



National Service & Legislative Headquarters  
807 Maine Avenue, S.W.  
Washington, D.C. 20024-2410  
Phone (202) 554-3501  
Fax (202) 554-3581  
[www.dav.org](http://www.dav.org)

***STATEMENT OF  
JOY J. ILEM  
DAV NATIONAL LEGISLATIVE DIRECTOR  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
MARCH 7, 2017***

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

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this hearing to examine the Department of Veterans Affairs (VA) Choice program, as well as plans to consolidate community care programs and reform the VA health care system. 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 because most of our members choose and rely heavily or entirely on VA health care.

Mr. Chairman, in exactly five months the authorization to provide community care through the Choice program – established by the Veterans Access, Choice and Accountability Act (VACAA) (Public Law 113-146) – is set to expire, even though there is projected to be approximately \$1 billion remaining in Choice account at that time. Born out of the waiting list scandals and access crisis in that culminated in the spring of 2014, the Choice program has never met Congress' or veterans' expectations. Despite the difficult rollout of the program, VA saw both increased access to care in the community and increased demand for care in VA. If the Choice program and its resources were to suddenly disappear in August without an effective and functioning 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.

For these reasons, Congress and the new Administration must take action soon to ensure that veterans who currently receive care through the Choice program continue to have access to needed medical services. We urge Congress to pass a temporary extension of Choice while also moving forward with the next evolution of the VA health care system in order to provide all enrolled veterans with timely access to comprehensive, high-quality and veteran-focused care.

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. VA should remain the coordinator and primary provider of care with community partners, including the Department of Defense and Indian Health Service systems, providing additional expertise and access whenever and wherever necessary. That is a system that puts veterans first and gives them real choice. However, the continuing push by some for unfettered and unlimited “choice” is unrealistic and has the potential to delay and distort plans to move forward with implementing the shared vision of the veterans community and active users of the VA health care system. In order to better understand where VA needs to go in the future, it is important to first understand the lessons and problems of the past.

## **BACKGROUND**

Since the catalyst that began this debate was lack of access, it is important to understand the true underlying causes of the access problems facing veterans.

For more than a decade, DAV and our IB partners have testified to Congress about the challenges in accurately measuring and consistently providing veterans with timely access to VA health care; and these testimonies have been validated by outside audits. For example, in December 2012, GAO investigated reports of long wait times for outpatient medical appointments and found that the metrics provided by VHA were “unreliable.” Furthermore, GAO found that VHA’s scheduling policy and training documents were “unclear” and led to inconsistent reporting of wait times. We have also consistently testified about the inadequate scheduling, financial and IT systems, as well as aging infrastructure that all hindered VA’s ability to meet veterans health care needs on a timely basis. Furthermore, the limited funds provided to local facilities too often forced them to choose between meeting internal clinical needs or expanding purchased community care.

The ability of VA to provide veterans timely access to medical care is primarily driven by four factors: how many medical personnel are available to provide medical care (resources), how much usable space is available to treat veterans (infrastructure), how well VA leverages health care capacity in the community (purchased care), and can VA produce accurate and valid data to properly manage access issues (metrics). Each of these interrelated issues challenged VA for years and the inability to fully address them eventually led to the most recent access crisis and subsequently, enactment of the VACAA in 2014.

When Congress created 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. 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,” with a core recommendation of “increasing physician hiring.” The report also identified key barriers that limited provider productivity, including “a shortage of examination rooms and poor

configuration of space,” and “insufficient clinical and administrative support staff,” all of which would require additional funding for the VA health care system.

Furthermore, the assessment found that the “capital requirement for the Veterans Health Administration (VHA) to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen.” It estimated this gap at between \$26 and \$36 billion over the next decade, although management strategies could potentially lower the projected gap down to between \$7 billion and \$22 billion.

The findings of this assessment confirmed what *The Independent Budget* veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet the 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 be rationing of care, waiting lists and access problems.

To be clear, 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 out VA 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.

## **CHALLENGES IMPLEMENTING AND OPERATING THE CHOICE PROGRAM**

As approved by Congress on August 7, 2014, the Choice Program allows certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for required care or to travel more than 40 miles to a VA facility to receive such care. However, despite the scope and scale of the law, VA was required to stand up this nationwide program for potentially all 9 million enrolled veterans in just 90 days.

Since its inception just over 2 years ago, the Choice program has been beset with problems, some resulting from the flawed design of the law and others due to the unrealistic implementation schedule mandated by Congress. Within weeks of the Choice program’s commencement, both veterans and VA health care personnel reported confusion about how, when, and for what types of care the program was to be utilized. Problems with scheduling, health record transfers, care coordination, doctor payments, and veterans’ copayments all hindered usage of the Choice program during its first several months. To address these and other technical and implementation challenges, Congress passed, and the President signed, two subsequent pieces of legislation (Public Law 113-175 and Public Law 114-41) which, among other changes, redefined how to calculate the 40-mile distance criteria for Choice eligibility and removed a requirement that medical records be returned to VA before provider payments were made.

These adjustments, as well as additional training of VA personnel, slowly increased utilization of the program. Today, about 31 percent of all care paid for by VA is delivered through Choice and other community care programs, up from about 22 percent just a couple of years ago. At the same time, the VA is also delivering more care inside its own facilities and wait times are dropping, according to VA, as new access programs, such as same day care, are instituted. The challenge is how to move forward with a long-term solution that continues to close access gaps, while maintaining a robust VA health care system that millions of disabled veterans choose and rely on.

## **DEVELOPING PLANS FOR REFORMING VA HEALTH CARE**

As mandated by Public Law 114-41, VA developed and submitted a plan to Congress in September 2015 to consolidate non-VA community care programs, including the Choice Program. VA's plan called for creating a "high-performing network" comprising both VA and community providers to create seamless health care access for enrolled veterans. In building its network, VA proposed first relying on the most cost-effective, compatible, and highest quality community partners (particularly the Department of Defense [DOD], the Indian Health Service [IHS], and other federal health systems), then university hospitals that have existing academic affiliations with VA, followed by the best of private providers. Under its plan, VA would serve as the coordinator and guarantor of care for veterans to ensure that all veterans have a seamless experience when accessing VA and non-VA care in the community. Most enrolled veterans would continue to get most of their care directly from VA, with network partners filling in access gaps whenever and wherever they occur.

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 veterans-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 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 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.

## **COMMISSION ON CARE**

VACAA also required Congress to create an independent Commission on Care to study and report recommendations to VA and Congress about how to strengthen the VA health care system over the next 20 years. The Commission examined a wide range of ideas and options, including the IB's proposed Framework and VA's Community Care Consolidation Plan. It also considered proposals to privatize or dismantle the VA health care system, but ultimately the Commission rejected such radical ideas, instead reaching an overwhelming consensus on a series of recommendations to strengthen and reform the VA health care system.

The Commission's principal recommendation called for establishment of "high-performing, integrated community-based health care networks." Similar to the VA and IB plans, the Commission recommendation would maintain VA as the coordinator and primary provider of care and use community providers to expand access in circumstances in which VA is unable to meet local demand for care. Unlike the IB framework or VA plan, the Commission proposed allowing veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care in a timely fashion. The Commission itself recognized that this would likely result in higher costs for networks under its recommended "choice" option, cautioning that VA "must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources." In fact, the Commission's economists estimated that the recommended "choice" option could increase VA spending by at least \$5 billion in the first full year and that it could be as high as \$35 billion per year without strong management control of the network. The Commission also considered a more expanded "choice" option to allow veterans the ability to choose any VA or non-VA provider without requiring it to be part of a VA network. The economists estimated such a plan could cost up to \$2 trillion more than baseline projections over just the first 10 years.

The Commission acknowledged that, "veterans who receive health care exclusively through VHA generally receive well-coordinated care . . . [whereas] . . . fragmentation [of medical care] often results in lower quality, threatens patient safety, and shifts cost among payers." While veterans' individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high-quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the commission's report states, "well-managed, narrow networks can maximize clinical quality," while "achieving high quality and cost effectiveness may constrain consumer choice."

With such broad consensus among veteran experts and stakeholders, the question that this Committee and this Congress face is whether to continue debating prohibitively expensive, clinically unsound and politically unrealistic proposals to offer every veteran unfettered “choice,” or whether to move forward and build integrated networks capable of ensuring that all veterans have a real choice for quality care.

## **EXTENSION OF TEMPORARY CHOICE PROGRAM**

Mr. Chairman, with just five months until the current authorization ends, it is critical that Congress work with VA to extend the Choice program to allow VA to utilize all of the remaining funds in the Choice account and to ensure continuity for veterans who access care through this program. H.R. 369, legislation you introduced earlier this year, would accomplish that by removing the sunset date and allowing the program to continue until the funds provided for this program are exhausted. DAV supports this legislation as a short-term and temporary measure to ensure that veterans using Choice do not fall through the cracks while waiting for further reforms, as discussed above, to be enacted and implemented.

However, Choice should be extended on a short-term basis and only for as long as necessary to enact and implement a long-term solution based on the integrated network model. Choice should not be expanded to open up the program to new categories of veterans for both clinical and fiscal reasons. Absent a well-managed, high-performing network, putting more veterans into the Choice program would 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.

In order to ensure continuity, Congress will need to act quickly, however there are additional changes that have been proposed to address related issues with Choice and community care programs, including making VA the first payer, changing when obligations are recorded, and authorizing new provider agreement authority. These changes would strengthen not just Choice, but all community care programs, and are essential to support the creation of an integrated network proposed by DAV, VA, the Commission and others. Whether some or all of these and other improvements to integrated community VA care are included in the legislation to extend the Choice program’s authorization, these changes should be fully debated, carefully drafted and subsequently enacted in order support development of integrated networks necessary to provide veterans with real choices for quality care.

In addition to providing a short-term bridge, VA needs to move forward 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 and other VSOs, would lead to a contracting process with national health care providers capable of serving as VA’s community partners in an integrated network. Given the history of problems standing up the Choice program, it is essential that VA and its new partners have sufficient time to carefully develop and implement the new integrated network model of care. There are, however, a

number of critical issues that still need to be fully resolved before such implementation; including new scheduling and claims payment systems, as well as the ability for sharing health records, providing care management and defining patient eligibility. While continuing to appropriately fulfill its oversight responsibilities, we urge Congress to support VA's efforts to move the RFP process forward so that VA can enter into contracts with appropriate national providers before the end of this year.

Furthermore, Congress must 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 support a truly seamless integrated network capable of delivering consistently high-quality and timely care will need to be developed, optimized and customized for VA before full implementation of the new system. Also, the goal of eliminating all access limitations on community care, including the current 40-mile and 30-day Choice standards, can only be phased out as the integrated network becomes fully operational to avoid unintended negative fiscal and clinical outcomes. Further, the challenge of providing seamless, timely access to veterans living in rural and remote communities will require special attention, creative approaches and sufficient time and resources to be accomplished. The Commission's charge was 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: "The 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 imperative that Congress and VA begin moving forward, now.

## **SETTING THE RECORD STRAIGHT**

Unfortunately, despite the broad agreement among stakeholders and policymakers, there are still some individuals and organizations promoting an unrealistic vision of "choice" without providing any clear definition or specifics, adding confusion and delay. That's why DAV is continuing its "Setting the Record Straight" campaign: to ensure that the cost and consequences of "choice" are understood in any plan that Congress considers. Last month we released a short video entitled "Putting Choice in Context" that explores the real costs and consequences of unrealistic "choice" options, and debunks a number of misconceptions about "choice" and VA health care. For example, the idea that veterans would be able to choose any doctor in their community is simply not true. Some doctors don't accept "choice" payment rates and in many communities, particularly rural America, there are not enough or even sometimes any physicians to choose from. For too many veterans, simply having a "choice" card could leave them without any options to find a qualified physician.

Another false premise is that allowing all veterans to go to private providers would lead to better quality health care and outcomes. The reality is that numerous independent studies by Rand Corp. and others have consistently shown that VA today provides equal or better care than the private sector. Furthermore, if expanding "choice" forces more veterans to receive part of their care in the community – without first establishing a managed and coordinated network, the result will be more care that is fragmented, which can actually lower quality and lead to worse health outcomes for many veterans. Even the idea that "choice" will increase access for veterans is a

much more complicated issue. If “choice” were significantly expanded, moving more veterans to the private sector, VA would almost certainly be forced to significantly downsize or close some hospitals and clinics, and curtail medical services in others due to lesser demand. However, veterans who continue to choose VA for their care would find fewer services being offered, or they would have to travel further or wait longer to receive care. The result for many veterans, particularly disabled veterans who disproportionately rely on VA, could be less access and no “choice” to use VA.

The idea that “choice” is a “magic bullet” capable of solving all of VA’s health care challenges is simply not supported by objective facts, was not the conclusion of the Independent Assessment or Commission on Care and does not have significant support within VA or the veterans community. The use of community care, or “choice,” should certainly be a part of the long-term solution, but only if it fits into the big picture of strengthening and reforming the VA health care system as outlined above.

Mr. Chairman, after more than two years of spirited and passionate debate in the 114th Congress over the future of veterans health care, there is now a growing 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. 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.