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***STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
SEPTEMBER 14, 2016***

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify on the report and recommendations of the Commission on Care focused on improving veterans health care over the next twenty years. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Virtually all of our members rely on the Department of Veterans Affairs (VA) health care system for some or all of their health care, particularly for specialized treatment related to injuries and illnesses they incurred in service to the nation.

Since the waiting list scandal and access crisis were uncovered by Congress and the national media in the spring of 2014, a vigorous debate has taken place about how best to provide timely, high-quality, comprehensive and veteran-focused health care to our nation's veterans. There have been dozens of Congressional hearings, multiple internal reviews, numerous media investigations, enactment of temporary programs and laws, expert stakeholder input, an independent assessment, and recently a comprehensive report with recommendations from the Commission on Care. Yet despite having diverse perspectives, virtually all of the major stakeholders have coalesced around a common solution: creating an integrated network of VA and community providers, with VA serving as the coordinator and primary provider of care. This transformative approach has been endorsed by DAV, the *Independent Budget* veterans service organizations (IBVSOs) (DAV, the Veterans of Foreign Wars, and Paralyzed Veterans of America), VA Secretary McDonald, key Congressional leaders and the Congressionally-mandated Commission on Care.

Mr. Chairman, with millions of America's veterans continuing to choose and rely on VA, and increasing numbers seeking care every day, it's time to move from debating VA's past problems and start taking actions to create the future VA health care system America's veterans deserve. With the current veterans' "choice" program expected to expire early next year, Congress must now decide whether to extend, expand or modify the current program or move beyond the "choice" paradigm by creating a new model of health care delivery based upon an integrated network of VA and community providers capable of providing care to veterans whenever and wherever needed.

As this Committee is well aware, the Veterans Access, Choice, and Accountability Act (Public Law 113-146) was enacted in August 2014 in direct response to the access crisis and waiting list scandal at the Phoenix, Arizona VA Medical Center and other locations around the VA system. The primary purpose of the Choice Act was to address veterans' access barriers by creating a new temporary choice program that allowed certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for requested care, or travel more than 40 miles to a VA facility to receive requested care. The act also required an outside, independent assessment of the VA health care system, and it established the Commission on Care to study and develop recommendations for VA to improve the delivery of health care to veterans on a longer term basis.

Since its inception two years ago, the choice program has been beset with problems, some caused by the design of the law and others due to the urgent implementation schedule mandated by Congress. As the number of veterans using the choice program has risen, so have the number of problems they have encountered related to timely access, care coordination, appointment scheduling and provider payments. Although DAV and other VSOs supported passage of the choice program as an emergency response to the access crisis, it was neither intended to be nor supported as a permanent centerpiece of VA's health care delivery model. To address technical and implementation challenges with the choice program, Congress enacted two subsequent acts (Public Laws 113-175 and 114-41) but has not made any further legislative changes while awaiting the Commission on Care's final report.

The Independent Assessment mandated by Public Law 113-146, conducted primarily by the MITRE and Rand Corporations, produced voluminous data, information and recommendations about improving health care to veterans. The first and most important finding of the assessment was that the root cause of VA's access problems was a "...*misalignment of demand with available resources both overall and locally...*" leading to the conclusion that "...*increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care...*" in the future.¹ Further, despite these deficits, the assessment confirmed what DAV, other VSOs and dozens of independent studies have reported over the past two decades: VA quality of care, on average, is as good as or better than, care in the private sector.

Last year, as mandated by Public Law 114-41, VA developed and submitted a plan to Congress to consolidate non-VA community care programs, including the choice program. VA's plan would create a high-performing network comprised of both VA and certified community providers. Although VA has already begun taking steps to move forward with a consolidation plan, VA is awaiting Congress to enact enabling legislation to facilitate the new consolidated program that would bring VA's plan to fruition.

Furthermore, the IBVSOs developed a joint *Framework for Veterans Health Care Reform* that proposed a similar concept of local veteran-focused integrated health care networks. Notably, both the IB framework and the VA plan call for VA to remain the coordinator and primary provider of care, with community providers integrated when needed to guarantee veterans timely

¹ *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, The MITRE Corporation, September 1, 2015, p. B-3.

access to care. This integrated network approach has been publicly supported by dozens of other veterans and related organizations, reflecting the views and sentiments of millions of veterans they, and DAV, represent.

The Commission on Care spent almost a year reviewing the Independent Assessment, hearing from stakeholders and other outside experts, and developing its recommendations to improve health care for veterans. While the Commission considered a wide range of ideas and options, including proposals to privatize VA, and one plan (the “strawman proposal”) that called for dismantling the VA health care system over the next two decades. Ultimately, the Commission rejected the radical ideas, instead reaching a consensus on recommendations that hold many similarities to the plans put forward by VA and mainstream veterans organizations. The first and foremost Commission recommendation calls for establishment of “high-performing, integrated community-based health care networks” with VA acting as the coordinator and primary provider of care. Although some important differences are apparent among the integrated network plan proposed by the Commission, the IBVSOs and VA, respectively, call for strengthening the existing VA health care system by incorporating community providers *into* integrated networks. Moreover, each proposal maintains VA as the coordinator and primary provider of care, and each views the use of community providers and choice as a limited means to expand access in circumstances in which VA is unable to meet local demand for care.

After two years of spirited and passionate debate about the future of veterans health care, we envision a clear path forward that builds on the strengths of the existing VA system, while expanding access by seamlessly integrating the best of community care to ensure no veteran must travel too far or wait too long for care. Congress and VA must now begin the steps to finalize plans and move forward with the evolution of veterans health care. Equally important, both Congress and the next Administration must make a commitment to ensure that the resources necessary are provided to complete this transformation.

While we agree with most of the Commission’s recommendations to strengthen the leadership, management and operation of the VA health care system, some remain of concern to us, and are explained below.

Recommendation #1:

Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Based on National Resolution No. 238 calling for reform of VA health care, adopted by delegates to our most recent National Convention, DAV supports the overall structure and intent of this recommendation to create an integrated care network model. However, DAV does not support the Commission’s recommended option to allow veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care. This open choice option would result in less coordinated care, worse health outcomes, lower the overall quality of care and result in significantly higher costs that could ultimately endanger the overall VA system of care that millions of veterans rely on, particularly veterans who were injured or made ill during military service.

As the Commission report states, “veterans who receive health care exclusively through VHA generally receive well-coordinated care... [whereas] ...fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.”² While veterans’ individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the Commission’s report states, “Well-managed, narrow networks can maximize clinical quality...” and, “Achieving high quality and cost effectiveness may constrain consumer choice.”³

Furthermore, the Commission’s recommended option to allow every individual veteran to determine which VA or non-VA providers in the network they would use could affect access for other veterans and would lead to increased costs. The Commission itself recognizes the likelihood of higher costs for networks under their recommended option, cautioning that, VA “...must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans’ choice, yet would also consume far more financial resources...”⁴ In fact, the Commission’s economists estimate that the recommended option could increase VA spending by at least \$5 billion in the first full year, and that it could be as high as \$35 billion per year without strong management control of the network. The Commission also considered a more expanded choice option to allow veterans the ability to choose any VA or non-VA provider without requiring them to be part of the VA network. Economists estimated such a plan could cost up to \$2 trillion more than baseline projections over just the first ten years.

While we agree that the VA health care system must evolve by integrating community providers into its networks, VA must retain the ability to coordinate care and manage workload within the networks. In general, the networks must have the ability to expand to include community providers if veterans face access challenges or VA is unable to provide sufficiently high quality care. However, the size, scope and design of local networks, as well as clinical workflow, must be directed by VA based on a demand-capacity analysis in each market in order to assure quality and adequate access to care.

DAV is particularly concerned about the Commission’s projection that more than 40% of the medical care currently provided inside VA facilities could shift to non-VA network providers if this recommended option is implemented.⁵ (Note that the “40% estimate is derived from the Commission’s estimate that 60% of the 68% of care that is eligible for community care under the recommended option would shift.) If such a large transfer of patient care workload from VA facilities took place, it would have a dramatic impact on VA’s ability to maintain a critical mass of patients necessary to safely and efficiently operate its current programs and facilities. An outflow of workload of this magnitude would undoubtedly lead to a number of facilities cutting services or closing, thereby depriving veterans of the option to receive all or even any of their

² Commission on Care Final Report, June 30, 2016, p. 28.

³ Commission on Care Final Report, June 30, 2016, p. 29.

⁴ Ibid.

⁵ Ibid, p. 31.

care from VA providers in certain locations. Such downsizing or elimination of VA as an option would be particularly devastating for severely injured, ill and disabled veterans who rely on VA for comprehensive, integrated and specialized care.

Furthermore, we are alarmed that the Commission report specifically states that *no* consideration was given to whether its recommended option would weaken or diminish VA's medical and prosthetic research, academic, and national emergency preparedness missions, which continue to be vital aspects of the VA health care system overall. In particular, the VA research program helps to ensure that veterans receive the most current, safest and most effective treatments available for service-related conditions, and help to advance the standard of health care both within VA and beyond. The report also explicitly states that the Commission did not consider whether a sufficient number of private providers would be willing to take on additional patient loads from VA at Medicare reimbursement rates, how such a shift from VA to private providers would affect underserved communities, or how reduced patient workload within VA facilities would affect the quality of care of veterans remaining in the VA system.⁶

In addition to these concerns, it is critical to emphasize that the creation of seamless integrated community networks cannot be accomplished quickly or without a significant infusion of new resources to develop and deploy a modern Information Technology (IT) and management infrastructure necessary to successfully operate the networks, particularly to achieve seamless scheduling, care coordination and provider payment functions. DAV and our IB partners have repeatedly documented the shortfall in appropriations for medical care, appropriate staffing levels, infrastructure, IT, and other critical elements of VA's health care programs over the past decade, all of which helped to precipitate the access crisis. Now that there is a consensus about how to move forward to reform, strengthen and sustain the VA health care system, it is imperative that Congress take decisive action to ensure that sufficient funding to accomplish this new mission be provided.

We agree with the Commission that networks should be, "... built out in a well-planned, phased approach..."⁷ in order to ensure that the potential secondary impacts discussed above are avoided or reasonably mitigated. Furthermore, it is imperative that before and during the development of these networks, VA should regularly consult and collaborate with local and national veterans organizations and leaders, as well as other key stakeholders and community partners to gauge progress and properly address legitimate concerns.

Recommendation #6:

Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

DAV agrees with the recommendation to streamline and strengthen VA's facility and capital asset program management and operations. We also agree with the recommendation to give VA greater budgetary flexibility to meet its facility and capital asset needs, particularly overcoming Congressional budget scoring rules that have complicated VA's ability to open new leased clinic space. We also agree that VA needs to have the ability to realign its health care resources to

⁶ Commission on Care Final Report, June 30, 2016, pp. 32-33.

⁷ Ibid, p. 4.

address changes in the veteran population, demographics, location and health care needs, as well as evolving health science and technology. However, we do not agree that it is necessary or advisable to create an inflexible process, similar to the BRAC process, which has been employed to close military bases. The development of integrated community networks must be based on dynamic demand and capacity analysis, which would include modeling of the need to expand, contract, or relocate VA facilities. Local stakeholder input would be essential to ensure that local health care coverage would not be negatively affected by any facility realignment. DAV and our IB partners also believe that expanded usage of public-private partnerships should be explored as another way to address VA's infrastructure needs.

However, even with these reforms, significant increases in infrastructure funding will be necessary to address VA's access challenges. The Independent Assessment mandated by the Choice Act, found that the, "...capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen."⁸ Without change, the estimated gap will be between \$26 and \$36 billion over the next decade. For Fiscal Year (FY) 2017, DAV and our IB partners recommended \$2.5 billion for all VA infrastructure programs; however, the Administration requested only \$1 billion. Over the last several budget cycles, Congress also failed to address this growing problem or provide necessary resources for VA to meet all of its infrastructure maintenance and modernization plans. To complicate matters VA has lacked expertise to efficiently manage its Capital Assets Program resulting in significant cost overruns on several projects. While certainly a need exists to maximize savings from closing unused or underutilized facilities, the Commission's report points out that these savings are estimated at only \$26 million per year, an amount that would not begin to make up for the shortfall in infrastructure spending required to maintain the remaining VA system. Also, under budget formulation policies, any such savings from closed or downsized facilities most likely would be lost to VA. Unless Congress and future Administrations begin to provide realistic funding levels to repair, maintain and replace existing VA health care infrastructure, these reforms will be significantly challenged.

Recommendation #9:

Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

While a board of directors is commonplace in the private sector hospital setting, DAV does not support the recommendation that would eliminate the VA Secretary's control of the VA health care system and give it to an unelected, independent Board of Directors that would be less accountable to the President, Congress, veterans and the American people. Separating veterans health care services from other veterans benefits and services would result in a loss of comprehensive and coordinated support for veterans, particularly those injured or ill from their service. In our opinion, creating another layer of bureaucracy between veterans and the VA health care system would create more problems than solutions. We appreciate the Commission's interest in recommending greater stability and continuity of leadership; however, we believe

⁸ *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, The MITRE Corporation, September 1, 2015, p. K-1.

better means are available to accomplish these goals without undercutting VA's uniquely integrated system of services and benefits.

Rather than create an inherently political and bureaucratic layer between veterans and their health care system, these same purposes could be accomplished through the establishment of strategic planning mechanisms currently being used by the Departments of Defense and Homeland Security. Specifically, we propose that VA be required to undergo a Quadrennial Veterans Review (QVR), similar to the Quadrennial Defense Review (QDR) and Quadrennial Homeland Security Review (QHSR). The QVR, similar to its counterparts, would establish a national strategy to guide the creation of federal policies and programs for veterans, and would be timed to overlap with Presidential administrations to provide continuity and insulation from political influence.

In addition, similar to the Departments of Defense and Homeland Security, there should be established a Future Year Veterans Program (FYVP) that would establish five-year resource needs and projections that VA would need in order to implement the policies and programs set out in the QVR. VA should also fully convert its budgeting and spending systems to a Planning, Programming, Budgeting and Execution (PPBE) system also used by the Departments of Defense and Homeland Security in order to assure accountability in how VA allocates its resources to meet immediate, short-term and long-term strategic goals. Establishing new planning and budgeting functions could provide VA stability and continuity in a more practical, effective and feasible manner than trying to establish a semi-independent governance board.

In addition, consideration should be given to overlapping the terms of the Under Secretary for Health and other senior VA leaders with Presidential elections, to provide additional stability and continuity, and to insulate these officials from political influence.

ADDITIONAL COMMENTS ON COMMISSION ON CARE RECOMMENDATIONS

Recommendation #2:

Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

DAV generally supports the intent of this recommendation but notes that additional funding would be essential for VA to hire new support staff discussed by the Commission. We also note the recommendation to eliminate bed reporting requirements under the Millennium Act is unclear.

We believe the oversight afforded by this Act is important; however, given changes in the veteran patient population, their health care needs, and the manner in which health care is delivered today, reinstating or maintaining the existing comparison year of 1998 [for bed levels] for a number of important programs would not produce information useful for Congressional oversight, veterans service organizations, and for others with interest in VA capacity.

Recommendation #3:

Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-funded programs.

DAV supports the recommendation to create a fair, transparent and timely process to appeal clinical decisions, and we have testified before Congress on this concept. We would emphasize the importance of including veteran patients and veterans advocates during the development of this procedure.

Recommendation #4:

Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

DAV supports the recommendation for VHA to adopt a model of continuous improvement and to share and standardize best practices in accordance with our Resolution No. 244, which calls for VA to maintain a comprehensive health care system for enrolled veterans, endemic to which is continuous improvement and the advent of best practices. We also agree that the three Veterans Engineering Resource Centers should play a more prominent role in the maintenance and improvement of such a system. Currently, VA employs numerous clinical researchers and operates several centers of excellence, health services research and development centers, and other centers devoted to continuous improvement, quality enhancement, patient safety and other factors affecting the model of care for veterans' health. Each has its own history, mission and proven accomplishments that have and continue to serve veterans. In addition, because systems engineering, as with other systemic change approaches, has limitations particularly in complex network-based adaptive systems, such limitations should also be considered when implementing this recommendation.

Recommendation #5:

Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

DAV supports the recommendation to more effectively address health care equity issues in VA's ethnic and minority populations. We refer the Committee to DAV's 2014 report, *Women Veterans: The Long Journey Home*, which details the barriers and program inequities that women veterans face. Our report offered specific recommendations to remedy these challenges.

Recommendation #7:

Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

DAV supports the recommendation to modernize and give VHA functional control over its IT systems in accordance with our recommendations in the IB. To assure full coordination of the proposed integrated networks will require full implementation of new IT systems and complete

interoperability across VA and network providers. We would again note that significant time and dedicated resources will be required to achieve this goal.

Recommendation #8:

Transform the management of the supply chain in VHA.

DAV generally agrees with this recommendation. We would note in consonance with our recommendations in the IB that some supply and acquisition programs and services are critically important to seriously disabled veterans, such as those affecting the procurement of certain types of prosthetics and sensory aids. Careful consideration must be given to balancing national standardization concepts with local flexibility to meet the unique needs and preferences of veterans who need these specialized services to address their disabilities.

Recommendation #10:

Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

DAV supports this recommendation and we note our specific support for VA's MyVA initiative that is underway and already beginning to address these concerns.

Recommendation #11:

Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

DAV supports the intent of this recommendation on the basis of our recommendations in the IB dealing with the need for reforms in VA's human resources management programs, and again note that VA's MyVA initiative and other new leadership initiatives are beginning to address these issues.

Recommendation #12:

Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

DAV generally supports the intent of this recommendation; however, transformation of this size and scope impacting the entire VA health organizational structure will have far reaching effects and must be carefully evaluated to mitigate any adverse consequences while achieving the overall goal.

Recommendation #13:

Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance

measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

DAV generally supports the intent of this recommendation, although we would emphasize that not all performance metrics could or should be identical to those used in the private sector due to the unique nature of the VA health care system and the significant differences between patient cases mix in VA facilities versus those in private care. Health care outcomes and patient satisfaction could be measured consistently between VA and private providers; however, metrics related to cost, value or efficiency are less likely to provide meaningful comparisons because of differences in how VA and private systems are funded, the role of private health insurance, the primary-preventative model of VA health care and the interconnection of VA's complementary psych-social services and benefits—none of which generally exist in private care. VA should continue to develop and optimize metrics that provide meaningful feedback about its unique health care model, as well as help develop new benchmarks that both VA and the private sector can use to strengthen health outcomes and performance measurement.

Recommendation #14:

Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

DAV generally agrees with this recommendation. In terms of providing military culture competency, VA providers are generally well-trained, though there remains room for improvement. As networks are developed, ensuring some level of military/veteran cultural competency to non-VA providers will be critical, although they may never possess the same level of immersion or understanding about the impact of military service as VA providers who work full-time inside a veteran-focused environment. We would also agree that non-VA providers should be expected to deliver the same level of veteran-focused care as VA providers. For example, all providers treating veteran patients need to ask about their military history and possible toxic exposures and be knowledgeable about medical conditions generally associated with certain wars or military conflicts.

Recommendation #15:

Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

DAV recognizes that the current laws governing VA personnel issues are complex and may need to be amended. We also recognize the need to strengthen VA's ability to recruit, hire, retain and be competitive with the private sector. However, we do not have a formal position on whether the creation of an alternative personnel system would be the best way to accomplish these goals.

Recommendation #16:

Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

DAV fully supports this recommendation on the basis of our human resources management concerns expressed in the IB.

Recommendation #17:

Provide a streamlined path to eligibility for health care for those with other than honorable discharge who have substantial honorable service.

DAV supports this recommendation on the basis of our National Resolution No. 226, adopted by delegates to our most recent National Convention, which calls for a more liberal review of other than honorable discharges for purposes of receiving VA benefits and health care services in cases of former service members whose post-traumatic stress disorder, traumatic brain injury and military sexual trauma or other trauma contributed to their administrative discharges characterized as other than honorable.

Recommendation #18:

Establish an expert body to develop recommendations for VA care eligibility and benefit design.

DAV does not believe a new commission or task force is needed to make adjustments to veterans health care eligibility or benefits design. The Secretary already possesses tools to control access through enrollment decisions, and Congress retains complete discretion to modify eligibility requirements, to adjust the health care benefits package or other benefits through the legislative process.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you and other Members of the Committee may have about the Commission's report and VA health care reform.