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***STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Chairman Isakson, Ranking Member Tester, Distinguished Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing to examine the Department of Veterans Affairs (VA) Veterans Choice program and the future of care in the community.

As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Today's hearing is critically important to DAV as most of our members choose and rely heavily or entirely on VA health care.

In the VA health care system, too many veterans are experiencing uneven and delayed access to quality veteran-centered care because of a "disconnect in the alignment of demand, resources and authorities" for VA health care.¹ Even before the Veterans Choice program was established as authorized by the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146), VA facilities had limitations on the services it could offer due to a variety of factors, including changing veteran demographics, aging facilities and the types of providers that could be recruited and retained at different regions of the country. VA's legacy purchased care programs, such as fee basis, were generally used to address a VA facility's limited availability of clinical services, the distance that veterans would have to travel to receive care at a VA facility, and the amount of time veterans had to wait for an appointment.

Additionally, the manner in which VA historically referred veterans to community care was fragmented. VA did not track how long it took for veterans to be seen when referred to a community provider, the quality of care they received in the community, how it impacted veterans' health outcomes, or veterans' satisfaction. We frequently heard complaints that due to limited resources, VA providers were not allowed to send veterans to the community resulting in delayed access to needed care.

¹ Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare (operated by MITRE Corporation). "Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume I: Integrated Report." https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf

Yet these issues persisted. Born out of the waiting list scandals and access crisis that culminated in the spring of 2014, the Choice program was authorized and implemented but has never fully met Congress' or veterans' expectations.

Despite a difficult and complex national rollout mandated in just 90 days, VA quadrupled the number of Choice authorizations from fiscal year (FY) 2015 to FY 2016. Veterans received more than 2.5 million Choice program appointments, and VA is poised to provide even more care in the community in FY 2017.

We applaud Congress' work with VA to enact Public Law 115-26, which extended the Choice program until all of the remaining choice funds have been spent and to ensure continuity for veterans who access care through this program. As this Committee is aware, DAV supported this law as a short-term and temporary measure to ensure that veterans using the Choice program do not fall through the cracks while waiting for realistic and meaningful reforms to be enacted and implemented.

DAV believes the current Choice program should continue to be used as a short-term solution, but only for as long as necessary to enact and implement a long-term solution based on a comprehensive plan to build an integrated, high performing network with a modernized VA health care system seamlessly working with other federal and community providers.

As this Committee is aware, problems remain in the Choice program and we continue to receive complaints from veterans and community providers. The Commission on Care also found, "[t]he design and execution of the *Choice Program* are flawed."² As such, DAV does not believe the Choice program should be expanded to new categories of veterans. Absent a high-performing integrated network, putting more veterans into the Choice program could result in less coordination of care, increased fragmentation of services, lower quality and ultimately worse health outcomes for more veterans. In addition, even a limited expansion of the current eligibility for the Choice program would add significant fiscal costs at a time when demand for VA health care is already rising faster than resources provided by Congress.

While the Choice program relieves some of the demand for VA medical care, it does not have the necessary elements to serve as a solid foundation for the future of community care. The underlying law has been fundamentally amended twice, the original contract has been modified over 70 times, 23 letters of correction have been issued to the contractors, and there are a number of pending and draft bills to amend the Choice program—yet necessary improvements to the overall VA health care system remain largely unaddressed.

Thus, if the Choice program ends without an effective, comprehensive replacement, there would be tremendous dislocation and hardship for hundreds of thousands of veterans who would find themselves unable to access timely care in an already overburdened VA health care system.

² Commission on Care. "Final Report" June 30, 2016. <https://commissiononcare.sites.usa.gov/>

Beyond the Choice Program:

Over the past year, DAV, along with our partners in the *Independent Budget* (IB) (Paralyzed Veterans of America and Veterans of Foreign Wars), other major veterans service organizations (VSOs), VA Secretary Shulkin, the Commission on Care and many Members of the House and Senate, have discussed, debated and ultimately coalesced around a common long-term vision for reforming the veterans health care system. All support the concept of developing an integrated network that combines the strength of the VA health care system with the best of community care to offer seamless access for enrolled veterans.

Yet there is a continued push by some for unfettered and unlimited choice. In our opinion, such pursuit of this unrealistic and narrow goal to expand access to care without a plan for containing costs and ensuring quality is unwise and unsustainable. Access to care without a focus on quality should not be the objective, nor should reducing cost at the expense of quality be acceptable. The pyrrhic goal of unfettered and unlimited choice also carries with it the potential to delay and distort realistic plans to move forward with implementing the shared vision of the veterans community and most active users of the VA health care system. We must not let this generational opportunity to reform VA health care to be encumbered by lack of a clear strategy toward an overarching goal to build an integrated, high performing network with a modernized VA health care system seamlessly working with other federal and community providers.

Veterans should not have to wait any longer to move forward with true and meaningful reform that keeps VA as the coordinator and primary provider of care. Even with the additional options of the Choice program, veterans in general overwhelmingly prefer to use VA.³ DAV strongly urges this Committee, Congress, and the Administration to honor the clear preference of the vast majority of veterans who choose to use the VA health care system—a system created to meet their unique needs.

In 2015, DAV and our IB partners developed our proposed Framework for Veterans Health Care Reform based around four main pillars. First, we proposed restructuring the veterans health care delivery system by creating local integrated veteran-centric networks to ensure that all enrollees have timely access to high quality medical care. VA would remain the coordinator and primary provider for most veterans. We also called for establishing a veteran-managed community care program to ensure that veterans living in rural and remote areas have a realistic option to receive veteran-centric, coordinated care wherever they may live. This would require local communities to work with VA's Office of Rural Care to develop relationships with local providers, as well as increased flexibility in reimbursement rates to attract and retain community partners.

Our second pillar for reform called for redesigning the systems and procedures that facilitate access to health care by creating a new urgent care benefit and taking other actions to expand access to care, such as extended hours in evenings and on weekends, as well as increased use of telehealth. We recommended that as the new integrated networks are fully phased in, decisions about providing veterans access to community network providers should be based on

³ Of the over 1.2 million veterans who have received some community care in the Choice program, only about 5,000 veterans used the Choice program as their sole health care provider. United States. Cong. House. Committee on Veterans' Affairs. Hearings, Mar. 7, 2017. 115th Cong. 1st sess. Washington: GPO, 2017.

clinical determinations and veteran preferences, rather than arbitrary time or distance standards that exist in the current Choice program.

Third, we proposed realigning the provision and allocation of VA's resources to better reflect its mission by making structural changes to the way federal funds are appropriated, distributed and audited. Our plan calls for strengthening VA's budget and strategic planning process by establishing a Quadrennial Veterans Review, similar to the Quadrennial Defense Review currently used by the Department of Defense.

The fourth and final pillar of our framework called for reforming VA's culture with transparency and accountability. In this regard, we strongly support the MyVA initiative, which has already resulted in good progress in making system-wide changes putting veterans in the center of VA's planning and operations, so that their needs and preferences are paramount.

A High Performing Health Care System:

To address salient questions about how expanding access to and options for veterans health care will affect overall costs, it must be considered in terms of being cost effective while achieving the best outcomes and quality of life for veterans. Private sector providers and regional health organizations have been working more rapidly in recent years from volume and profitability of services towards providing holistic, patient-centered and coordinated care—the kind of care that VA strives to provide to all veteran patients. DAV believes that to provide holistic, veteran-centric and coordinated care while increasing access in a cost-effective manner, VA must remain the coordinator and primary provider of care in a high performing network, with federal and community partners providing additional expertise and access whenever and wherever necessary.

Coordination of care between VA and community providers is critical because studies have continually shown that lack of coordination increases the risk of unfavorable health outcomes for veterans. For example, a lack of care coordination may lead to unnecessary duplication of services, which is not only costly, but may also pose health risks to veterans who may receive and pay for care that is not needed. Moreover, the quality of care may be adversely affected if important clinical information is not promptly and clearly communicated between VA, federal and community providers.

In order to serve veterans effectively in a seamless integrated network as the coordinator and primary provider of care, VA itself must first be modernized and strengthened to address known gaps and deficiencies. Congress must therefore act to resolve a number of known legislative, policy and budgetary matters, including:

- Consolidating the plethora of statutory authorities⁴ and at least nine distinct programs with different administrative and clinical processes to purchase community care for veterans;

⁴ 38 U.S.C. §§1701 note (Veterans Choice Program), 1703 (Contract Care in the Community), 1703 note (Project Access Received Closer to Home), 1720 (Community Nursing Home Care), 1720C (Home and Community Based Care), 1725 (Emergency Care for Nonservice-connected Conditions), 1728 (Emergency Care for Certain Veterans with Service-Connected Conditions), 1741 (State Nursing Home Care), 1745 (State Nursing Home Medication) 8111 (Health Resource Sharing of VA

- The widening salary gap between private sector and VA to allow the Department to hire and pay the best and brightest;
- Improving VA’s infrastructure to align with veterans’ needs—beginning with VA leases, which have not been authorized since 2012;
- Gaps in VA’s medical care benefits package such as access to urgent care in the community, and differing eligibility for dental care and vision care;⁵
- The inadequate clinical grievance and appeals process available to veterans when there is a difference of opinion between the patient and provider;
- A permanent Provider Agreement authority for VA to purchase such things as in-home and community care for the most severely ill and injured veterans;
- Authority that would allow veterans greater access to telemedicine;
- Modernize its IT system—beginning with a new less cumbersome scheduling system, which allows veterans to self-schedule, allows meaningful health information sharing, simpler authorization and referral, and improved community provider payment systems.

A central piece of a high-performing health system is its ability to empower its patients to make important decisions to protect their health and quality of life. One of the most common sources of patient dissatisfaction is not feeling properly informed about, and involved in, their treatment or in the developing their treatment plan. Shared decision-making—where patients are involved as active partners with the clinician in treatment decisions, to clarify acceptable medical options and choose appropriate treatments. While not all patients want to play an active role in choosing a treatment, most want clinicians to inform them and take their preferences into account.

DAV calls on Congress and the VA to focus on the goal of ensuring a veteran and their doctor—not government bureaucrats—choose when a veteran should receive care in the community. VA must use evidence-based patient decision aids and improve the communications skills of all their health care providers to assist veterans in making informed decisions about their care, improve their knowledge and understanding of different treatment options, and give veterans a more accurate perception of risk, to help veterans identify—not dictate—the most appropriate treatments.

We are supportive of VA’s approach of moving away from using arbitrary wait times and geographic distances in determining when veterans should be given the option to receive care in the community. Through shared decision-making leveraging the relationship between a veteran and their doctor, and using business intelligence about clinical performance and quality of care, this new focus will strike a better balance in using community care to fill gaps in service than unfettered choice. This approach is more likely to be sustainable, a hallmark of good governance and garner higher patient satisfaction.

and Department of Defense), 8153 (Enhanced Sharing Authority, Patient-Centered Community Care), and 25 U.S.C. §1645 (Indian Health Service/Tribal Health Program)

⁵ VA provides audiology and eye care services (including preventive services and routine vision testing) for all enrolled veterans, but eyeglasses and hearing aids are provided only to veterans meeting certain criteria (See 38 U.S.C. § 1707). Eligibility for VA dental care is limited by law and differs significantly from eligibility for medical care (See 38 U.S.C. § 1712).

However, this new approach, much like building an integrated, high performing network with community providers, is a fundamental change culturally and operationally in how VA provides care to our nation's veterans. It will take time and patience and will require collaborative work between Congress, VA, and VSOs.

Community Partners:

VA continues to be challenged in fostering its relationship with community providers. Previous studies by the Government Accountability Office – including its most recent June 2015 report – demonstrate that its claims processing remains largely reliant on staff rather than leveraging IT solutions, resulting in frequent inappropriate actions such as non-payment, delayed payment or incorrect payment amounts. VA must act now to become a trusted and collaborative partner with community providers in order to rebuild lost or damaged relationships, enhance good relationships, and foster new ones.

The Commission on Care also pointed out that community partners must undergo a thorough credentialing process to ensure that all providers have, "...appropriate education, training, and experience, provide veteran access that meets [Veterans Health Administration (VHA)] standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange." That is why the Commission on Care recommended that "[n]etworks be built out in a well-planned, phased approach..."

DAV calls on Congress and the new Administration to begin taking actions necessary for the next evolution of veterans health care to begin. VA health care must become an integrated, high-performing system first before it can serve as the foundation for a larger integrated network with other federal and community providers, one in which all enrolled veterans will have the best experience possible through timely access to comprehensive, high-quality and veteran-focused care.

Resources:

As Congress and VA move forward, it is critical that every legislative action to increase access to care must simultaneously include a commensurate increase in resources. As evidenced in the Choice program, VA saw both increased access to care in the community and increased demand for care in VA, putting a strain on VA's budget.

Last year, then-VA Secretary McDonald indicated the cost implication of increasing demand on VA stating, "[J]ust a one percent increase in Veteran reliance on VA health care will increase costs by \$1.4 billion."⁶ This year's budget request for VA notes the impact of the Choice Act with an increase of 1.89 percent in reliance on VA versus their other health care options,⁷ a roughly a \$2.65 billion increase in needed resources.

⁶ United States. Cong. House. Committee on Veterans' Affairs. Hearings, Feb. 10, 2017. 115th Cong. 1st sess. Washington: GPO, 2017.

⁷ Department of Veterans Affairs Volume II Medical Programs and Information Technology Programs Congressional Submission FY 2018 Funding and FY 2019 Advance Appropriations, pagesVHA-364, 366

Moreover, DAV disagrees with the proposed budgetary approach to use both discretionary and mandatory funds to provide medical care to veterans. VA's community care program must be allowed to compete with other VA medical care programs such as long-term care, mental health and gender-specific care for the same finite resources. Moreover, we vehemently oppose the reduction of veterans compensation as a means to fund the Choice program. Increases in veterans' health care should be paid for by the federal government, not by disabled veterans.

DAV and out IB partners have consistently testified about VA's inadequate resources to purchase community care, cumbersome and confusing purchase care authorities, inadequate IT systems for scheduling, financial and business processing, as well as insufficient resources and ineffective tools to address constrained and aging infrastructure that all hindered VA's ability to meet veterans health care needs on a timely basis. Of these concerns, none has a more direct impact on a veteran's ability to receive care in the community than limited funds provided to local VA facilities, which too often forced them to choose between meeting internal clinical needs or expanding access to community care.

When Congress authorized the creation of the Choice program, they also authorized an "independent assessment" of VA health care to study the causes of and offer solutions for the access problems, resulting in a report by the MITRE Corporation, the Rand Corporation, and others in September 2015. As previously noted, the independent assessment's first finding was that there was a "disconnect in the alignment of demand, resources and authorities" for VA health care. Its first recommendation was that VA must "address the misalignment of demand with available resources both overall and locally." In terms of access to care, it found that "increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years."

The findings of this assessment confirmed what IB veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet its comprehensive mission of care for veterans. While there are many factors that contributed to the access crisis, when there are not enough doctors, nurses, and other clinical professionals or enough usable treatment space to meet the rising demand for care by enrolled veterans, the result will inevitably be rationing of care, waiting lists and access problems. Further proof that demand was greater than VA capacity can be seen in the fact that even as care in the community increased dramatically over the last two years, care inside VA health care facilities still continued to increase, and according to VA 16 percent of its primary care clinics are over capacity today.

If it is not already evident in this testimony, DAV and our IB partners have not suggested that simply increasing funding by itself—without making significant reforms in VA—will lead to better health outcomes for veterans over the next 20 years. However, history shows that no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true demand for services. With more and more veterans seeking VA care as it improves access, Congress will have to continue investing resources to allow VA to keep up with rising demand, or make difficult decisions to restrict enrollment or propose increased fees or copayments for veterans' care.

Mind the Gap:

We are cognizant Choice funds are projected to run out by the end of this year or early next year, and that any legislation enacted by Congress – even if enacted before the end of this fiscal year – will require more than 90 days to implement as clearly evidenced by the recent experience with the Choice program roll-out. Moreover, existing VA community care authorities and programs are not sufficient to serve as a seamless bridge towards a long-term solution of a high performing integrated network combining VA with other federal and community providers. To provide a short-term bridge, we believe VA needs to move forward expeditiously with its Request for Proposal (RFP) that was drafted and issued late last year. The RFP developed by VA in consultation and collaboration with a number of stakeholders, including DAV, would be a natural progression toward the future high performing integrated health care system we all envision.

While continuing to appropriately fulfill its oversight responsibilities, DAV urges Congress to support the Department's efforts to move the RFP process forward so VA can enter into contracts with appropriate national providers before the end of this year to ensure veterans continuity of care so that no one falls through the gap.

Realistic Expectations:

Finally, we urge Congress to work with VA to set realistic expectations for the implementation of these much needed long-term reforms. Many of the supporting systems and technologies necessary to promote a truly seamless integrated network capable of delivering consistently high-quality, veteran-centric and timely care will need to be developed, optimized and customized for VA before full implementation of the new system. Also, while we support the goal of eliminating all access limitations on community care, including the current 40-mile and 30-day choice standards, these limitations can only be phased out as the integrated network becomes fully operational to avoid unintended negative fiscal and clinical outcomes.

The Commission on Care was charged to develop plans to strengthen the VA health care system over the next 20 years. In its report, the Commission makes clear that this is a significant undertaking that will likely take a decade or more to accomplish. The report states: “[t]he fruits of the transformation... will not be realized over the course of a single Congress or a single 4-year administration.” Considering the magnitude and importance of this transformation, it is not only imperative that Congress and VA have the patience and vision for the long haul, but that they begin moving forward now.

Mr. Chairman, after more than three years of spirited and passionate debate in Congress over the future of veterans health care, there is now remarkable consensus on how best to strengthen, reform and sustain the VA health care system. Veterans and their representative organizations, independent experts, VA leaders and many members of Congress agree that the best veterans health care system would consist of integrated networks that combine the strength of VA with the best of community care to offer veterans real choices for quality and timely care. However, in order to build a truly high-performing network, VA must first modernize its own infrastructure, IT and operations before it can begin to integrate with qualified and credentialed community partners.

We look forward to working with you to help fill in the details of such a plan for the next evolution of VA health care and we urge you and your colleagues in the 115th Congress to start implementing this shared vision so that ill and injured veterans can get the care they have earned and deserve, whenever and wherever they need it.

That concludes my testimony and I would be pleased to answer any questions that the Committee may have.