

STATEMENT OF
RAYMOND C. KELLEY, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

ON BEHALF OF THE INDEPENDENT BUDGET

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Choice Consolidation: Assessing VA's Plan to Improve Care in the Community

WASHINGTON, DC

DECEMBER 2, 2015

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the co-authors of *The Independent Budget* (IB), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW), thank you for the opportunity to offer our thoughts regarding the Department of Veterans Affairs' (VA) plan to consolidate its community care programs into a new choice program, as required by Public Law (P.L.) 114-41.

After months of working closely with VA officials and other stakeholders, we are pleased that many of our key recommendations were incorporated into VA's plan, such as ensuring VA remains accountable for the care veterans receive through seamless care coordination – regardless of where the care is delivered. We are also pleased that other key aspects of VA's plan are closely aligned with the IB's veterans health care reform framework, which is appended at the end of this statement.

The IB veterans service organizations (IBVSOs) strongly believe that veterans have earned and deserve to receive high quality, comprehensive, accessible and veteran-centric care. In most instances VA care is the best and preferred option, but the IBVSOs acknowledge that VA cannot provide all services to all veterans in all locations at all times; that is why VA must leverage private sector providers and other public health care system to expand viable options. However, when and where a veteran receives care should not be determined by federal mandates. For that reason, the IBVSOs support VA's plan to move beyond arbitrary federal standards regulating veterans' access to care in the community. We believe it is time to move towards a health care delivery system that keeps clinical decisions about when and where to receive care between a veteran and his or her doctor – without bureaucrats, regulations or legislation getting in the way.

The IBVSOs strongly support VA's concept of developing high performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community, whenever necessary, resulting in expanded options for veterans to receive high quality care closer to home. This marks a significant shift in the role private health care providers play in the veterans' health care system, and is an important step towards ensuring veterans receive high quality, comprehensive, accessible and veteran-centric health care now and in the future.

VA's plan is particularly sensitive to the importance of ensuring culturally competent providers for veterans. In a recent study entitled "*Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and their Families,*" the RAND Corporation found that only 13 percent of private sector mental health care providers were able to deliver culturally competent and evidence-based mental health care to veterans and their families. Similarly, less than 50 percent of private sector mental health providers who were affiliated with VA or the Department of Defense met RAND's readiness criteria.

VA's plan to adapt high performing networks to local communities recognizes that the private sector is not a panacea to health care quality and access. We support VA's plan to identify and empower private sector providers who are ready and able to deliver high quality, comprehensive, and veteran-centric health care. Doing so ensures the quality of care veterans receive from private sector providers is at least equal to or better than the care they are accustomed to receiving from VA. As the nation's largest trainer of health care professionals, VA is already increasing the number of private sector providers who are able to deliver culturally competent, high quality care to veterans. The IBVSOs support VA's plan to build on existing programs by making military culture training and educational resources available to providers who want to participate in high performing networks. However, education alone is not enough. By leveraging the best capabilities of each community's health care market, VA would also ensure private sector providers who invest in learning how to care for veterans are given the appropriate workload to ensure they retain what they have learned.

The IBVSOs firmly believe that VA's medical home model and experience providing veteran-centric care results in the best health outcomes for veterans and, therefore, VA must remain the primary health care provider for enrolled veterans. However, we recognize that VA lacks the resources and capacity to be everything to every veteran it serves. By establishing high performing networks to fill these gaps, VA can leverage the best capabilities that already exist in each health care market and free up resources to invest in services the community lacks. This type of blended health care delivery model will result in improved health care outcomes for veterans by providing them with more options closer to home and ensuring they receive the best quality care available in their communities.

Other models currently being proposed to reform the way our nation provides care to veterans fall dramatically short. For example, proposals to turn VA in to a voucher system would leave veterans with two lackluster choices: a VA health care system that would continue to be overburdened and underfunded; or private health care that does not guarantee access and lacks the required specialized care services and cultural competencies uniquely defined by veterans' needs. Meanwhile, proposals to privatize VA health care by establishing a health care exchange

for veterans to shop for health care coverage would erode the benefits of VA's medical home model, which provides veterans a full continuum of care that is unmatched in the private sector.

Creating health care exchanges for veterans also ignores findings outlined by the Centers of Medicare and Medicaid Services Alliance to Modernize Healthcare in its report entitled "*Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*" (released on September 1, 2015) that veterans are sicker and higher users of health care than the general population. Furthermore, veterans who turn to VA tend to be the most indigent, disabled, and geographically isolated segment of the veterans population. In order to take on such a high risk portfolio of beneficiaries, insurance companies who participate in a veterans health care exchange will need to charge exorbitant premiums to offset the risk - significantly increasing health care costs for millions of veterans who can least afford it.

Instead of moving towards privatization or pushing veterans out of VA and into government-run insurance plans, the IBVSOs believe that creating integrated networks combining VA with top tier private providers is the best way to expand access, improve quality and achieve better health outcomes for veterans.

VA's consolidation plan has identified 11 legislative recommendations that seemingly must be enacted to ensure VA has the authority to implement planned reforms. Since there are not yet details or legislative language for most of these proposals, we cannot offer final views; however the IBVSOs offer the following initial observations and comments on each legislative recommendation:

1. Improving VA's Partnerships with Community Providers to Increase Access to Care

VA and Congress have been working for months to agree upon legislation that would fulfill this recommendation, and the IBVSOs have supported legislation to authorize VA to purchase care through agreements that are not subject to provisions of law governing federal contracts. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with community care options when needed.

Provider agreements are a necessary tool to allow VA to meet the wide-ranging and unique health care needs of veterans, particularly veterans with spinal cord injury and dysfunction. This proposal would also protect VA's ability to continue to purchase private medical care when not otherwise available through VA, contracts, or sharing agreements.

The IBVSOs would also like to thank Senator Blumenthal for his inclusion of certain federally recognized providers in the text of S. 2179, the "Veteran Care Agreements Rule Enhancement Act." These entities serve on the front lines of a partnership between the VA and the Department of Health and Human Services that has served

more than 3,400 veterans across 31 States, the District of Columbia and Puerto Rico. These agencies provide severely ill and injured veterans of all ages the opportunity to determine their own support services to live independently at home.

The IBVSOs have heard from veterans who live in contract extended care facilities who they may be required to leave the place they have called home for years because VA does not have the authority to renew provider agreements. We urge this Committee to quickly consider and pass this important legislation to ensure severely disabled veterans are not harmed by VA's inability to enter into provider agreements.

2. Improving Access to Community Care through Choice Fund Flexibility

This proposal would authorize VA to use the Veterans Choice Fund to pay for compensation and pension exams; any health care services under Chapter 17 of title 38, United States Code (U.S.C.); community care; emergency room and urgent care; and the cost of implementing VA's consolidation plan. While the IBVSOs support the intent of the proposal, we would need to review the legislative language before taking a position.

The IBVSOs believe it is detrimental to veterans' health care when VA is unable to access all of the resources provided to accomplish its mission. Unfortunately, P.L. 113-146, the "Veterans Access, Choice and Accountability Act of 2014," limited expenditure of the Veterans Choice Fund to care provided through the Choice Program. The fund was created to ensure VA has the resources necessary to provide community care when VA care is not readily available. In July, Congress granted VA the authority to transfer more than \$3 billion of Veterans Choice Fund money to offset higher than expected demand on VA community care programs.

The IBVSOs believe that another budget shortfall is a real possibility in fiscal year 2016, and requiring that a funding shortfall exist before VA is able to use this fund for purchasing community care could risk harming veterans. However, the IBVSOs do not support the use of this account as a slush fund to pay for unrelated services outside of its intended purpose. If VA has shortfalls in other accounts that are used to pay for non-health care services, such as compensation and pension exams, VA should request additional funding through the regular budget and appropriations process, including requests for supplemental appropriations.

3. Increasing Accuracy of Funding by Recording Community Care Obligations at Payment

The IBVSOs do not object to the purpose of this proposal, which would authorize VA to obligate funds for community care consults when payment is due instead of using an estimated amount to obligate funds. Such an accounting change could result in a more efficient way to track planned expenditures and obligate necessary funds when an authorization for care in the community takes place. It could also bring clarity to

the authorization and obligation process so as to mitigate the possibility of a recurrence of the budget shortfall that occurred earlier this year.

4. Improving Access to Community Care by Establishing the New VCP

As previously stated, the IBVSOs support VA's concept of consolidating existing care in the community programs into a single program that relies on high performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community whenever necessary. Rather than simply giving veterans a choice card and leaving them on their own to navigate the private health market, this plan would require VA to ensure that sufficient real options exist for veterans to receive care closer to home through the new networks, which is far more likely to result in better health outcomes for veterans. The creation of these seamless and blended networks represents the central concept of the new Veterans Choice Program and we look forward to working with VA and Congress to develop the details required to implement this plan.

While the VA plan starts to move beyond arbitrary federal standards regulating when and where veterans can access medical care, we believe it should go further to ensure access is not determined by the distance veterans live from a VA medical facility or waiting longer than 30 days for care. The IBVSOs support the consolidation of community care programs, but do not agree with VA's proposal to define geographic access as 40 miles from a VA primary care provider. We firmly believe that the distance a veteran travels is not as important as determining the severity of his or her health care conditions and allowing the health care provider to decide the most appropriate time and location to received care for those conditions. Furthermore, geographic distance should not be used to determine when a veteran is authorized to seek care in the private sector. Private sector network providers should be considered an extension of VA. Doing so would ensure all veterans are afforded the opportunity to receive veteran-centric and coordinated care when they need it and where it is most appropriate.

5. Increasing Access and Transparency by Requesting Budget Authority for a Community Care Account

The IBVSOs understand the intent of this proposal, which would ensure more accurate and accountable funding for community care programs. Based on recent history of changes in VA's appropriations request structure, it is not clear that VA needs specific legislation to make this change. However, until we see more specific details, particularly about the proposed transfer authority, we are not able to offer support for this legislative proposal.

6. Streamlining Community Care Funding

Similar to our position on the prior legislative proposal (#5 above), we understand the intent of this proposal, but would need to see the specific language to accomplish this change before taking a formal position.

7. Improving Veterans Experience by Consolidating Existing Programs

The IBVSOs cautiously support this proposal, which would sunset the numerous community care programs VA intends to consolidate. The IBVSOs believe that VA's transition to the new choice program must ensure veterans who are currently receiving community care through existing programs are afforded the opportunity to continue their care with the same providers. Before allowing these programs to sunset, VA must ensure the new Veterans Choice Program can handle the workload governed by the existing authorities that provide care to veterans.

Permitting the Assisted Living for Veterans with TBI (AL-TBI) program to sunset without granting VA the authority to continue such services would have negative consequences on the veterans who are currently enrolled in the program. There is no indication that there will be follow-on services under the new Veterans Choice Program that will meet the specific needs of the veterans currently served by the AL-TBI program. In fact, the new program guarantees nothing to this segment of the veterans' population, and yet, these veterans are some of the most vulnerable served by VA. Additionally, we are concerned that VA does not have, nor has it requested, the authority to provide assisted living services to these veterans or other veterans enrolled in the VA health care system in need of extended care. Like the realignment of authorities for emergency and urgent care, assisted living is a service that should be expanded.

8. Improving Veterans Access to Emergency Treatment and Urgent Care

The IBVSOs support the plan to expand emergency treatment and urgent care in the community. However, we oppose the proposal for an across the board \$100 co-payment for emergency care and \$50 for urgent care. This proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. Veterans currently exempted from co-payments should not be required to bear a cost-share for emergency and urgent care services.

As an alternative, VA should consider establishing a national nurse advice line to help reduce overreliance on emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Beneficiaries who are uncertain if they are experiencing a medical emergency and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use

emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance of emergency room care without having to increase cost-shares for veterans.

Additionally, the IBVSOs have concerns about the requirement that eligible veterans must be "active health care participants in VA" in order to access these benefits. The strict 24-month requirement is problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to appointment wait times, despite their timely, good faith efforts to make appointments following their separation from military service. This barrier has caused undue hardship on veterans who are undergoing the difficult transition from military service back to civilian life, and has resulted in veterans receiving unnecessarily large medical bills through no fault of their own. VA is aware of this problem and has requested the authority to make this exemption, however, the consolidation plan does not specifically address this needed change.

Furthermore, this restriction could negatively impact some healthier veterans who do not need as much health care as others and may go more than two years without accessing VA care. This requirement could encourage veterans to seek unnecessary care from VA in order to remain eligible for VA's emergency and urgent care services.

9. Improving Care Coordination for Veterans through Exchange of Certain Medical Records

The IBVSOs support the intent of this proposal, which would lift a restriction on VA's ability to disclose certain medical information. Proper sharing or exchange of veterans' medical records is imperative if VA is going to responsibly coordinate care. While we understand patient privacy concerns that have been raised in the past, VA must be authorized to make all health information available to community providers who will be integral to the care being provided.

The original intent of precluding VA from disclosing patient information regarding drug abuse, alcoholism, and infection of HIV or sickle cell anemia was to prevent veterans from being discriminated against based on their health care conditions. The IBVSOs believe that P.L. 111-148, the "Patient Protection and Affordable Care Act," prohibition on discrimination based on health care conditions by health care providers renders the current VA restriction unnecessary.

10. Aligning with Best Practices on Collection of Health Insurance Information

This proposal would authorize VA to withhold health care from veterans if they fail to provide other health insurance information (OHI). The IBVSOs support the intent of requiring veterans to report information on other health insurance, however, we oppose the enforcement mechanism used to ensure veterans report their health

insurance information. We are concerned that efforts to collect other health insurance information could result in veterans being denied non-emergent care.

Veterans are currently required to inform VA when their insurance information has changed and VA typically asks veterans about any changes to their insurance coverage when they present to a VA medical facility. To preclude veterans from receiving VA health care because they may not have known their insurance status changed or because they did not disclose this information could harm the veterans VA was created to serve.

Additionally, the Government Accountability Office and the Congressional Budget Office have both found that VA's ineffective billing process affects its ability to collect the full cost of non-service-connected VA care delivered to veterans with OHI coverage. The IBVSOs have also heard from veterans that VA has erroneously billed their private health insurance for service-connected care. While we understand VA's need to increase the amount of billing it processes, it is more important that it improve the efficacy of its billing process. Doing so would increase medical care collections without placing an undue burden on veterans.

It is important to remember that VA health care is an earned benefit. This proposal would also diminish veterans' service and sacrifices by relegating this benefit to one that can be negated in order to increase the federal government's financial revenue. Rather than punishing veterans, VA should consider other ways to incentivize veterans to provide OHI and increase third party medical care collections.

11. Formalizing VA's Prompt Payment Standard to Promote Timely Payments to Providers

The IBVSOs support the intent of this proposal, which would formalize a VA Prompt Pay standard.

While the IBVSOs generally believe that most of VA's legislative proposals outlined above are sound and necessary, we cannot offer final judgment without reviewing the legislative text of each these proposals in detail.

Overall, the IBVSOs are glad to see that many aspects of VA's consolidation plan are aligned with the IB's veterans health care reform framework. The IB's framework builds on VA's progress by addressing barriers that are outside of the VA plan's limited scope. The IBVSOs have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a veterans health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system.

The IBVSO's four-pronged framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans.

Restructure the Veterans Health Care Delivery System

The IB framework would optimize the strengths and capabilities of VA and combine them with other public and private health care providers by establishing local Veterans-Centered Integrated Health Care Networks. VA would be responsible for organizing the networks, coordinating care, and in most cases, would remain the principal provider of care for veterans.

Similar to VA's consolidation plan, the IB framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the IB framework would establish a Veterans Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care wherever they live.

Redesign the Systems and Procedures that Facilitate Access to Health Care

We recommend that VA move away from single, arbitrary federally regulated access standards. Under the IB's framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

We also recommend establishing a nationwide system of urgent care at existing VA clinics, and affording veterans the opportunity to receive urgent care from smaller urgent care clinics around the country to alleviate much of the pressure on VA outpatient clinics.

Realign the Provision and Allocation of VA's Resources to Reflect its Mission

The IBVSOs call for significant change to VA's Strategic Capital Investment Planning (SCIP) process by including public-private partnership options and blending existing replacement options to better leverage federal and local resources. VA must be required to engage community leaders to develop broader sharing agreements, so it can plan infrastructure in a way that allows communities to share resources and VA can invest in services the community lacks. Furthermore, VA should be required to publicly update and report annually actuarial estimates for maintaining and modernizing adequate infrastructure, so that the real financial need for infrastructure resources is known to Congress, veterans and the public.

Our framework also calls for reforming the congressional appropriations process to ensure VA has the resources it needs and the flexibility to allocate them to provide for the health care and services veterans need, instead of limiting the amount of care VA is able to provide. Finally, we call for the establishment of a Quadrennial Veterans Review process, similar to the Quadrennial Defense Review, to align VA's strategic mission with

its budgets and operational plans, and help provide continuity of planning across all administrations.

Reform VA's Culture with Workforce Innovations and Real Accountability

The IB framework would establish a biennial independent audit of VA's budgetary accounts to identify accounts and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

In addition, we call for strengthening VA's Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code (U.S.C.), including a veteran's right to seek redress through clinical appeals; claims under section 1151 of title 38, U.S.C.; the Federal Tort Claims Act; and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, including both private and public health care entities.

Congress, the Administration, the IBVSOs, and other key stakeholders in the veterans' community all have an interest in fixing and strengthening the veterans health care system so that it is properly aligned to meet the unique needs of the veterans it serves. Today, the VA is at a crossroads that will determine how it will carry out its mission to America's veterans. This is an historic opportunity to put VA on a path to meet the needs of veterans today and far into the future. The IBVSOs will continue working to ensure that our nation's veterans receive high quality, accessible, comprehensive, and veteran-centric health care designed around their needs and preferences.

Thank you for the opportunity to present this testimony to the Committee today. We would be pleased to answer any questions the Committee may have.

This page intentionally left blank.

A Framework for Veterans Health Care Reform

In April 2014, whistleblowers from around the country brought to light instances of fraud and manipulation within the Department of Veterans Affairs (VA) that have since led to changes in executive leadership and a wide array of proposals to overhaul the VA health care system. To *The Independent Budget* (IB), the fact that veterans were waiting too long for the care they have earned and deserve was no surprise.

The IB co-authors—Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—have been ringing the alarm on VA health care access problems for more than a decade. In 2002, the IB included an article on waiting times for outpatient appointments, in which the IB veterans service organizations (IBVSOs) urged the Veterans Health Administration (VHA) to “identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide.”

The transformative effort underway at VA, known as MyVA, and recent actions taken by congressional leaders, such as enactment of P.L. 113-146, the “Veterans Access, Choice, and Accountability Act of 2014,” have made progress in addressing the access issues that have plagued VA. While such progress is commendable, access remains the principle problem facing the VA health care system, and this problem will continue to negatively impact the health care veterans receive until the VA health care system is significantly reformed. Organizations, politicians, members of Congress, VA officials and other stakeholders are advocating for specific reforms. What has been missing from these discussions is a plan that truly represents what veterans want, expect, and need their health care system to be and a comprehensive set of reforms to accomplish that vision.

In order to develop a framework that puts veterans’ needs and preferences first and understand the extent of the health care access problem from a veteran’s perspective, the IBVSOs have sought direct feedback from our members and the veterans’ community as a whole. Their responses have validated what we have long known:

1. Veterans prefer to receive their care from VA.
2. They turn to VA because they like the quality of care they receive.
3. They believe VA health care is an earned benefit and VA is best suited to provide veteran-specific health care.

When asked how they would improve the VA health care system, veterans suggest that VA hire more doctors and extend clinic hours to expand internal capacity, improve customer service, and expand overall access by providing convenient health care options in their local communities.

The IBVSOs have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a veterans’ health care reform framework centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The IB’s framework includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high quality, and veteran-centered health care system. The framework would

provide high-quality health care closer to home by seamlessly combining the capabilities of the VA health care system with public and private health care providers in the community when and where necessary.

In order to accomplish our long-term vision, veterans' health care reform must address four fundamental ideas:

1. Restructure the Veterans Health Care Delivery System
2. Redesign the Systems and Procedures that Facilitate Access to Health Care
3. Realign the Provision and Allocation of VA's Resources to Reflect the Mission
4. Reform VA's Culture with Workforce Innovations and Real Accountability

We hope that Congress, VA, veterans, and other key stakeholders will consider these ideas as the ongoing efforts to reform veterans health care move forward.

Restructure the Veterans Health Care Delivery System

In the 1990s, under the leadership of Dr. Kenneth W. Kizer, the VA health care system underwent a dramatic transformation from a hospital based system to an integrated ambulatory care system. While the shift to a holistic approach of providing a full continuum of care has made VA one of the premier health care providers in the world, it has largely ignored one of Dr. Kizer's objectives: "Seek opportunities for sharing activities with private sector entities when doing so would be cost effective and improve service to VA patients." In its plan to consolidate community care programs and authorities entitled "*Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*," (mandated by P.L. 114-41, the "Surface Transportation and Veterans Health Care Choice Improvement Act") VA reports having existing agreements or contracts with more than 200 federal health care facilities, 700 academic teaching affiliates, 700 federally qualified health centers, and 76,000 locally contracted providers. Such contracts and agreements are generally used as safety valves to augment health care veterans receive from VA medical facilities, rather than integrating them into the health care delivery model.

Traditionally, the relationship between VA and non-academically affiliated private sector providers has been unnecessarily adversarial. Many VA medical center directors have wanted their facilities to be everything for every veteran and have viewed the use of private sector providers as a threat to their ability to provide high quality care to the veterans they serve. In addition, the overall inadequate levels of funding provided to meet veterans needs has resulted in a conflict between fully funding VA services and properly utilizing community care options. As a result, VA medical facilities rarely benefited from leveraging the capacity of private sector medicine to improve its health care delivery model. Far too often, community care was uncoordinated, failed to guarantee sufficient access or quality, and was highly susceptible to improper billing of veteran patients and improper payments by VA. Additionally, with inadequate funding levels for medical services, as the IBVSOs have pointed out regularly, VA has been unable to expand capacity fast enough to keep up with demand for services, continues to rely upon outdated software and processes, and has suffered from inconsistent administration of community care throughout the system. As a result, veterans who have faced barriers

accessing VA care are forced to wait longer for community care, placed on waiting lists when they should be given the opportunity to receive community care, or forced to forgo needed health care altogether.

With the implementation of coordinated community care programs like Project Healthcare Effectiveness through Resource Optimization (HERO), Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program supported by reform efforts like Secretary McDonald's MyVA initiative, VA has made significant improvements to the way it purchases health care. Through this work, VA has expanded partnerships with private sector providers, identified and addressed a number of the issues highlighted above, and dramatically increased the use of community care. However, VA's consolidated plan acknowledged that VA's community care programs continue to lack system wide consistency and integration with the larger VA health care system.

Several ideas for reforming the way VA purchases care have gained national attention in the past year. Many of them fail to put veterans' needs and preferences first and some do not properly account for second or third order effects that would lead to unintended consequences for the health and wellbeing of our Nation's veterans. For example, proposals that would require VA to compete with private sector providers for veterans' health care dollars perpetuates the adversarial relationship between VA health care and community providers. Rather than force veterans to choose between an overburdened and underfunded system (VA) and one that does not guarantee access and lacks the required specialized care services and cultural competencies uniquely defined by veterans' needs (private sector), veterans deserve a system that integrates the two so that VA's veterans' health care expertise can be complimented with the convenience of private sector providers.

The IBVSOs acknowledge that an exclusively federal solution is not feasible due to the changing nature of the veterans' population. Moreover, simply making VA a payer of veterans' health care erodes the benefits of VA's patient centered medical home model. That is why the IB's framework takes a logic based approach that optimizes the strengths and capabilities of VA and combines them with other public and private health care providers. Simply put, we recommend establishing local Veterans-Centered Integrated Health Care Networks. These networks would leverage the capabilities and strengths of existing local health care resources (including VA, other public health care systems, and private providers) to meet the needs of veterans in each uniquely different health care market. This includes increasing capacity to deliver urgent care at existing VA medical facilities and developing new capacity through private sector urgent care clinics around the country to create new options between emergency care and primary care.

VA must be responsible for organizing these integrated health care networks, coordinating care, and in most cases, it would remain the principal provider of care for veterans. Similar to VA's proposed consolidation plan, the IB framework would consider network providers an extension of VA care, which would enable veterans to work with their health care providers to determine the best way to receive care. For rural and remote veterans who live outside network catchment areas, the IB framework recommends creation of a Veterans Managed Community Care program that would ensure all veterans have an option to receive veteran-centric and coordinated care when they need it and where it is most appropriate.

Redesign the Systems and Procedures that Facilitate Access to Health Care

Over the years, the VA health care system has relied on a number of methods and standards to measure access and timeliness of health care delivery. Prior to the scandal that enveloped the VA health care system in the spring of 2014, the Department's wait-time goal was 14 days from a veterans preferred date for existing patients or 14 days from the date an appointment request was created for new patients. After the health care access crisis exposed that the 14-day goal was unattainable, VA reevaluated its standard and moved to 30 days from a veteran's preferred date. Less than a year later, VA changed its wait-time standard again to facilitate the implementation of the Veterans Choice Program. In an attempt to align its standards with industry best practices, VA elected to base its wait-time goal on clinical need first and rely on a veteran's preference when a clinically indicated date was not identified.

VA has also relied upon a number of geographic based access standards over the years to determine accessibility. Through the Strategic Capital Investment Planning (SCIP) process, dating back to its fiscal year 2008 budget request, VA has used a 60 minute drive-time distance for veterans who live in urban areas and 90 minutes for veterans who live in rural areas as a standard for specialty care. In 2013, VA's long range SCIP process began to include a corporate target of 70 percent of veterans having access to VA primary care within a 30 minute drive time in urban areas and 60 minutes in rural areas.

Additional geographic based standards have accompanied statutory programs, to include 40 miles from a primary care provider (as well as 30 days) for the Veterans Choice Program, or 60 minute drive time from primary care, 120 minutes from acute care, and 240 minutes from tertiary care under Project ARCH. VA has also established geographic based network standards for contracted programs. Under Project HERO, VA required Humana to provide access to required services within 50 miles of a veteran's home. Under PC3, HealthNet and TriWest are required to provide health care options within a 60 minute drive for veterans who live in urban areas, 120 minutes for veterans who live in rural areas, and 240 minutes for veterans who live in highly rural areas, when seeking general care. For veterans who need a higher level of care, the PC3 network must provide them options within 120 minutes for urban areas, 240 minutes for rural areas, and an acceptable community standard for highly rural veterans.

The independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait-times similar to the Veterans Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days-based calculations, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. The IBVSOs strongly agree with IOM's recommendation that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families."¹

¹ IOM (Institute of Medicine). 2015. Transforming Health Care Scheduling and Access: Getting to Now. Washington, DC: The National Academies Press

The IBVSOs have reported for years that VA's access standards are not aligned with veterans' perceptions. Moreover, the IB firmly believes that federally regulated, arbitrary access standards, such as living 40 miles from a VA clinic or waiting up to 30 days for an appointment, should not inhibit a veteran's access to care. That is why the IBVSOs propose to move away from federally regulated access standards. Under the IB's framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

Realign the Provision and Allocation of VA's Resources to Reflect its Mission

Since it was not required by P.L. 114-41, VA did not address the issue of capital infrastructure in its plan to consolidate its community care programs. However, without proper planning of its current infrastructure responsibilities and needs, VA will face significant challenges in order to effectively deliver quality, timely health care to our veterans.

For more than 100 years, the government's solution to providing facilities to provide health care for our military veterans has been to build, manage and maintain a network of veterans' hospitals themselves. While building these facilities was a necessity, maintaining them and replacing them has saddled the Department with a \$60 billion bill that will need to be paid over the next 10 years in order to properly address the existing access, utilization, and condition and safety gaps to provide veterans with access to the care they have earned and need in a safe and timely manner. Moving forward, VA will need to streamline its procurement and project delivery processes, leverage community resources, realign its footprint to provide appropriately sized facilities in more locations, and ensure VA budget requests for capital infrastructure projects are based on a defined plan to address infrastructure gaps instead of arbitrary lists of needed projects.

Currently, VA takes too long and makes too many changes to construction plans leading up to and during the building phase. We only have to examine the problems experienced in the construction of the new VA medical center in Aurora (Denver), Colorado, to affirm this point. Changes proposed to reform construction management through the inclusion of the Army Corps of Engineers are a necessary reform that must be monitored and assessed going forward.

In addition, VA's infrastructure problems will never be met if they do not find a better way to estimate and request resources through the budget development and appropriations process. Currently, VA's budget requests for construction are unrelated to the actual cost of maintaining their capital infrastructure, as evidenced by the funding gap between SCIP projections and budget requests, a fact verified by the Independent Assessment. In order to resolve this structural problem, VA must base its resource requests for infrastructure on demand capacity assessments and through the development of an actuarial estimate and schedule for maintaining that infrastructure. VA should be required to publicly update and report these actuarial estimates each year concurrent with the budget submission so that the real need for infrastructure resources is known to Congress, veterans and the public.

To better align medical care and services with where veterans need that care, the IB's framework would require VA to reassess all currently proposed and future major construction projects and find ways to leverage community resources to identify private capital for public-private partnerships (P3) as an alternative and more efficient manner to build and maintain VA health care facilities. This would enable VA to invest in services the community lacks, while ensuring it continues to provide specialty care, such as mental health and spinal cord injury/disease care, in state-of-the-art facilities. Future capital infrastructure expansion would be based on need and demand capacity assessments, which would incorporate the availability of local resources.

The IB framework would also change VA's SCIP process to include P3 options that would blend existing replacement options to better leverage federal and local resources. It would also require VA to engage community leaders to develop broader sharing agreements so it can plan infrastructure in a way that allows communities to share resources, while allowing VA to invest in services the community lacks.

The access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system that impact VA's ability to provide direct care. Evaluating VA's capacity to care for veterans requires a comprehensive analysis of veterans' health care demand and utilization measured against VA's staffing, funding, and infrastructure. However, VA's capacity metrics are based on deflated utilization numbers that fail to properly account for the true demand on its system.

For example, a shortage of nurses within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and has forced SCI/D centers to reduce the amount of veterans they admit. This has caused a decrease in the daily average census at some SCI/D centers and implies that there is a lack of demand on the system, when in reality veterans who want to access SCI/D care are turned away because those centers lack the staff to man available beds.

Recognizing that VA's Veterans Equitable Resource Allocation (VERA) model is based on utilization, VA's inadequate staffing ratios cause a downstream impact on funding for capital infrastructure projects and the resources local VA facility leaders are given to meet demand. For this reason, the IB's framework recommends establishing staffing models based on population density thresholds, actual medical need, functional level and other critical factors. This model would also need to account for changes in the veteran population and surges in demand as VA health care improves and military downsizing continues. Doing so would ensure VA is able to measure the true capacity of and demand for services at its medical facilities.

Regardless of how well VA reforms staffing and capital infrastructure processes, it will not be able to close access gaps if it does not receive the resources it needs to meet demand. In fact, the CMS Alliance to Modernize Healthcare emphasized in its report "*Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*" (released on September 1, 2015) that VA's ability to meet its promise to veterans is limited by the resources it receives from Congress, and that VA would need increases over the next five years to meet expected demand. The IBVSOs annually conduct a thorough analysis of VA health care utilization and submit detailed recommendations for full and sufficient funding to

address current and future utilization and access gaps. Unfortunately, for fiscal year 2015, Congress enacted appropriations that were nearly \$2.0 billion short of the IB's fiscal year 2015 recommendations for VA's Medical Services accounts. Less than six months after passage of that bill, VA reported a \$2.6 billion budget shortfall in its Medical Services accounts that could have forced the Department to limit health care to veterans if Congress was unable to provide additional funds. Fortunately, VA was authorized to use the Veterans Choice Fund to address the short fall. The IBVSOs believe that it is likely VA will face another budget shortfall in fiscal year 2016, and this pattern could continue without additional structural changes.

The IB agrees with the Independent Assessment's finding that the congressional appropriations process does not provide VA the flexibility it requires to meet the demands on its health care system. With this in mind, the IBVSOs believe that the congressional appropriations process must be reformed to ensure VA has the resources it needs to provide the timely, high quality health care services veterans demand instead of limiting the amount of care VA is able to provide. While the IB was at the forefront of efforts to enact advance appropriations to relieve the pressures of a broken appropriations process on the VA health care system, we believe that consideration should be given to new proposals that might optimize the funding process. There have been a number of proposals over the years to address this issue ranging from adopting methods that have worked for other departments (a VA health care fund similar to the Department of Defense's overseas contingency operations fund) to technical changes to the existing appropriations process (authority to transfer advance appropriations to current year budget). The IB's framework calls on Congress to evaluate the merits and feasibility of these and other proposals to strengthen the appropriations process to ensure VA has the ability to provide the health care veterans need.

To ensure VA's budget requests are accurate and properly aligned with the health care needs of the veterans population, the IBVSOs would also call for reforming VA's current planning methodology, budget forecasting and resource allocation systems to align them with the changing demographic and health care needs of the veterans population. The IB framework recommends the establishment of a Quadrennial Veterans Review (QVR) process, similar to the Quadrennial Defense Review. The QVR would serve as the benchmark for the Future-Year Veterans Program (FYVP) that can take a long view of the prospective resource needs based on demand for health care services within the entire integrated health care network. This would better align VA's strategic mission with its budgets and operational plans, and help provide continuity of planning across all administrations.

While ensuring VA has the resources it needs to meet demand is vitally important, it is also critical that VA continue to serve as a good steward of federal resources used to provide timely, quality care to veterans. To support this point, the IB's framework calls for a biennial independent audit of VA's budgetary accounts to identify line items and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations.

Reform VA's Culture with Workforce Innovations and Real Accountability

Secretary McDonald has made improving veterans experience a main pillar of the MyVA transformation. To ensure VA leaders are aware of the issues veterans face when they obtain their earned benefits and health care, the MyVA taskforce has established the Veterans Experience Office, with a Chief Veterans Experience Officer who reports directly to the Office of the Secretary. VA plans to have veterans experience officers throughout the country who collect and disseminate best practices for improving customer service, coordinate community outreach efforts, and serve as subject matter experts on the benefits and services VA provides to veterans.

The IBVSOs have consistently heard from veterans that their patient advocates are ineffective or seek to protect the medical facility's leadership instead of addressing their concerns. The IB believes that patient advocates cannot effectively meet their obligations to veterans if their chain of command includes VA medical facility staff that is responsible for the actions and policies they are required to address.

The IB framework would strengthen the Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code (U.S.C.), a veteran's right to seek redress through clinical appeals, claims under section 1151 of title 38, U.S.C., the Federal Tort Claims Act, and the right to free representation by accredited veteran service organizations are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, both in the public and private sector.

Finally, any plan to reform the culture of VA must also take into consideration the need to modernize VA's workforce and ensure VA employees serve the interest of the veterans' community. While Congress has focused on firing underperforming employees, the IB partners believe that the situation is more complicated and demands a holistic approach to workforce development that allows VA to recruit, train, and retain quality professionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly discipline employees whenever appropriate.

The IB partners applaud the MyVA taskforce for acknowledging that employee experience is vital to its transformation efforts. The MyVA taskforce has developed a number of programs and initiatives to engage and empower VA employees. However, federal hiring still reflects a mismatch between the skills desired and the compensation provided for many of the professionals VA recruits. If Congress is focused on bolstering VA's ability to fire poor-performing employees, Congress must also give VA the leverage to hire employees quickly and offer compensation commensurate with their skill level.

By focusing solely on disciplinary proceedings and failing to properly cultivate a motivated and compassionate workforce, we make VA an unattractive employer to potential recruits. The

IBVSOs believe that we must build a framework that makes VA an attractive employment option for the best and brightest who want to care for our veterans.

Conclusion

Congress, the Administration, the IBVSOs, and other key stakeholders in the veterans community have an obligation to ensure that the veterans' health care system is properly aligned to meet the unique needs of the veterans it serves. Meanwhile, the VA is at a crossroads that will determine how it will carry out its mission to America's veterans. The IBVSOs will continue working to ensure that our nation's veterans receive high-quality, accessible, comprehensive, and veteran-centric health care designed around their needs and preferences.

The IB's four-pronged health care reform framework looks beyond the current organization and division between VA care and community care to create a blended and seamless system that is best for veterans. Moving forward, the IBVSOs will use this framework to inform legislative proposals and ensure reforms of the VA health care system focus on veterans experience, service delivery, management, accountability, and budget and planning process changes needed to meet the unique and complex health care demands of the men and women who have served and sacrificed. Only through meaningful reforms can we live up to President Lincoln's promise "...to care for him who shall have borne the battle, and his widow and his orphan."