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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 Blumenthal, and Members of the Committee:

On behalf of the DAV and our 1.2 million members, all of whom were wounded, injured or made ill from their wartime service, thank you for the opportunity to testify before the Committee today to discuss the implementation of the temporary “choice” program authorized by the Veterans Access, Choice and Accountability Act of 2014 (VACAA), and how it fits into the larger issue of providing high-quality, timely care to America’s veterans.

It has been just over a year since the waiting list scandal exploded in Phoenix; nine months since passage of the VACAA; six months since the first “choice” cards were mailed out; and just over three months since the mailing of nearly 9 million “choice” cards was substantially completed. While it is still far too early to reach significant conclusions about whether this program will achieve its intended purpose, we are now beginning to see the outlines of early lessons from this grand experiment.

Today’s hearing is an appropriate opportunity to examine the challenges VA has faced in implementing this unprecedented, temporary program, to explore some of the reasons for the lower-than-expected usage, to consider changes and improvements to the program so that it can achieve its short-term goal of providing timely and convenient access for veterans seeking health care, and to start the discussion about how best to reform the VA health care system so that we never face this kind of access crisis again.

ORIGINS OF THE VA HEALTH CARE ACCESS CRISIS

Mr. Chairman, in order to evaluate the success of the “choice” program, it is important to understand the underlying causes of the access crisis that precipitated enactment of VACAA. While the scandal that enveloped VA last year certainly involved mismanagement in Phoenix and at other VA sites, we have no doubt that the principle reason veterans were put on waiting lists was the mismatch between funding available to VA and demand for health care from VA by veterans, a phenomenon that is hardly new. In fact, this mismatch has been regularly reported to Congress by DAV, our partners in the *Independent Budget (IB)*, and others for more than a decade.

In May 2003, the bipartisan Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans examined chronic VA funding shortages in the wake of growing waiting lists at VA, which had resulted in the suspension of new enrollments for nonservice-connected veterans. At that time, 236,000 enrolled veterans were already waiting more than six months without any appointments—a much higher number than during last year's crisis. However, despite clear evidence of inadequate funding, successive Administrations and Congresses failed to adequately increase VA funding to address the heart of the mismatch, or to end the moratorium on new enrollment. Unfortunately, that mismatch continues today.

Mr. Chairman, over the past decade, the IB has recommended billions of dollars to support VA health care that the Administration did not request and Congress never appropriated. Over that period, we and our partner veterans service organizations have presented testimony to this Committee and others detailing shortfalls in VA's medical care and infrastructure budgets. In fact, in the prior 10 VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$7.8 billion less than the amounts we recommended. Over the past five budgets, the IB recommended \$4 billion more than VA requested and Congress approved. For this fiscal year, FY 2015, the IB had recommended over \$2 billion more than VA requested or Congress appropriated.

The other major contributor to VA's access crisis is the lack of sufficient physical space to examine and treat all veterans in need of care. Over the past decade, the amount of funding requested by VA for major and minor construction to sustain its medical centers and clinics, compared to the amount appropriated by Congress, has been more than \$9 billion less than what the IB estimated was needed. Over the past five years alone, that shortfall was more than \$6.6 billion, and for this year the VA budget request is more than \$2.5 billion less than the IB recommendation.

Mr. Chairman, we are all aware that funding levels for VA have risen every year for more than a decade, and we appreciate that fact. However, the demand – as measured not only by enrollees and users, but more importantly by the number of appointments – has risen even faster. In addition, the cost of care is rising not just due to medical inflation, but also because of the increased cost of specialized care provided to so many veterans being treated for traumatic physical and mental injuries, many from the ongoing wars in Iraq and Afghanistan. When VA does not have enough physicians, nurses and other clinical staff, and when VA's facilities are not being properly maintained, repaired, replaced or constructed, veterans will be required to wait for care. It was under these circumstances that DAV and many others supported the emergency VACAA legislation last year, but our support was predicated on a number of very important conditions and principles.

BACKGROUND OF THE TEMPORARY CHOICE PROGRAM

First, DAV and all major veterans organizations agreed that the most important priority was to ensure that any veteran waiting for necessary medical care was taken care of, whether that care was provided inside VA or in some form of care in the community. Second, in setting up the new “choice” program, Congress established a separate and mandatory funding source to ensure that VA would not need to make a choice between providing care to veterans who chose

to receive their care at VA and paying for those who chose to access care through the non-VA “choice” program. In fact, one of the primary reasons that VA’s purchased care program had struggled to meet veterans’ needs was the fact that it lacked a separate, mandated funding stream. Going forward, Congress and VA must ensure that funding for non-VA extended health care, however that program might be reformed, remains separate from funding for the VA health care system.

Another principle that was central to our support for the “choice” program was the coordination of care, which is vital to quality. Care coordination helps ensure that the veteran’s needs and preferences for health services and information sharing are met in a timely manner. VA’s use of third party administrator (TPA) networks helps to assure that medical records are returned to VA, that quality controls are in place on clinical providers, and that neither VA nor veterans are improperly invoiced for these services. VA’s use of the TPA structure has many similarities with VA’s Patient Centered Community Care (PC3) program. Through PC3, VA obtains standardized health care quality measurements, timely documentation of care, cost-avoidance with fixed rates for services across the board, guaranteed access to care, and enhanced tracking and reporting of VA expenditures. While the use of TPAs for non-VA care does not guarantee that coordination of care and health outcomes will meet the same standard as an integrated VA health care system, it remains an important component of how non-VA care should be provided in the future.

Finally, and most importantly, while the VACAA established a temporary “choice” program to address an immediate need for expanded access, it also included a significant infusion of new resources to rebuild VA’s capacity to provide timely health care. As we have testified to this Committee and others, the underlying reason for VA’s access crisis last year was a long-term, systemic lack of resources to hire enough physicians, nurses and other clinical professionals, along with a lack of usable treatment space to meet the demand for care by patients. Regardless of how both VA and non-VA care health care programs are reformed in the future, unless adequate – and separate – funding is provided for both, veterans will likely continue to have unacceptable access problems.

CHALLENGES FACING THE CHOICE PROGRAM

According to VA, as of last week, 53,828 Choice authorizations for care had been made to date by the TPAs and 43,044 actual appointments for care had been scheduled. By comparison, according to VA, about 6.4 million appointments are completed each month inside the VA health care system, and another 1.3 million appointments are completed outside VA each month using non-VA care programs other than the “choice” program, including the fee-basis, contract care, PC3, Access Achieved Closer to Home (ARCH) and other programs.

A number of reasons likely contributed to this lower than expected utilization of the “choice” program. On the positive side, since the most recent access crisis gained attention last spring, the VA has used every available resource to increase its capacity to provide timely care at facilities across the nation. VA health care facilities expanded their days and hours of operation; mobile health units were deployed to areas with higher-than-average demand; and VA made

greater use of existing non-VA care authorities. VA's ability to expand its capacity on a temporary basis may have shifted some of the demand away from "choice."

It is also very clear that VA was slow in rolling out "choice" cards and in educating its own staff about how and when the "choice" program could be utilized. In part this was due to the extremely aggressive implementation schedule in the law. However, even today we are hearing reports of VA personnel who do not understand the "choice" program or its role among non-VA care authorities. As a result, some veterans who are eligible for "choice" are not being properly referred to the program, and some veterans who are eligible for non-VA care programs, such as PC3, are inappropriately being referred to "choice." Both of these factors may have deterred some veterans from exploring their eligibility for the "choice" program. VA must do a better job of ensuring that all VA employees understand the proper role and relationship of all non-VA care programs, including "choice."

We also continue to hear troubling reports of a significant lag time between when a VA clinician determines a veteran is eligible for "choice" and the time that the TPA can see this authorization in its system. In some cases, we have been told up to 30 days or more could be required. VA must determine the cause of such unacceptable delays, whether IT related or not, and ensure that there is a rapid and seamless handoff from VA to the appropriate TPA. Such delays certainly might dampen veteran interest in using the "choice" program.

Another possible contributing factor for the low utilization is the restrictive manner in which the 40-mile distance criterion mandated by VACAA was implemented. The bill established two primary access standards to determine when and which veterans would be authorized to use the new "choice" program: those who would have to wait longer than 30 days or travel more than 40 miles for VA care. Unfortunately, due to cost and scoring implications, the 40-mile standard was crafted, interpreted and implemented in a way that was more restrictive than logic and common sense would dictate, although VA has now revised that criterion in part.

As was clearly stated in the report accompanying the law, the determination of whether a veteran resided more than 40 miles from the nearest VA medical facility was based on a geodesic measurement, essentially the distance in a straight line from point-to-point, or "as the crow flies." Fortunately, following further discussions between VA and Congress, this distance criteria has been revised so that the calculation of 40 miles is now done by the shortest driving distance in road miles. This change has expanded the number of veterans eligible under the distance standard and could lead to some increase in utilization.

The second inequity in the distance criteria is that the measurement is taken from the veteran's residence to the nearest VA medical facility regardless if that facility can actually provide the service required by the veteran. As has been acknowledged by the law's primary sponsors, these restrictive standards for measuring 40 miles were due to the high cost estimates received from the Congressional Budget Office (CBO) during the bill's consideration, and a need to lower that projected cost. As we have testified previously, such a measurement makes no logical sense and should be changed in the temporary "choice" program.

However, it is important to note that creating a system that will allow VA to immediately determine whether a service is or is not available at a VA and/or private facility, or will be available within a 30-day window, could be very difficult. Furthermore, VA has indicated that the number of veterans who may live farther than 40 miles from a VA medical center, where most VA specialty care is delivered, could rise to as high as 3.9 million, which could significantly expand the utilization of the program.

Finally, another reason so few veterans have used the “choice” program may be because they simply prefer to go to the VA. Even with the “choice” card, some veterans with non-urgent medical needs may prefer the VA physician, treatment team, or facility they know, rather than look for a new, unknown provider in the private sector. The bottom line is that we simply do not have sufficient data to determine exactly which factors are behind the low utilization rates at this point. Therefore, it is absolutely essential to take steps now so that we have sufficient data and analysis before it is the appropriate time to consider permanent changes to the VA health care system.

LEARNING FROM THE CHOICE PROGRAM

The “choice” program is an unprecedented experiment, launched during a crisis in order to address a short-term emergency need. Therefore, it is incumbent upon us to ensure that the proper measurements and metrics are in place in order to evaluate the success of the program and learn the appropriate lessons. Unfortunately, a number of important questions and metrics at present are not being studied.

The “choice” program was principally intended to address the unacceptable waiting times facing veterans to receive care within the VA by allowing them to choose private care providers. As such, it is imperative that VA measure the time that veterans wait for appointments, including follow-up appointments, when authorized to go outside the VA. It is also necessary to understand what the waiting times, or access standards, are for the private sector, both in general and in detail. After all, the waiting time for a routine dermatology appointment should not be the same as that for a serious cardiac condition.

One of the key questions, and one of the primary contributing factors to the waiting list scandals, was unrealistic access standards in place at VA, which were subsequently repealed. It is important for VA to develop new and realistic standards, regardless of the future structure of non-VA care, not only for waiting times, but also for travel distances. As we and others have pointed out in prior hearings, the distance that is reasonable to expect a younger veteran in relatively good health to travel may be significantly different from what a 90-year old World War II veteran with serious physical disabilities would be required to travel. Furthermore, these standards must be clinically based to ensure the best health outcomes, not randomly set for financial or political reasons.

Mr. Chairman, given the importance of determining appropriate access standards, we would recommend that Congress authorize a comprehensive and independent study to review the access standards used in the private sector, and to make recommendations for such standards for the VA health care system.

In order to properly evaluate the “choice” program, VA must also collect, study and analyze data on patient satisfaction and health outcomes for those who use private providers through the “choice” program. VA needs to establish baseline data from which it can compare satisfaction for those who use “choice,” those who use other non-VA care programs, and those who use VA care. Measuring health outcomes may prove more challenging, given that it takes many years before true outcomes are known; however, since this is the ultimate measure of success, VA must begin to explore appropriate research, analysis and metrics that could be implemented now in order to help with such analysis in the future.

Another key area that must be evaluated is the coordination of care for veterans who go outside the VA, both through the “choice” program and other non-VA care authorities. Over the next couple of years, veterans may find themselves receiving care inside VA as well as outside, and VA must be able to determine how well that care is coordinated through the various programs. It is imperative that VA carefully monitor how and what kind of medical information is transmitted back and forth between VA and non-VA providers.

THE CONGRESSIONALLY-MANDATED “COMMISSION ON CARE”

In addition to the temporary three-year “choice” program and the investment of new resources in the VA health care system, the VACAA also requires the creation of a “Commission on Care” to study and make recommendations for long-term improvements to best deliver timely and high quality health care to veterans over the next two decades. Specifically, the law requires that members of this Commission be appointed not later than one year after the date of enactment of Public Law 113-146, which would be no later than August 7, 2015. The President, Majority and Minority Leaders of the Senate, Speaker and Minority Leader of the House, will each appoint three members of the Commission, with the President designating the Chairman.

Under the law, once a majority of appointments is made, the Commission must hold its first meeting within 15 days, and then it is provided only 90 days to produce an interim report with both findings and recommendations for legislative or administrative actions, and then only 90 additional days to submit a final report.

Mr. Chairman, last month, DAV, PVA, VFW, The American Legion, IAVA and a number of other VSOs wrote to Senate and House leaders to call for extending the mandate of this Commission to allow at least 12 months before the interim report is due, and at least six additional months before the final report is presented to Congress. In our jointly signed letter, we argued that, “... 90 days does not provide nearly sufficient time for a newly constituted Commission of 15 individuals – each with their own unique background, experience and understanding of the current VA health care system – to comprehensively examine all of the issues involved, to conduct and review sufficient research and analysis, and to discuss, debate and reach agreement on specific findings and recommendations that could change how health care will be delivered to millions of veterans over the next twenty years.”

In addition, we called on Congress to refrain from taking any, “...permanent, systemic changes ... until after the Commission has had sufficient opportunity to consider how best to

deliver health care to veterans for the next two decades, submitted its recommendations, and then allowed sufficient opportunity for other stakeholders and Congress to engage in a debate worthy of the men and women who served.”

By gathering essential data and performing crucial research over the next year or so, the Commission, Congress and other stakeholders would be able to work together to ensure that veterans receive the health care they have earned. However, it is also important that before we engage in a debate about how to structure both VA and non-VA care programs, we gain a consensus about the proper role and responsibility of the VA.

THE PRINCIPLE MISSION OF VA HEALTH CARE

One hundred and fifty years ago, only a month before the Civil War ended, President Abraham Lincoln stood on the East Front of the U.S. Capitol to make his Second Inaugural Address, in which he made a solemn promise on behalf of the nation “...to care for him who shall have borne the battle, for his widow, and his orphan...” Those words which are engraved on the entrance of the Department’s building here in Washington, DC, were spoken just one day after Lincoln signed legislation to create the very first federal facility devoted exclusively to the care of war veterans, which ultimately evolved into today’s VA health care system.

Since that date, leaders of Congress and Presidents of all parties have been united in their bipartisan support of a robust federal health system to care for veterans. But after a very difficult year filled with a waiting list scandal and a health care access crisis – which resulted in the resignation of a sitting VA Secretary – there is now discussion about how and whether to keep that promise to the men and women who served. While we certainly agree that change and reform are needed at the VA, we have a sacred obligation to ensure that America never abandons Lincoln’s promise.

While the VA health care system has long been the embodiment of our national promise, some are now proposing to make it just another “choice” among all health care providers, while others are calling for VA to be downsized or eliminated altogether. For millions of veterans wounded, injured or made ill from their service, their only “choice” for receiving the specialized care they need is a robust VA.

Although the VA today provides comprehensive medical care to more than 6.5 million veterans each year, the VA system’s primary mission is to meet the unique, specialized health care needs of service-connected disabled veterans. To accomplish this mission, VA health care is integrated with a clinical research program and academic affiliation with well over 100 of the world’s most prominent schools of health professions to ensure veterans have access to the most advanced treatments in the world.

Furthermore, in order to achieve the best health outcomes, it is necessary to treat the whole veteran, and that is exactly what the VA is organized to do. VA provides comprehensive, holistic and preventative care that results in demonstrably improved quality, higher patient satisfaction and better health outcomes for the veterans it serves. For those veterans who rely on

VA for care, those who have suffered amputations, paralysis, burns and other injuries and illnesses, we believe they deserve the “choice” to receive all or most of their care from the VA.

If the VA health care system ends up being downsized as a result of allowing all veterans to leave VA through expanded “choice” programs, some or all of the 3.8 million service-connected disabled veterans who rely on VA for their health care today would no longer have the “choice” to receive all their care from VA. Instead, they would end up with fractured care, receiving care through a combination of VA and non-VA providers.

And if VA was eliminated outright and no longer an option for seriously disabled veterans, would the private health care system be able to provide timely access to the specialized care they require? While the private sector also treats many of the same conditions that VA specializes in – including amputations, paralysis, severe burns, blindness, traumatic brain injury (TBI) and even post-traumatic stress disorder (PTSD) – there is simply no comparison with the frequency, severity and comorbidities routinely seen by VA physicians. Even if all 3.8 million disabled veterans were dispersed into private care, they would still make up just 1.5% of the adult patient population. Does anyone truly believe that a market-based civilian health system would provide the focus and resources necessary to advance the level of care for this small minority in the way that a dedicated, federal VA system would?

SETTING A NEW FRAMEWORK FOR REFORMING VA HEALTH CARE

While it is far too soon to settle on how to reform the VA health care system and integrate non-VA care, we must begin to establish at least a road map to guide us. We propose a new framework to meet the needs of the next generation of America’s veterans based on rebuilding, restructuring, realigning and reforming the VA health care system.

First, we must rebuild and sustain VA’s capacity to provide timely, high quality care. That must begin with a long-term strategy to recruit, hire and retain sufficient clinical staff at all VA facilities. In addition, VA must gain the commitment and funding to implement a long-term strategy to repair, maintain and expand, as necessary, usable treatment space to maximize access points where veterans can receive their care. VA must build upon its temporary access initiatives implemented last year by permanently extending hours of operations around the country at CBOCs and other VA treatment facilities to increase access for veterans outside traditional working hours. To provide the highest quality care, we must strengthen VA’s clinical research programs to prepare for veterans’ future health care needs. In addition, we must sustain VA’s academic affiliations to support the teaching and research programs and to help support future staffing recruitment efforts.

Second, VA must restructure its non-VA care program into a single integrated extended care network. This will require that VA first complete the research and analysis related to the “choice” program discussed above, and allow the Commission on Care to complete its work. Then based on that research and data, VA must develop an integrated VA Extended Care Network which incorporates the best features of fee-basis, contract care, ARCH, PC3, “choice,” and other purchased care programs. However, this will only work if Congress also provides a single, separate and guaranteed funding mechanism for this VA Extended Care program. To

make this program veteran-centric, VA must complete the research discussed above related to private sector access standards in order to establish a new clinically-based access policy that is informed, objective and based on rigorously established factual evidence. In addition, VA must develop an appropriate and effective decision mechanism that ensures that veterans are able to access VA's Extended Care Network whenever medically necessary, as well as a new, transparent, and dedicated review and appeal process capable of making rapid decisions to ensure veterans have timely access.

Third, we must realign and expand VA health care services to meet the diverse needs of future generations of veterans, beginning with VA expanding urgent care clinics with extended operating hours. The VA, like any large health care system should provide walk-in capability to meet the urgent care needs of enrolled veterans. These services would be delivered by dedicated doctors and nurses in existing VA facilities, or smaller urgent care clinics strategically situated in new locations around the country, such as in shopping malls. In addition, VA must extend access to care further through enhanced web-based and tele-medicine options to reach even the most remote and rural veterans. And with veteran demographics continuing to change, VA must eliminate barriers and expand services to ensure that women veterans have equal access to high quality, gender-specific, holistic, preventative health care. VA must also rebalance its long-term supports and services to provide greater access to home- and community-based services to meet current and future needs, including expanding support for caregivers of veterans from all generations.

Fourth, VA must reform its management of the health care system by increasing efficiency, transparency and accountability in order to become a veteran-centric organization. VA can begin by developing a new patient-driven scheduling system, including web and app-based programs that allow veterans to self-schedule health care appointments. To support responsible organizational behavior, VA should redesign its Performance and Accountability Report (PAR) to establish new metrics that are focused on veteran-centric outcomes with clear transparency and accountability mechanisms. VA's budgeting process would benefit by implementing a more transparent and accountable system known as PPBE, which stands for planning, programming, budgeting and execution. This approach is already working for the Departments of Defense and Homeland Security, and there is legislation pending to bring the same to VA. Finally, VA must hold all of its employees – from the Secretary to receptionists – to the highest standards, while always balancing the need to make the VA an employer of choice among federal agencies and the private sector.

Mr. Chairman, the framework outlined here certainly is not intended to be a final or detailed plan for reforming VA, nor could it be at this point with so much unknown, but it offers a new pathway that could lead toward a future that would truly fulfill Lincoln's promise. DAV is convinced that the VA health care system has been, can be and must be the centerpiece of how our nation delivers health care to America's wounded, injured and ill veterans.

While the VA faces serious challenges, the answer is not to abandon it, or to destroy it. Instead, we must honor the service and sacrifices of our nation's heroes by creating a modern, high-quality, accessible and accountable VA health care system. Anything less breaks Lincoln's

promise, ignores our sacred national obligation, and leaves our veterans to fend for themselves in a private sector health system ill prepared to care for them.

That concludes my testimony and I would be pleased to address questions from you or other Members of the Committee.