STATEMENT OF
THE HONORABLE DAVID SHULKIN, M.D., SECRETARY OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Good morning, Chairman Roe, Ranking Member Walz, and Members of the Committee. Thank you for inviting us here today to present our views on bills on the agenda today, including very critical legislation to improve—in a comprehensive way—the delivery of health care to Veterans. Joining me today are Carolyn Clancy, Executive in Charge, Veterans Health Administration, and Dr. Laurie Zephyrin, Acting Deputy Under Secretary for Health for Community Care.

We greatly appreciate the Committee including the Administration's proposal for comprehensive improvements to the Department of Veterans Affairs' (VA) Community Care program, the Veteran Coordinated Access & Rewarding Experiences (CARE) Act. We look forward to working with the Committee in the days ahead to continue our dialogue on how we move forward together on the critical and complex issue of how we provide the best possible health care for Veterans, using the best that VA and other health care providers can deliver in a complementary way.

We received a discussion draft from the Committee describing the future of VA Community Care, dated September 19, 2017, and it is this draft we will discuss in this statement. We understand this discussion draft continues to evolve, and we are happy to assist the Committee in this effort.

We are unable at this time to provide views on the following bills: H.R. 2601, the VICTOR Act, H.R. 3642, the Military SAVE Act, a draft bill to furnish mental health care to veterans at community or non-profit mental health providers that participate in the Choice program, and a draft bill to conduct a study of the Veterans Crisis Line. We will be glad to follow up with the Committee on these bills after the hearing.

H.R. 1133 Veterans Transplant Coverage Act of 2017

H.R. 1133 would add section 1788 to Title 38, authorizing the Secretary of Veterans Affairs to provide for an operation on a live donor to carry out a transplant procedure for an eligible Veteran, notwithstanding that the live donor may not be eligible for VA health care. VA would be required to provide to a live donor any care or services before and after conducting the transplant procedure that may be required in connection with the transplant. The bill would specifically authorize the Secretary to furnish this

care at a VA facility or through an agreement or contract with a non-Department entity or provider

VA supports H.R. 1133, contingent on the provision of additional resources to support implementation, although we recommend some clarifications in the bill language. We believe it would be appropriate to limit the duty and responsibility to furnish follow-on care and treatment of a living donor to 2 years after the procedure is furnished by VA. This would be consistent with the recommendations of the United Network for Organ Sharing and the Organ Procurement and Transplant Network. We further recommend that the duty to provide follow-on care and treatment should be limited to that which is "directly related to" the living donor procedure (rather than what "may be required in connection with such procedure," as the bill would provide).

There are other potential issues related to organ transplantation that the bill does not address that we would be pleased to discuss with the Committee in its contemplation of this proposal.

We estimate the bill as written would cost $1.8 million in fiscal year 2018, $9.7 million over 5 years, and $21.5 million over 10 years.

H.R. 2123 Veterans E-Health and Telemedicine Support Act of 2017

Section 2(a) of H.R. 2123, the "Veterans E-Health and Telemedicine Support Act of 2017," would amend title 38, United States Code (U.S.C.), to add a new section 1730B, which would permit a covered health care professional to practice their health care profession at any location in any state, regardless of where such health care professional or the patient is located, if the health care professional is using telemedicine to provide treatment under chapter 17 of title 38. New section 1730B would specify that this authority would apply regardless of whether the covered health care professional is located in a facility owned by the Federal Government. In addition, new section 1730B would state that nothing in that section would be construed to alter any obligation of the covered health care professional under the Controlled Substances Act (21 U.S.C. 801 et seq.). New section 1730B would define "covered health care professional" to mean an individual who: (a) is employed by VA and appointed under the authority of sections 7306, 7401, 7405, 7406, or 7408 of title 38, or title 5; (b) is authorized by the Secretary to provide health care under chapter 17 of title 38; (c) is required to adhere to all quality standards relating to the provision of telemedicine in accordance with applicable VA policies; and (d) has an active, current, full, and unrestricted license, registration, or certification in a state to practice the health care profession of the health care professional.

Section 2(b) would provide a clerical amendment to the table of sections at the beginning of chapter 17 of title 38.

Section 2(c) would require the Secretary, not later than 1 year after the date of enactment of the Act, to submit to Congress a report on VA's effective use of

telemedicine. The report would require specific elements such as the assessment of the satisfaction of Veterans and health care providers with VA telemedicine; the effect of VA-funded telemedicine on the ability of Veterans to access health care; the frequency of use by Veterans of telemedicine; the productivity of health care providers; wait times for appointments; any reduction in the use of in-person services by Veterans; the types of appointments for telemedicine that were provided; the number of requested appointments for telemedicine disaggregated by Veterans Integrated Service Networks (VISN); and any VA savings, including travel costs.

VA supports this bill, which is similar to section 301 of the Administration's Veteran CARE Act and section 4 of one of the draft bills; however, VA prefers the language in section 301 of the Administration's Veteran CARE Act and section 4 of the draft bill to the language in H.R. 2123 for the reasons expressed in our views on those bills.

VA does not have a cost estimate for section 2(a) of the bill at this time. VA estimates that implementation of the one-time reporting requirement in section 2(c) of the bill would cost $17,000.

H.R. XXXX Draft Veteran Coordinated Access & Rewarding Experiences (CARE) Act

VA presented the House and Senate Veterans' Affairs Committees on October 6, 2017, with its draft Administration legislative proposal, the Veteran CARE Act, designed to improve Veterans' experiences with and access to healthcare, building on the best features of VA's existing Community Care programs and strengthening VA's ability to furnish care in its facilities. The bill also would provide new workforce tools to assist in maintaining and strengthening VA's world-class medical staff, enhance business processes to improve financial management of the Community Care program, and strengthen VA's ability to partner with other Federal agencies and streamline VA's real property management authorities.

The bill's provisions would clarify and simplify eligibility requirements, set the framework for VA to continue to build a high-performing network, streamline clinical and administrative processes, implement new care coordination support for Veterans, and merge and modernize community care programs.

The bill would replace the current wait-time and distance eligibility criteria under the Choice Program (30 days/40 miles) with criteria based on clinical need in light of access, quality of care, and convenience.

A description of each provision of the CARE Act follows.

Section 101 of the bill would improve VA's flexibility to meet Veterans' demands for hospital care, medical services, and extended care services by authorizing VA to enter into agreements (Veterans Care Agreements, or VCA) that, in general, would not

be subject to the competition or other requirements associated with Federal contracts, while still subjecting eligible entities and providers to all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.

Section 102 would allow similar flexibility for State Veterans Homes.

Section 111 would create a new section 1730B to allow VA to record an obligation for community care when the amount is certain (i.e., when VA approves the payment of the claim for the incident of care). This provision would reduce the potential for large de-obligation amounts after the funds have expired.

Section 112 would reform VA's payment process to provide prompt payment of all community care.

Section 113 would clarify the payment rates for VA-provided community care..

Section 114 would allow the Secretary to pay a provider for services rendered even if the Secretary has not entered into a contract, agreement, or other arrangement for the furnishing of care and services with that specific provider. This would provide a legal authority for the Department to pay for care or services furnished in good faith by a provider.

Section 121 would amend the existing provision in section 7332(b)(2)(H) that permits VA to disclose protected information to community providers and create a new exception in subparagraph (I) that would allow VA to share records with third parties to recover or collect reasonable charges for care provided. The amendment to existing law would revise subparagraph (H) to clarify that VA could share records with non-Department providers for the purpose of furnishing hospital care, medical services, or extended care services to an individual and for performing other health care-related activities or functions. This authority would also allow VA to disclose medical records for purposes of billing, thereby increasing VA's ability to recover funds from Veterans' other health plan contracts or other responsible third parties for care furnished by VA.

Sections 131 and 132 would strengthen VA's ability to collect reimbursements due for non-service-connected care from health plan contracts and third parties responsible for the payment of such care.

Section 201 would amend section 1703 to establish the eligibility criteria for the consolidated VA Community Care program to improve Veterans' access to community care. The bill would provide for a clinically-driven referral process that would enable a Veteran to access community care if the service they need is not available at a VA facility, if the Department could not schedule an appointment for the Veteran within a clinically acceptable period of time, or if the Veteran and the Veteran's primary care provider agree that it would be in the best medical interest of the Veteran to receive care in the community. In making the determination regarding the best medical interest, the Secretary would consider, for example, the distance the Veteran would travel for

such care, the nature of the care or services required, and the frequency that such care or services need to be furnished.

In addition, Veterans would be authorized to opt to receive community care if the Secretary determines that a certain type of care furnished by a VA facility does not meet the quality and access standards of the Department. The Secretary would make regular determinations once each year and would have the authority to limit access to community care by the type of care or service required, the length of time such services would be available, and where such services would be available.

Decisions under either of these scenarios would be considered clinical determinations and outside the jurisdiction of the Board of Veterans' Appeals.

Section 202 would create a new section 1725A to provide Veterans access to walk-in care from community providers that are part of VA's community care network to ensure their access to care when minor injury or illness arises.

VA would be required to develop procedures to ensure that enrolled Veterans who have received care from VA within the prior 24 months are able to access walk-in care from qualifying non-Department entities or providers.

Section 211 would amend section 802 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) to authorize VA to use the existing Veterans Choice Fund to pay for any health care services under Chapter 17 of Title 38 at non-VA facilities or through non-Department providers furnishing care in VA facilities.

Section 221 would repeal and amend current authorities to account for the changes to section 1703 made by section 201 of the bill.

Section 301 would create a new section 1730C to authorize VA health care professionals to practice in any state, including by telemedicine, notwithstanding the location of the health care provider or the patient.

Section 302 would rescind section 7409, which is VA's authority to contract for scarce medical resources. This authority has not been used by VA recently as other authorities are sufficient to fulfill the purpose of section 7409.

Section 303 would authorize VA to increase the number of graduate medical education residency positions at covered facilities by up to 1,500 positions in the 10-year period following enactment of this Act. The Secretary would be authorized to provide a stipend and other benefits for residents appointed under this section, whether they are assigned in a Department facility or not. Individuals would be required to apply to participate and agree to serve a period of obligated service in return for payment of educational assistance. These benefits and requirements would apply solely to the new positions and will assist the Department in determining whether such a program is attractive to graduate medical education residents.

Section 304 would repeal section 705 of VACAA (Public Law (P.L.) 113-146; 38 U.S.C. 703 note), which currently prescribes limits on awards and bonuses that can be paid to VA employees through fiscal year 2024.

Section 305 would amend 38 U.S.C. § 7411 to include authority to reimburse continuing professional education for full-time board certified Advanced Practice Registered Nurses.

Section 306 would modify 38 U.S.C. § 7309 to remove the requirements for the Chief Officer of the Readjustment Counseling Service (RCS) to have at least 3 years of experience in providing and administrating direct counseling services or outreach service that is specifically within RCS. This would expand the pool of applicants for the RCS Chief Officer position.

Section 307 would enact a technical correction to ensure that individuals appointed under 38 U.S.C. § 7401(4) can be compensated within the full-range for Senior Executive Service pay, $124,406 to $187,000. Section 207 of the VA Accountability and Whistleblower Protection Act of 2017 (P.L. 115-41) allows for an individual to have their pay set up to $187,000, but because the Act failed to amend 38 U.S.C. § 7404(d), it prevents such an individual from being paid more than $151,700.

Section 308 would expand the definition of compensation to include pay earned by employees when performing duties authorized by the Secretary or when the employee is approved to use annual, sick, family medical, military, or court leave, or other paid absences for which pay is not already regulated.

Section 309 would amend 38 U.S.C. §§ 7455 and 7401 to include Certified Clinical Perfusionists in the list of excepted positions and convert such positions to full Title 38 status to assist in the recruitment and retention of highly skilled Perfusionists.

Section 321 would amend section 8104(a)(3)(B) to redefine the term “major medical facility lease,” providing a cost increase to a dollar threshold that was last changed in October 2008.

Section 322 would amend sections 8101 and 8104 to expand VA’s capacity to do more detailed planning and design, leasing, and construction of joint facilities in an integrated manner.

Section 323 would amend section 8104(a)(3)(A) to exclude the Department’s non-recurring maintenance projects from the definition of a “major medical facility project.”

Section 324 would amend section 8162 to improve VA’s Enhanced-Use Lease (EUL) authority. Specifically, it would modify section 8162(a)(2) to allow the Secretary to enter into new EULs if the lease will not be inconsistent with or adversely affect the

Department's mission and will either enhance the use of the property or be for the provision of "supportive housing" as defined in section 8161(3).

Section 401 would allow VA and DoD to collaborate to carry out a joint pilot program to determine the feasibility and advisability of sharing health care resources without entering into reimbursement agreements for such services.

Section 501 would amend section 101(p) of VACAA to modify the termination date for the Veterans Choice Program. VA would have authority to authorize care and services under the Veterans Choice Program through September 30, 2018, and would be able to complete all episodes of care authorized on or before that date.

Section 502 would authorize to be appropriated to the Veterans Choice Fund established by section 802 of VACAA, as amended, $4,000,000,000 in mandatory funds.

Section 503 would extend until 2027 the requirement that, in computing cost-of-living adjustments for disability compensation and dependency and indemnity compensation, increased monthly rates and limitations must be rounded down to the nearest whole dollar amount.

Section 504 would amend section 3313 to impose tuition and fee payment caps at Institutions of Higher Learning with flight training programs and establish that only flight courses determined necessary for completion of a degree program may be approved for payment.

Section 505 would amend section 5503(d)(7) to extend by 1 year until September 30, 2028, VA's authority to reduce the amount of pension furnished by VA for certain Veterans covered by Medicaid plans for services furnished by nursing facilities.

Section 506 would amend section 3729 to extend by 1 year until September 30, 2028, VA's authority to continue collecting home loan fees at their current rates.

VA strongly supports enactment of all of these provisions. We will continue to work closely with the Committee as we create additional legislative proposals to strengthen our ability to modernize the VA healthcare system and to develop innovative ways of delivering high-quality, timely healthcare to our Nation's Veterans.

H.R. XXXX Draft Bill to Establish a Permanent Veterans Choice Program

Description of Discussion Draft

The draft bill contains a number of provisions amending different authorities related to VA's Community Care program. Section 101(a) would create a new section 1703A in title 38, U.S.C., titled "Veterans Choice Program." Proposed section 1703A(a) would broadly require the Secretary, subject to the availability of appropriations, to furnish hospital care and medical services to eligible Veterans, at the election of the Veteran, through contracts or agreements with network providers. The Secretary would be required to establish regional networks of providers and would be required to determine the regions based on annual capacity and market assessments of the VISN; such assessments would be required by a later provision of this bill.

Proposed § 1703A(b) would require the Secretary to assign each Veteran upon enrollment into the VA health care system to a VA patient-aligned care team (PACT) or otherwise to a dedicated primary care provider of the Department. If the Secretary were unable to assign a Veteran to a VA PACT or primary care provider, the Veteran would select a community primary care provider from a list of such providers among network providers in the Veteran's community. Each year, the Secretary would determine if the Veteran could be assigned to a VA PACT or primary care provider and make such an assignment if able. VA could only furnish specialty care or services to eligible Veterans upon the referral from the Veteran's primary care provider. The Secretary would determine whether or not to furnish such specialty care in a VA facility, through a network provider, or pursuant to another agreement where a non-Department provider furnishes care in a VA facility or a VA provider furnishes care in a non-Department facility. In determining where to furnish the care, the Secretary would give priority to VA medical facilities and providers, but would take into account several factors, including whether the Veteran faces an unusual or excessive burden in accessing such specialty care based on several criteria and whether the Veteran's primary care provider recommends the care be furnished by a network provider.

Proposed § 1703A(c) would require the Secretary ensure that, at the election of an eligible Veteran receiving care and services under this section, the Veteran receives care through the completion of the episode of care, including all specialty and ancillary services determined necessary by the provider. If the provider were a network provider, the provider would consult with the Secretary to determine which specialty and ancillary services are necessary.

Proposed § 1703A(d) would require the Secretary to enter into contracts or agreements with network providers to furnish care and services to eligible Veterans under this section. The Secretary would be required to negotiate rates for the furnishing of care and services under this section. In general, reimbursement rates could not exceed the Medicare rate, although the bill includes six exceptions to or conditions on this requirement. Under proposed § 1703A(d)(5), the Secretary could compensate a provider for furnishing care and services if any part of care or services were furnished

by a medical provider who was not a network provider, but the Secretary would be required to take reasonable efforts to enter into a contract or agreement with that provider.

Proposed § 1703A(e) would require the Secretary to ensure that claims for payments for care and services furnished under this section are processed in accordance with the prompt payment standards articulated in this subsection. This requirement would apply regardless of whether the claim was made by a network provider to the Secretary, by a network provider to a regional network, or by a regional network to the Secretary. This subsection would define deadlines for submission and payment of claims for covered claimants and covered payers.

Proposed § 1703A(f) would require an eligible Veteran to pay a copayment for the receipt of care or services under this section only if the Veteran would have owed a copayment for the receipt of such care or services at a VA medical facility and such copayments could not exceed what the Veteran would have owed if the care or services were furnished at a VA medical facility. VA would be authorized to recover or collect reasonable charges from a health care plan for care or services for a non-service-connected disability in accordance with section 1729 of title 38, U.S.C.

Proposed § 1703A(h) would require the Secretary to ensure that the Veterans Health Identification Card, or its successor, includes sufficient information to act as an identification card for an eligible entity or non-Department facility. The Secretary would not be authorized to use any available funds to issue separate identification cards with respect to care or services furnished under this section.

Proposed § 1703A(k) would require the Secretary, on an annual basis, to assess the capacity of each VISN and VA medical facility to furnish care and services under chapter 17 of title 38, U.S.C., including how network providers can fill gaps in care or services. In forecasting short- and long-term demand, the Secretary would have to forecast based on future projections, rather than historical trends.

Proposed § 1703A(l) would require the Secretary to develop a plan to allocate funds from the Medical Community Care account and such plan would have to be modeled on the Veterans Equitable Resource Allocation system or any successor system.

Section 101(b) would make various conforming amendments to reflect this new authority.

Section 101(c) would amend section 1701 of title 38, U.S.C., to include definitions of the terms “network provider” and “Veterans Choice Program.”

Section 101(d) would prohibit this Act, and the amendments made by this Act, from being construed as affecting the Secretary’s obligations under contracts or

agreements for the furnishing of care or services under contracts or agreements entered into before this Act's enactment.

Section 102 would require, by the implementation date of the new Veterans Choice Program created by section 101, VA's Chief Information Officer to ensure the information technology system used by VA to receive, process, and pay claims under the Veterans Choice Program includes a number of specific elements.

Section 103 would provide that funding to carry out the Veterans Choice Program would be derived from the Medical Community Care account. It would further provide that any amounts in the Veterans Choice Fund would be transferred to the Medical Community Care account on the date that is 1 year from the date of the enactment of this Act. Section 802 of VACAA (P.L. 113-146, 38 U.S.C. 1701 note), which established the Veterans Choice Fund, would be repealed, and section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41) would be amended to allow for the use of the Medical Community Care account for the Veterans Choice Program.

Section 104 would terminate VA's authority in section 1703 effective on the date the Secretary certifies to the Committees on Veterans' Affairs of the House of Representatives and the Senate that the Secretary is fully implementing section 1703A, as established by section 101 of this bill. It would further make conforming repeals to a number of authorities in title 38 and title 42 to reflect the new program's authority and to repeal other authorities.

Section 105 would require the Secretary to commence operation of the new Veterans Choice Program established by section 101 of this bill by not later than 1 year from the date of the enactment of this Act. Before commencing the new Veterans Choice Program, the Secretary would be required to certify to the Committees on Veterans' Affairs of the House of Representatives and the Senate that each network provider and non-Department health care provider that furnishes care or services under the new section 1703A has been trained to furnish such care and services under this program, and that each VA employee that refers, authorizes, or coordinates such care or services is trained to carry out this program. It would also require the Secretary to establish standard, written guidance for network providers, non-Department health care providers, and any non-Department administrative entities acting on behalf of such providers with respect to the policies and procedures for furnishing care or services under such section.

Section 106 would establish a new section 1703B in title 38, U.S.C., authorizing the Secretary to enter into Veterans Care Agreements (VCAs) with certain providers. Under proposed § 1703B(a)(2), these VCAs could be entered into to furnish hospital care, medical services, and extended care services when the Secretary determines that it would be impracticable or inadvisable to furnish care to a Veteran at a VA facility or through contracts or sharing agreements otherwise established by the Secretary.

Proposed § 1703B(c) would define eligibility criteria for providers. First, the gross annual revenue of the provider under contracts or agreements entered into with the Secretary in the preceding year could not exceed $2 million, as adjusted in a manner similar to the amounts adjusted pursuant to section 5312 of this title. Second, the provider could not otherwise provide care or services to patients pursuant to a contract entered into with a Federal department or agency. Third, the provider would have to be a Medicare or Medicaid provider or supplier; an Aging and Disability Resource Center, an area agency on aging, or a state agency; or a center for independent living. The provider would also have to meet any further criteria determined appropriate by the Secretary.

Proposed § 1703B(d) would require the Secretary to establish a process for the certification of eligible providers to enter into VCAs under this section.

Proposed § 1703B(e) would stipulate a number of terms in these agreements. In general, payment under VCAs would be limited to the Medicare rate, but VA could pay higher amounts in six different situations or areas.

Proposed § 1703B(f) would provide that the Secretary could enter into a VCA using procedures other than competitive procedures. In general, eligible providers that enter into a VCA would not be subject to any provision of law that providers of services and suppliers under the original Medicare fee-for-service program or the Medicaid program are not subject to. Providers entering into a VCA would be subject to any applicable law regarding integrity, ethics, or fraud, or that subject a person to civil or criminal penalties. Providers would also be subject to certain identified provisions of law, including Title VII of the Civil Rights Act of 1964, to the same extent as such title applies with respect to the eligible provider in providing care or services through an agreement or arrangement other than under a VCA.

Proposed § 1703B(g) would allow an eligible provider and VA to terminate a VCA at such time and upon such notice as the Secretary may specify.

Proposed § 1703B(h) would require the Secretary to establish administrative procedures for eligible providers to present any dispute arising under or related to a VCA.

Proposed § 1703B(i) would authorize the Secretary to compensate a provider who is not an eligible provider, but who furnished hospital care, medical services, or extended care to an eligible Veteran pursuant to a VCA. The Secretary would be required to make reasonable efforts to enter into a VCA with any provider who is compensated under this subsection.

Proposed § 1703B(j) would require the Secretary to report by October 1 of each year after VA has first begun using VCAs a list of all VCAs entered into as of the date of the report.

Proposed § 1703B(k) would require the Secretary, in carrying out this section, to use the quality of care standards set forth or used by the Centers for Medicare & Medicaid Services.

Proposed § 1703B(l) would allow the Secretary to delegate the authority to enter into or terminate a VCA, or to make a determination under the dispute resolution procedures referenced in subsection (h)(2), at a level not below the Assistant Deputy Under Secretary for Health for Community Care.

Section 201 would amend section 1725(c) of title 38, U.S.C., to require the Secretary to treat such services as emergency services for which reimbursement may be made under this section if the Secretary determined that the request for ambulance services was made as a result of the sudden onset of a medical emergency and that the individual was transported to the closest and most appropriate medical facility capable of treating the emergency medical condition. These amendments would apply with respect to ambulance services provided on or after January 1, 2018.

Section 202 would amend section 7332(b) of title 38, U.S.C., to authorize the disclosure of certain medical records of Veterans to a public or private health care provider to provide treatment or health care to a shared patient, and to third parties in order to recover or collect reasonable charges for care furnished to a Veteran for a non-service connected disability under section 1729 of title 38, U.S.C.

Section 203 would establish that copayments required by chapter 17 of title 38, U.S.C., would apply notwithstanding any other provision of law that would allow the Secretary to offset a Veteran's copayment obligation with amounts recovered from a third party under section 1729.

Commentary on Discussion Draft

First, we would like to thank the Committee for their hard work in preparing this discussion draft and for your willingness to share prior drafts with the Department for discussion and consideration, including the Committee's October 3 Roundtable. We look forward to continuing to collaborate closely on the future of VA Community Care.

We recognize that both the Committee and the Department are committed to developing legislation on the future of VA Community Care, and we believe there is a fair amount of alignment between the Department's proposed Veteran CARE Act and the discussion draft.

There are a number of provisions in this bill that are consistent with the Department's proposals. For example, the discussion draft provides broad flexibility in payment rates, which we have found to be important in ensuring we are able to bring the most talented providers into our network to furnish care to Veterans. We appreciate the legislation's recognition of the role of contractors in establishing the provider network and in the importance of conducting market assessments to determine what

services are available in VA and the community. The discussion draft also clarifies prompt payment standards in ways that generally match the Department's proposal. We appreciate the discussion draft's efforts at providing clear funding for this program and in consolidating existing authorities to streamline community care. The discussion draft would further authorize VA to enter into VCAs, which is a critical authority for furnishing Veterans with timely and appropriate care when other options (such as care within the Department or obtained through other contracts or agreements) are not available. The discussion draft would give VA more authority to share records for shared patients and would also eliminate the current process whereby VA offsets a Veteran's first party copayment liability through use of funds received from their other health insurance or third-party payer.

There are some important differences in our approaches, however, that we wish to highlight in our statement.

Initially, the discussion draft defines eligibility for a Veteran to make a choice to receive community care in a manner that is considerably different from the Department's proposal. The Committee's discussion draft, for example, defines Veteran eligibility to choose to receive community care based on whether or not VA is able to assign the Veteran to a primary care provider of the Department. We are concerned that this approach is narrow and relies upon administrative, rather than clinical, criteria. We further believe that in operation, this could produce confusion among Veterans, as well as among VA and community providers. The discussion draft would allow any Veteran to receive community care, but the decision where to furnish such care would largely be in VA's control, except for those who are unable to be assigned a VA primary care provider and thus are able to select a primary care provider from a list of primary care providers. The Department's proposed CARE Act would base eligibility for all community care on clinical factors and the Veteran-provider relationship. We believe this is a more appropriate approach to determining whether or not a Veteran should receive community care, as it empowers Veterans and their providers to work together to make these decisions.

Furthermore, the scope of the Veteran's choice is noticeably different between the two proposals. Under the discussion draft, Veterans would only be able to choose a community primary care provider if VA were unable to assign the Veteran to a Department primary care provider. If VA had enough primary care providers, Veterans would have no choice in terms of where they receive care. Under the Department's CARE Act, Veterans and their VA providers would collaborate to determine the most appropriate place to receive subsequent care.

A third concern is the discussion draft's reliance on a clear distinction between primary and specialty care. We understand the Committee's intent with this approach, but we have found in practice that the distinction between primary and specialty care is not all that clear. Certain services that would generally be considered specialty care, such as audiology and optometry, are now available at VA facilities without a referral from a primary care provider. Additionally, through the current Veterans Choice

Program, VA authorizes the full episode of care, including necessary specialty and ancillary services, to be furnished by community providers when needed. The discussion draft's approach would interrupt these referral patterns and create confusion among Veterans and community providers alike. It would also increase VA's workload without an appreciable improvement in patient care or care coordination.

Finally, while we appreciate the Committee's inclusion of provider agreement authority, we are concerned that, as drafted, this provision would only address some of the problems that require the use of such agreements in the first place. Provider agreements are intended as a backup only in cases where our contracted network cannot provide the care a Veteran requires. The discussion draft would impose a cap of $2 million on how much VA could spend in a year through a provider agreement. In our experience, providers of certain services or in certain areas have exceeded this threshold, and such providers would generally be unable to comply with the requirements of a Federal contract. For example, the top nine highest value provider agreements currently in effect (all of which are in excess of $2 million) are with providers of homemaker/home health aide services, but these organizations could not operate and furnish these services if they were subject to Federal contracting requirements. We also note that the requirement that each provider agreement be signed by someone at or above the level of the Assistant Deputy Under Secretary for Health for Community Care would be administratively burdensome and create a bottleneck that could impede Veterans' access to care. We understand the intent behind these and similar limitations, but we caution against constraining our authority in this area. We would be pleased to discuss this further with the Committee.

We look forward to working closely with the Committee on its draft bill as well as concepts and provisions in the draft Veterans CARE Act. Together I know VA and Congress can provide the comprehensive improvements Veterans deserve.

H.R. XXXX Draft Bill on Agreements with State Homes, Graduate Medical Education Expansion, and Other Matters

Section 1 of the draft bill would amend section 1745 to authorize the Secretary to enter into agreements with State Veterans Homes that would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. State Homes entering into these agreements would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to State homes entering into these agreements. These changes would become effective upon the Secretary's publishing regulations to implement these new authorities.

We generally support section 1, although we have some concerns with respect to the applicability of certain laws. Section 102 of the Administration's CARE Act, we

believe, includes language that addresses these concerns, and we support enactment of our proposed language.

Section 2 of the draft bill would create a new section 1730B in title 38 authorizing the Secretary to record as an obligation of the United States Government amounts owed for hospital care or medical services furnished at non-Department facilities on the date on which a claim is approved, rather than the date on which the services are authorized.

Section 2 of the draft bill is similar to section 111 of the Administration's Veteran CARE Act, but we prefer the language in the Veteran CARE Act for several reasons. First, the Veteran CARE Act's language is not discretionary. Second, the Veteran CARE Act's language includes additional services by using the term "health care" instead of the more limited "hospital care or medical services" in section 2 of the draft bill. Third, the Administration's Veteran CARE Act delays the effective date of these changes until the beginning of the next fiscal year after enactment. This would allow VA to begin a fiscal year using a common approach, rather than attempting to change how obligations are recorded during the middle of a year, which could create administrative confusion and budgeting issues.

Section 3 of the draft bill would require the Secretary to carry out a program of educational assistance (which would be determined by the Secretary) to encourage individuals to fill currently unfilled graduate medical education residency positions established pursuant to section 7302 of title 38 and section 301(b)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146, as amended). This section further provides terms and conditions relating to administration of this benefit,

This section is similar to section 303 of the Administration's Veteran CARE Act, and we prefer the language in the Veteran CARE Act, as it is discretionary and would provide greater flexibility to the Secretary in terms of recruiting residents and offering them benefits (in particular when they are not at a VA facility).

Section 4 of the draft bill would create a new section 1730B that would authorize VA health care providers to practice, regardless of their location within a State, their health care profession, including through the practice of telemedicine. Such authority would extend to situations where the provider is not located on Federal property. It would specifically invoke Federal Supremacy to protect VA health care providers operating within the scope of their employment from any adverse action by a state or local government based upon their Federal employment. It would also require a report on how this authority has affected the use of and satisfaction with telemedicine by VA providers and patients.

VA strongly supports section 4 of the draft bill, which matches section 301 of the Administration's draft Veteran CARE Act. We have one minor technical edit to offer, amending the proposed section 1730B(a) to refer to "the direction of the Secretary," rather than "the discretion of the Secretary." While VA has published a proposed rule to assert Federal Supremacy for telemedicine providers, this legislation would go further by providing statutory protection and by codifying VA's longstanding practice of allowing VA providers to practice in any state as long as they are licensed in a state. We greatly appreciate Congress' attention to this issue and inclusion of this proposal in the draft bill.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to answer any questions you may have.