit of collaboration to provide high quality healthcare for our nations' veterans.

We believe the current draft discussion language, has several positive aspects for how to use community resources to supplement gaps in the provision of care. It also contains language that, as written, could potentially be harmful to the Veterans Health Administration (VHA) and the veterans who depend on it. The bill could accelerate a one directional flow of veterans' specialty hospital care and medical services out of the VHA and into the community. Choice care would be reimbursed first and the VHA would be forced to make do with remaining funds, thus draining VHA of staffing resources, and privatizing care over time. We provide examples of key aspects below.

Language that enhances the provision of care to veterans:

1. Right of First Refusal with Primary Care. The bill's most beneficial aspect is affording the Secretary the right of first refusal when a veteran establishes primary care. It allows local facilities the flexibility to determine whether they have a capacity of available health care professionals. If they do, the facility automatically becomes the care provider. This provision assures stability and predictability to VHA facilities in self-managing their primary care staffing and services.

2. Reappraisal of Capacity. After a veteran establishes primary care in the community, the bill authorizes the Secretary to conduct an annual reappraisal to determine whether the local VHA can resume being the provider for that veteran. This incentivizes facilities

with inadequate staffing to develop robust capacity. We have concern that directing a veteran's care back will be difficult to accomplish without explicit language that indicates the VHA can be newly established as the PCP if it has capacity at the point of reappraisal.

3. VHA as Care Coordinator and Case Manager. The bill identifies VHA staff to be the assigned as case manager of VA-community care coordination. This is a useful structure, and one that we have mentioned in previous testimony, but requires a significant increase in staffing. The bill doesn't recommend any additional funding for this role, so the net offset would be a reduction in staff that provides health care. Supplemental VHA allocations are warranted.

Language that erodes the VHA by diverting funds to the community:

1. Specialty Care Referral and Cost Control. Although the bill provides the Secretary a right of first refusal for primary care, a weaker prerogative exists for specialty care. Once a veteran receives primary care at a non-VA facility, ensuing referrals for specialty hospital care or medical services can easily bypass the VHA. The Secretary should be authorized to have the right of first refusal to provide specialty hospital care and medical services when it has the capacity to do so.

The language indicates that Choice providers only have to "consult" with the Secretary on specialty hospital care or medical services referrals. There is no process for VHA review and authorization of services. It is important to have an explicit requirement for Choice providers to "refer" back to VHA, and that VHA be required to oversee and control the provision of healthcare.

2. Demand/Supply Gaps. Although the bill allows local VHAs to define whether they have a shortage of available health care professionals, it does nothing to remedy shortages. It's Annual Capacity and Commercial Market Assessments makes no mention of identifying the supplemental allocations and resources that are needed to address human capital and infrastructure gaps. Nor does it show how money flowing to Choice providers are impacting local facility staffing and services. **We strongly affirm that strengthening and improving the VHA should go hand in hand with any Veterans Choice Program redesign**. Without adequate funding, VHA shortages will be inevitable and services slowly eroded.

Language that undermines provision of quality care to veterans:

1. Double Standards for Timeliness and Quality of Care. The bill requires the Secretary to publically report every month the average wait time at VHA facilities. However, it does

not require that Choice wait time data be obtained and published. Timeliness of Choice services -- as well as all other aspects of performance, screenings and on-going training requirements -- should be reported and held to the same high standards of VHA providers. Otherwise, care provided via Choice would be held to a lower standard than the VHA. This is a disservice to veterans. Finally, Choice providers should be required to continuously learn about the extent and quality of services the VHA provides, just as the VHA must do about the community.

2. PCP Referrals and Wait Times. At present, Choice wait time data are not published, therefore the Secretary is not able to use wait times in determining community providers' availability. A local VHA should be restricted from providing the veteran a list of available PCPs' until it first verifies that the providers on the list are more available than the VHA. It is well established that there exists and continues to be a growing scarcity of primary care physicians in the community.

3. Care Coordination via Medical Records. The bill gives network providers unlimited time to provide medical records to the VHA, and explicitly says they will be paid whether or not their records are late. There should be a penalty for undermining care coordination in this manner. Providers should be held accountable for any delay in care.

Once again, the Nurses Organization of Veterans Affairs, the Association of VA Psychologist Leaders, the Association of VA Social Workers and Veterans Healthcare Action Campaign thank the Committee for the opportunity to submit testimony on this critical topic. As health care professionals providing care and services to veterans across the country, we would be happy to assist with language in the final bill to accommodate any of the issues mentioned in our statement.

Contacts:

Nurses Organization of Veterans Affairs tmorris@vanurse.org
Association of VA Psychologist Leaders president1@avapl.org
Association of VA Social Workers president@vasocialworkers.org
Veterans Healthcare Action Campaign info@vhcac.org