MILITARY ORDER OF THE PURPLE HEART

CHARTERED BY CONGRESS

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STATEMENT FOR THE RECORD

SUBMITTED BY

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MILITARY ORDER OF THE PURPLE HEART

TO

THE HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS'AFFAIRS

WITH RESPECT TO

Pending Legislation

WASHINGTON, DC OCTOBER 24, 2017

Chairman Roe, Ranking Member Walz, and Members of the Committee, on behalf of the Military Order of the Purple Heart (MOPH), whose membership is comprised entirely of combat wounded veterans, I thank you for inviting us to offer our views on today's pending legislation. The bills being discussed today deal with the future of the Veterans Choice Program, as well as several other important issues dealing with veterans' access to the health care that they have earned through their service, and we thank the Committee for bringing them forward.

Draft legislation, to establish a permanent VA Care in the Community Program, and for other purposes

MOPH strongly believes that veterans must have access to high quality health care that is timely, and within reasonable distances, in every instance. Since Department of Veterans Affairs (VA) facilities cannot always offer care to every veteran when and where they need it, it is critical that seamless, well-coordinated community care is available when necessary. Still, community care must be seen as a supplement to care provided at VA facilities; not a replacement. The necessity for a community care program must be balanced with the desire of many veterans who wish to continue to receive most, if not all, of their care at VA.

For the past three years, that balance has been primarily achieved by the Veterans Choice Program. While imperfect in many ways, the Choice Program was generally successful in easing the well-documented access problems from which VA suffered prior to its inception. Now, as the Choice Program nears its expiration, a permanent VA community care program must be authorized, so that veterans who currently receive care in the community under Choice do not experience any gaps in care. This creates an opportunity to improve upon the Choice program, and this draft legislation does so in many ways. MOPH supports the vast majority of the bill, and appreciates the urgency and thoughtfulness with which the Committee is addressing this important issue.

Of all the changes to the Choice Program envisioned by this bill, the one that would undoubtedly be most apparent to veterans is the elimination of the current 30-day/40-mile rule. Under the current program, veterans are only authorized to receive care in the community if it is determined that VA cannot provide an appointment within 30 days, or the veteran lives more than 40 miles from a VA facility. These standards are not only arbitrary; they often exclude certain veterans who would benefit from care in the community. This includes veterans who need an appointment in less than 30 days, and veterans who are unable to travel 40 miles due to their disabilities or other reasons. This legislation would do away with the 30-day/40-mile eligibility requirement, in favor of a clinical determination made by VA, in consultation with the veteran and their provider. With the understanding that VA would be required to remain the coordinator of all community care, MOPH strongly supports this change.

MOPH is pleased that the bill would require that only active users of VA health care, as opposed to all enrollees, will be assigned to either patient-aligned care teams (PACT) of the Department or primary care providers (PCP) in the community. This will prevent PACTs from being filled with enrollees who do not regularly use VA care, thus giving an accurate measure of capacity within VA when determining whether assignment to a community PCP is necessary.

We also support the provision of this bill that would allow the Secretary to exempt certain specialty care services from the primary care referral requirement. While we agree that specialty care ought to be granted based on PCP referrals in general, we believe this flexibility will allow veterans to continue to engage in direct scheduling for specialties that are appropriate, such as optometry and audiology, as they do now.

Other provision of the draft bill we support include the establishment of an appeal process for veterans who are not authorized community care but wish to be, prompt payment standards for community providers, annual capacity and commercial market assessments of each VA facility and Service Network, improvements to provider agreements, and the consolidation of existing community care programs into a single authority. All of these provisions would help to streamline the way VA provides care.

However, MOPH must oppose section 203 which would eliminate copayment offsets for veterans who carry other health insurance. Currently, when VA bills a veteran's health insurance for certain episodes of care, part of the money collected is used to offset any copayment for which the veteran would otherwise have been responsible. This policy incentivizes veterans to both share their insurance information with VA, and continue to carry other health insurance even if they receive most of their care at VA facilities. While we understand that the improvements contained in this bill will require additional funding, we do not believe that veterans should have to personally bear that burden with new out-of-pocket expenses. MOPH strongly urges the Committee to amend the bill to strike this provision.

VA legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act

MOPH appreciates VA's efforts in drafting its own bill to address the future of community care. This proposed legislation contains many provisions similar to those in the Committee's bill, but

also has several key differences. We will primarily focus our comments on those provisions of the Care Act to that differ considerably from the Committee's draft bill.

Like the Committee's bill, the Care Act eliminates the 30-day/40-mile rule in favor of clinical determinations, which MOPH strongly supports. In those cases where such a determination would be made, we appreciate the concise nature of the text that reads, "The decision to receive such care or services from a non-Department entity or provider…shall be at the election of the veteran."

However, the Care Act establishes an additional eligibility trigger, whereby veterans would be referred to community care if the VA facility where they are enrolled does not meet quality or access standards, which are yet to be determined. While we generally agree with the principle that veterans should not be offered substandard care as the only option, we would like greater clarity on what those quality and access standards would be before offering our support for this provision. Furthermore, we strongly believe that known deficiencies at any VA facility should be corrected with the highest priority, and that community care should not be viewed as a substitute for remediation.

MOPH strongly supports the provision of the CARE Act that proposes establishing a walk-in community care benefit for active enrollees. We believe this would greatly improve convenience and health outcomes for veterans suffering from acute illnesses that do not require emergency room care. However, we would like the text to be amended to explicitly state that copays for walk-in care would be at the same rate as current VA copay amounts, rather than leaving those amounts to be determined by regulation.

We further support provisions unique to the CARE Act that would expand telehealth authorities, increase the number of graduate medical education residencies, provide reimbursement for continuing professional education requirements for advanced practice registered nurses, and improve collaboration with federal partners.

However, MOPH strongly opposes the provision of the CARE Act that would eliminate copayment offsets for veterans who carry other health insurance for reasons previously stated. Likewise, we vigorously oppose the provision that would attempt to generate offsets for community care by rounding down annual cost-of-living adjustments for veterans' and survivors' benefits. Veterans and their families rely on these modest increases to ensure their benefits keep pace with inflation. Their payment rates should not be diminished in order to ensure that veterans receive the high quality care to which they are already entitled. MOPH opposes the inclusion of either of these provisions in any future drafts of VA community care legislation.

MOPH does support the provision that would place reasonable caps on the amounts that flight schools may charge under the Post-9/11 GI Bill, closing a loophole in current law.

H.R. 1133, the Veterans Transplant Coverage Act of 2017

MOPH supports this legislation, which would authorize VA to provide eligible veterans with organ transplants from live donors, in a VA facility or a non-Department facility under the Veterans Choice Program or a successor program, regardless of whether the donor is eligible for

VA health care. VA would provide the donor with any care before and after the transplant that may be required as a result of the procedure, regardless of the donor's eligibility status.

Organ transplants are often life-saving operations. When a transplant from a live donor is a viable option, such as in the case of a kidney transplant, and a volunteer donor is identified, MOPH strongly believes that veterans should receive the transplants they need as quickly as possible. We wholeheartedly support this bill, which would remove current barriers to that process.

H.R. 2123, the Veterans E-Health and Telemedicine Support (VETS) Act of 2017

MOPH strongly supports this legislation, which would codify VA's authority to provide telemedicine across state lines. Currently, both the veteran and the VA provider must be physically located in a federal facility in order to conduct telehealth appointments. This legislation would eliminate that barrier, allowing veterans to get the telehealth care they need at their homes, workplaces, and other locations that are convenient for them. This would be particularly helpful for veterans who are homebound or live in highly rural areas. This legislation will allow VA to continue to expand its growing telehealth initiatives, leading to shorter wait times and greater access for all veterans.

H.R. 2601, the Veterans Increased Choice for Transplanted Organs and Recovery (VICTOR) Act of 2017

MOPH supports this bill's intent, which is to grant veterans with greater access to organ transplants through the Veterans Choice Program. As previously stated, organ transplants are often life-saving procedures, and should be provided as quickly as possible in all cases. However, we oppose the provision of this bill that would limit eligibility for non-VA transplants to veterans who live more than 100 miles from a VA transplant center. MOPH believes that the current 40-mile rule of the Veterans Choice Program is arbitrary and disqualifies many veterans who would benefit from care in the community. Likewise, we will not support attaching additional arbitrary distance requirements to any expansion of community care. If the 100-mile requirement were to be replaced with a provision determining eligibility based on clinical need, MOPH would fully support this legislation.

H.R. 3642, the Military Sexual Assault Victims Empowerment (SAVE) Act

MOPH supports the spirit of this legislation, which would establish a pilot program to allow Military Sexual Trauma (MST) victims to receive care in the community if they so choose, without the current 30-day/40-mile restrictions of the Veterans Choice Program. Such restrictions are arbitrary and often wrongfully exclusive for veterans seeking care for any reason. Furthermore, victims of MST have unique needs, and it is important to their recovery that they are able to receive care in an environment in which they are comfortable.

However, MOPH could only fully support this bill if it were amended to more explicitly state that VA would remain the coordinator of care for the program. Additionally, VA should be granted the resources to continue to improve care and services for MST survivors at VA facilities. While we appreciate this bill's intent, and would be most interested in the findings of

the report it requires, MOPH certainly would not want the program it proposes to relieve VA of its responsibilities to coordinate care for the veterans who participate in the pilot, or be seen as a replacement for high quality MST treatment options within VA, in any instance.

Draft legislation, to direct the Secretary of Veterans Affairs to conduct a study on the Veterans Crisis Line

Although we appreciate the intent of this legislation to determine, and potentially identify ways to improve, the efficacy of the Veterans Crisis Line (VCL), MOPH must oppose it. The required study would contain multiple data points, to include whether or not veterans who contact the VCL are already receiving VA mental health care at the time of the call, whether they begin and continue to receive VA care following the call, and whether or not they eventually die by suicide. While this data may be useful in theory, gathering it would require VCL responders to collect personally identifiable information from veterans in crisis during the call. This would not only run the risk of disrupting a suicide intervention in progress, it may steer veterans who wish to remain anonymous away from calling the VCL in the first place. While MOPH supports continued improvement to the VCL, we do not believe this bill offers the correct approach to achieve that goal.

Draft legislation, to amend title 38, United States Code, to modify the authority of the Secretary of Veterans Affairs to enter into agreements with State homes to provide nursing home care to veterans, to direct the Secretary to carry out a program to increase the number of graduate medical education residency positions of the Department of Veterans Affairs, and for other purposes.

MOPH supports this legislation, which would provide VA with greater flexibility when entering into agreements with State Veterans Homes, and create a program to fill graduate medical education residency positions within VA. Under this program, medical students would receive financial assistance with their education, in exchange for a period of obligated service as full-time VA employees, as determined by the Secretary.

The ability of VA to meet veterans' demand for medical care is contingent on its ability to continuously recruit medical professionals. Accordingly, VA must have the programs and funding in place to attract those employees. This bill would assist in accomplishing that goal.

Similar to H.R. 2123, this bill would also authorize VA medical professionals to provide telehealth services to veterans across state lines, irrespective of whether the veteran or the provider are physically located in a federally-owned facility. MOPH fully supports this provision.

Chairman Roe, Ranking Member Walz, this concludes my statement. Once again, I thank you for inviting me to submit our views, and I would be happy to answer any questions for the record that you or any other Members of the Committee may have.

Disclosure of Federal Grants and Contracts:

The Military Order of the Purple Heart (MILITARY ORDER OF THE PURPLE HEART) does not currently receive, nor has MILITARY ORDER OF THE PURPLE HEART ever received any federal money for grants or contracts other than the routine allocation of office space and associated resources at government facilities for outreach and direct veteran assistance services through its Department of Veterans' Affairs accredited National Service Officer Program.