



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  
JOSEPH A. VIOLANTE  
DAV NATIONAL LEGISLATIVE DIRECTOR  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
MARCH 24, 2015**

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, I am pleased to appear before the Committee today to discuss issues raised with the implementation of the distance criteria contained in the Veterans Access, Choice and Accountability Act of 2014 (VACAA), Public Law 113-146.

As you know, the waiting list scandals of last year and the health care access crisis that were uncovered led to the creation of a new, *temporary* "Choice" program for certain veterans who were being required to wait too long or travel too far to receive timely care at a Department of Veterans Affairs (VA) medical facility. The bill established two primary access standards to determine when and which veterans would be authorized to use the new Choice program: those who wait longer than 30 days or travel more than 40 miles, the latter of which is the particular focus of today's hearing. 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 commonsense might dictate.

First, the determination of whether a veteran resides more than 40 miles from the nearest VA medical facility is based on a geodesic measurement, essentially the distance in a straight line from point-to-point, or "as the crow flies." Second, the measurement is taken from the veteran's residence to the nearest VA medical facility – even if that clinic or medical center cannot provide the service required. As has been acknowledged by the law's primary sponsors, these more restrictive standards for measuring 40 miles were driven by a need to address high cost estimates by the Congressional Budget Office (CBO). As a result, the final version of the law that contained these restrictive conditions received a lower CBO score than earlier estimates. VA has indicated that approximately 500,000 veterans qualify under that 40-mile standard. However, with the law now being implemented, many observers believe these restrictive conditions are not logical or equitable for determining which veterans are eligible to participate in this temporary, three-year Choice program. We agree.

DAV believes that the standard of 40 miles from a veteran's residence to the nearest VA health care facility must be measured as humans travel, not as crows fly. Typically, that measurement would be made in road mileage, similar to VA's Beneficiary Travel program; although an argument could be made that driving time ought to be considered as well. DAV would support amending Public Law 113-146 so that distances are measured using door-to-door driving, not geodesic, distances.

Further, it makes no sense to measure the distance to a facility that is unable to provide the needed service. DAV would support amending the law to reflect that the nearest VA facility must be one that can actually provide the service. We would note that VA's making such determinations, though equitable, may not be easy. Whether VA has the capability to quickly and accurately determine exactly which services are available, and where and when, may require some significant upgrades to IT systems and changes in business processes. As Congress considers how to make such a change to the Choice program, it is imperative that the VA's logistical capabilities be carefully considered before establishing implementation timeframes to avoid creating expectations among wounded, ill and injured veterans that VA might not be able to meet.

It is important to point out that even with these changes, the 40-mile standard for the Choice program is not a panacea to solve VA's access problems. For some veterans five miles might be too far to travel for primary care, particularly if they have severe physical or mental disabilities. On the other hand, for some veterans having to travel one hundred or more miles might not be too far away to receive highly specialized care. Rural people, including veterans, travel longer distances than suburban or urban people to gain access to all kinds of services, including health services, because they do not have the same options as people who live in urban or suburban locations. Moreover, when it comes to urgent or emergency care, rigid access standards such as 30 days or 40 miles could actually be an impediment to receiving timely access to care. In general, the most important access standard must always remain what is clinically appropriate for each individual veteran.

Mr. Chairman, while DAV supports these commonsense changes to the definition of 40 miles, we do so only in the broader context of how this temporary Choice program was structured. In establishing the Choice program, Congress also established a separate and mandatory funding source to ensure that VA would not be forced to make a choice between providing care to veterans who choose to receive their care at VA and those who access care through the non-VA Choice program. One of the primary reasons that VA's purchased care program has been unsuccessful in meeting all veterans' needs is the fact that it does not have a separate, mandated funding stream. Going forward, Congress and VA must ensure that funding for non-VA health care, however that program may be reformed, remains separate from funding for the VA direct care system.

Another principle central to our support for the temporary Choice program is coordination, which is vital to the quality of veterans' care. VA's use of third-party administrator (TPA) networks helps to assure that medical records are returned to VA, that there are quality controls on clinical providers and that neither VA nor veterans are improperly charged or billed for services. VA's use of the TPA structure displays many similarities to VA's Patient Centered Community Care (PCCC) program. Through PCCC, VA obtains standardized health care quality measurements, required 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 will produce the same outcomes as an integrated VA health care system, it remains an important component of how non-VA care should be provided in the future.

Most important, 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 employ enough physicians, nurses and other clinical professionals, along with a lack of usable treatment space to meet the demand for care. Regardless of how both VA and non-VA care health care programs are reformed in the future, until adequate – and separate – funding is available for both, veterans will continue to experience unacceptable access barriers.

While the scandal that enveloped VA last year certainly involved mismanagement in Phoenix and at other VA sites, we have no doubt that that underlying cause was the mismatch of VA funding and veterans' health care demand, a situation that is not new. In fact, it was widely discussed and publically reported to Congress in May 2003 by the President's Task Force to Improve Health Care for our Nation's Veterans. The task force examined VA chronic funding shortages in the wake of inadequate budgets and growing waiting lists, which then resulted in a Secretary-level decision to suspend additional enrollments by nonservice-connected veterans. At that time, 236,000 enrolled veterans were waiting more than six months, without any defined appointments—a much higher number than during last year's crisis. The Administration and Congress failed to address the heart of the mismatch or to end the cut-off of enrollment. That mismatch continues today. In response, the Administration and Congress made only marginal improvements in VA funding to address the heart of the mismatch and the cut-off of enrollment eligibility for millions of veterans. We believe, and the task force predicted this possibility, benign neglect led directly to the 2014 crisis that captured the attention of the press, the American people and the Congress. We must not allow history to repeat itself.

Mr. Chairman, over the past decade, DAV, as a partner in *The Independent Budget* (IB), has recommended billions of dollars to support VA health care that Congress never appropriated. Over that period, we have presented testimony to this Committee and others detailing shortfalls in VA's medical care and infrastructure needs. In fact in the prior ten 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 what we recommended. Only over the past five budgets, the IB recommended \$4 billion more than VA requested and that Congress approved. For this year, FY 2015, the IB recommended over \$2 billion more than VA requested.

The other major contributor to VA's access crisis is the lack of physical space to examine and treat veterans in need of care. Over the past decade, the amount of funding requested by VA for major and minor construction, and the final amount appropriated by Congress, have been more than \$9 billion less than what the IB estimated was needed to allow VA sufficient space to deliver timely, high-quality care. 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. In fact, the sum of those missing billions ironically almost equals what Congress appropriated in Public Law 113-146 (\$17.6 billion).

Mr. Chairman, in order for us to know where we are and where we should be going, we believe it is important to know how we got here. Over the past three decades and more, Congress has enacted several significant eligibility reform statutes, including Public Laws

97-72 (1981); 104-262 (1996) and 106-117 (1999). Each of these acts generally expanded eligibility for VA health care services, making entry into the VA system easier for veterans and, while in, providing them ever more health services. In particular, the 1996 eligibility reform act caused the most significant change in VA operations, because it was accompanied by a massive expansion of veteran enrollments and a concomitant establishment of hundreds of freestanding VA community-based outpatient clinics (CBOC). Millions of veterans responded by enrolling in VA health care. It should also be remembered that in the years following enactment of the 1996 act VA suffered through three consecutive years of flat-line budgets for health care, leading to the access problems reported by the task force in 2003.

By comparison, the VACAA was designed to respond primarily to VA's access-to-care crisis that exploded into public view early last year. The act provided significant new authority and emergency mandatory funding to enable veterans who were on unconscionable waiting lists another avenue to access care. The act also provided VA with \$5 billion to hire more health care staff, and to improve and expand VA health care facilities. In addition to the questions about how to define 40 miles for purposes of the Choice feature, VA has had difficulty in meeting the act's aggressive implementation schedule and requirements.

As mandated, VA has issued Choice cards to nine million enrollees, including to me personally and most of my DAV colleagues. I believe it is fair to state that in VA's effort to meet tight deadlines established in the law for issuing these cards to veterans, VA did not adequately prepare its staff across the system to deal with the response from veterans and the medical community, creating enormous confusion, both within the VA itself, among private providers, and throughout the veteran population. That is certainly one contributing factor for the apparently low number of authorizations that have been issued to veterans to use their cards in seeking private care.

It is still far too early to make any judgements about whether this new Choice program will function as Congress intended, whether it has enough or too much funding, if it will improve access for veterans, and most important, if it will improve health outcomes. Notably, the law does not require, nor has VA put in place, both qualitative and quantitative metrics that will transparently allow for such evaluations. Congress must continue its oversight to address critical questions about access, coordination, and quality of care to veterans who participate in the Choice program, compared to those who use other VA and non-VA health care programs. It would be reckless to make permanent, systemic changes without sufficient data, evidence and analysis.

The VACAA requires the creation of a "Commission on Care" to study and make recommendations for long-term improvements for VA to best deliver timely and high-quality health care 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, 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. As of today, no appointments have been made. The first meeting of the Commission would take place not later than 15 days after eight members have been appointed but the law then only allows the Commission 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 its final report.

In our view, 90 days is not sufficient time for a newly constituted Commission of 15 individuals – each with his or her own unique background, experience and understanding of the current VA health care system – to comprehensively examine all the issues involved, conduct and review sufficient research and analysis, and discuss, debate and come to agreement on specific findings and recommendations that could change how health care would be delivered to millions of veterans over the next twenty years. In addition, the Commission is required to evaluate the results of an independent assessment of the VA health care system now being undertaken by a private sector entity or entities. That independent assessment has dozens of very specific and complicated questions that must be addressed, but it does not have a specific deadline for producing a final report. As such, it would be impracticable to expect that the Commission could offer any independent assessment of that report without sufficient time to review it, and it may not even be available until after the Commission's reporting deadline. Based on our best judgement, we would strongly recommend that the Commission be provided at least 18 months to complete its work, and that any interim report be required no sooner than 12 months from its first meeting. In addition, we urge you to ensure that the Commission receives all the resources it needs to arrive at findings and recommendations that are based on independent analysis and judgement.

Once these changes are made to provide sufficient time and resources for the Commission to properly complete its work, we urge that all parties expeditiously appoint the members of the Commission so that it can begin. We would hope that in making appointments, the interests and perspectives of veterans remain most prominent in the work of the Commission, including highlighting the needs of wounded, injured and ill wartime veterans. While we certainly understand the need to consider all points of view, including those of the private sector, it is imperative that financial considerations never take precedence over the quality and safety of health care provided to wounded, injured and ill veterans. Therefore, we urge Congress and the Administration to give serious consideration to appointing veterans who have firsthand knowledge of and experience with the VA health care system.

We strongly urge that Congress and the Administration allow the Commission process to work by refraining from taking any permanent actions, whether through legislation or regulation, on matters being considered by the Commission. Since enactment of the VACAA, continued discussion has occurred in Congress, in the Administration, among veterans and by the public about how best to strengthen and reform the VA health care system. Also, some ideas have emerged that would radically reorganize or even dismantle the VA and eventually privatize all of veterans health care. We would certainly hope that these and other permanent changes would not be considered until after this Commission has had sufficient opportunity to determine how best to deliver health care to veterans for the next two decades, submitted its recommendations, and then allowed other stakeholders and Congress to engage in a debate worthy of the men and women who served, and in particular to protect the health of veterans wounded, injured and ill due to their military service.

We strongly believe that the VA health care system has been the centerpiece of how our nation delivers health care to America's wounded, injured and ill veterans, and must remain so. Without a robust and high-functioning VA, we would be concerned that millions of veterans who need, or who will need, VA's specialized services for spinal cord injury, amputations, blindness, mental health, long-term services and supports, and other needs, may end up with little recourse but to fend for themselves in the private sector. Without a critical mass to sustain VA health care, the impact on VA's statutory academic and research missions would be difficult to project, but their goals and past record of success would unquestionably be diminished. That would be a tragic loss not only to veterans, but to all Americans who have benefited from VA's many health science discoveries and medical advances.

Mr. Chairman, we have long held that no wounded, injured or ill veteran should be required to wait too long or travel too far to access the health care they have earned through their service and sacrifice. The needs of service-connected disabled veterans were not a part of the debate when Congress crafted this law. Any adjustment to this act must ensure that the needs of service-disabled veterans are met, particularly given their reliance on specialized VA services.

Because VA health care cannot be available at all times and in all geographic locations, there will always be a need for non-VA health care programs. Our shared goal must be to ensure that those programs function as seamlessly and efficiently together with a robust, safe, efficient, high-quality VA health system that provides the best health outcomes for the men and women who served and sacrificed for our nation.

Mr. Chairman, this concludes DAV's testimony. I would be pleased to address questions from you or other Members of the Committee.