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THE VETERANS CHOICE ACT—EXPLORING THE DISTANCE CRITERIA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

MARCH 24, 2015

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THE VETERANS CHOICE ACT—EXPLORING THE DISTANCE CRITERIA

TUESDAY, MARCH 24, 2015

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m., in room SR–418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Cassidy, Rounds, Tillis, Blumenthal, and Tester.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. We will call this hearing of the Senate Veterans' Affairs Committee together. Thanks to the Members that are here and thanks to our witnesses that are here.

We are focusing today on the 40-Mile Rule. This was published by the notice for this hearing. I want to thank Sloan Gibson for being here today, and Dr. Tuchschmidt, thank you for coming. I also want to acknowledge the release by the Veterans Administration yesterday of an approach to the 40-Mile Rule in terms of distance to go by miles driven rather than crow-flies miles. It makes a lot of sense.

What does not make a lot of sense is it took so long to come to that decision, but I am glad you finally did. I think the Committee's pressure on some of the things we talked about in terms of the 40-Mile Rule, in terms of the care a veteran needs in determining factors is something we are going to have to focus on. I know the care need issue is something that may take a statutory fix, but we are going to work with you to do that.

I want to encourage you to tell Secretary McDonald that we acknowledged how fast the VA was able to move once they realized we were not going to relent, and we were going to stay rigid and stay committed to get the 40-Mile Rule fixed.

There are other things we want to fix as well. The construction problems in Denver, we want to find out what we can do to make things like that not happen again. Want to see to it the care the veterans need is something they get. Also understand this: with the change in the 40-Mile Rule that you are proposing, which it says you are beginning to work on. I hope that will be a fast beginning to work on period, because the veterans need it.

We understand the burn rate on the appropriated money for Veterans Choice will accelerate as we accelerate accessibility. But do

not use that as an excuse not to do something. My job and Richard's job and the members of the Senate is to get more money if we need to and to find it; it is not to make excuses as to why we cannot do things for our veterans.

The veterans expect us to deliver and I expect you all to deliver. We will do it right, we will do it right the first time, and we will be committed. I appreciate very much the Secretary's movement. We are now not talking about what we cannot do, but we are now talking about what we can do.

Please understand. Do not let the burn rate be a reason you cannot do something. I would rather have a good problem, and that is the need for more money to see to it our veterans are being helped, than make excuses and tell a veteran who risked his life for us that we just cannot help him. That is just not right.

With that said, I will turn it over to the Ranking Member, Senator Blumenthal.

STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for scheduling this hearing focusing on a problem that, fortunately, has been greatly diminished by action from the VA. The rule change announced today, commendably, relies on common sense rather than flying crows in assessing the real life consequences to veterans of traveling distances to seek health care. The VA has responded to repeated calls—and I emphasize there have been repeated calls from public officials like myself and Chairman Isakson, the veteran service organizations, advocates, and the veterans themselves.

The distance now will be measured by road mileage, not by some geodesic line drawn on a map. But the change in policy that is reflected in this decision has to be, in my view, applied to a variety of other areas, and focusing on VA health care provided outside the VA system is a very important area of consideration.

There is evidence. There is real data and a factual basis to believe that some of the health care provided outside the VA system is uncoordinated, inconsistent in the way that veterans are advised and directed. These disconnects between the VA system and the outside health care system that it has an obligation to provide outside VA services should be provided seamlessly with VA services. Likewise, VA health care should be seamless with the Department of Defense military health care.

So, there are disconnects now within the system that need to be addressed that are every bit as irrational and unacceptable as the 40-Mile Rule was. I hope that in this hearing and others, we will address those kinds of disconnects, inconsistencies, and other issues that need to be corrected. I thank the Chairman for this opportunity to speak briefly and look forward to your testimony. Thank you for being here.

Chairman ISAKSON. As we established in our first meeting, we are going to have filed statements by any of our Members if they want to make a statement for the record. We will be glad to accept them, or to make one at the end of our meeting, but we want to go straight to our witnesses.

Everyone knows the Honorable Sloan Gibson. Sloan is the Deputy Secretary to Secretary McDonald and we appreciate him being here. His sidekick is Dr. Tuchschmidt—is that the correct pronunciation—who, I understand, your job is about this 40-Mile Rule. Is that correct?

Dr. TUCHSCHMIDT. It seems so.

Chairman ISAKSON. Well, we are glad that you are here. We want to be of service to you and we want to be of help to you. We want to be a seamless set of partners who make these solutions work for our veterans. So, I am glad that you came and we will accept any testimony that you have, in addition to what Sloan Gibson has. Sloan, it is all up to you.

STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. GIBSON. Thank you, Mr. Chairman. Dr. Tuchschmidt is VA's interim principal Deputy Under Secretary for Health and he has been the lead for VHA on implementation of Choice.

Let me start by being very clear on several points. First, we fully support implementing the Choice program effectively to provide veterans timely, quality health care while ensuring the best use of taxpayer resources as has been suggested here just very briefly.

Second, non-VA care is critical for veterans. In 2014, we obligated almost $7 billion for non-VA care for veterans under programs other than Choice. In the first quarter of fiscal year 2015, veterans completed almost 20 million appointments, and of those 20 million appointments, 3.3 million were appointments with non-VA providers in the community. It is about 17 percent of our total appointments during the first quarter. So, non-VA care is a fact of life in VA and it is going to continue to be a fact of life for us.

Third and most importantly, we know that Choice is not working as well for veterans as it should work. That assessment is based on input from veterans, from Congress, from members, from non-VA care provides, from VSOs, and from our own employees. But it is our program and we are working hard to improve it. We work to quickly overcome issues as we discover them and to ask for your assistance in areas where we need help.

Here are some of the issues that we are working on right now. A lot of veterans are frustrated. It has been noted the 40-mile straight line as the crow flies criteria for eligibility has nothing to do with how far they actually have to travel. They do not understand why we measure the distance to the nearest VA facility even though it may not provide the specific care that the veteran needs.

They do not understand why we cannot take into account the hardships and burdens that many face to travel to receive care. Or they simply just do not understand how the Choice program works. It is not like a health plan; it is different. And such confusion leads to lower use of Choice.

That is reflected in the statistics. As of the 20th of March, based on the daily data that we receive from the third-party administrators, approximately 46,000 authorizations had been issued for care under Choice, and 44,000 had been scheduled with non-VA providers.

Here is some of what we are doing to address the problems I alluded to earlier. As has been mentioned, we are going to change the distance criteria from straight line to travel distance, similar to the way that we measure beneficiary travel payments. Our original interpretation, straight line distance, was made to conform with what we believed was Congress's intent as reflected in the conference report and as confirmed in meetings with Congressional staff.

Based on feedback from veterans and members, we believe we need to change it. Our estimate for the impact of this change is that it will roughly double the number of veterans eligible as well as the costs associated with the 40-mile provision under the law, which we can talk about that further.

Second, we want to work with Congress to find alternatives to measuring 40 miles to any VA medical facility regardless of whether the facility offers the specific care a veteran needs. We believe we need statutory authority and your help on this issue.

We are running analyses on various options to identify alternatives that open the aperture to veteran eligibility for Choice while working within available resources and considering some of the longer term implications. As we have meaningful analysis to share in the days ahead, we will bring that to you for review and for discussion.

We are also requesting your legislative assistance to broaden VA's flexibility in determining Choice program eligibility, where traveling for care may present a particular hardship to the veteran. To date, only 125 veterans have been determined eligible for Choice under the unusual or excessive burden due to geographical challenges provision.

Last September, we asked that the geographical challenges language be amended to give the Secretary greater flexibility in extending Choice eligibility to veterans facing hardship or unusual or excessive burdens in reaching VA medical facilities. We believe that legislation providing that flexibility on this issue will enable more veterans to choose to receive care closer to home.

We will continue to focus on outreach and communication with veterans to ensure that they understand the Choice program to include—we are already working to establish a recurring veteran survey to measure their knowledge of and experience with the program. We are expanding our social media engagement with veterans, families, and care givers about the program, conducting program-related town halls at VA medical facilities which have already begun.

We will do a follow-on mailing to every veteran eligible for Choice to further clarify and explain how the program works. Finally, we will continue training programs for VA staff to help them better explain Choice to the veterans that they serve day in and day out inside VA facilities.

As we work to solve veterans issues, we must also ensure that non-VA providers are informed about the program and how to best serve veterans. We know that collaborative processes with our third party administrators are in place, but I would characterize them as immature. They are not working as well as they need to work yet.

Many providers are simply confused about how the Choice program works and that is, in many instances, not surprising since some of them are having to rationalize among five different non-VA care programs, everything from sharing agreements with universities to local contracts to individual authorizations, to PC3 to Choice. All of these are different channels through which—I might add ARCH to that list—channels through which we currently provide non-VA care to veterans that VA pays for.

In many instances, these pay at different rates, and in almost every case, there are various authorization and payment mechanisms that are used to process the payments for these five or six different channels for non-VA care.

We must also improve training and simplifying operations so that our own VA employees can best assist veterans eligible for the Choice program. Navigating the different types of non-VA care programs can be confusing and challenging for our own people.

I would like to share a story from my visit last week to the outpatient clinic in Rochester, NY. I was there talking about the development of our new outpatient clinic, but we got into, as we always do at every medical facility I visit, a discussion about Choice and how it was working.

First of all, this is an outpatient clinic that has some limited facilities, limited services, primarily primary care and mental health, and they have got quite good access numbers. So, when I asked about Choice, the comment was, "Well, there are a lot of specialty care services that we do not offer." I said, can you explain that some more?

The example they gave was colonoscopies. They do not do colonoscopies there at the outpatient clinic. They normally refer those colonoscopies to the VA medical facility in Buffalo, which is about 75 miles away. Well, it turns out that Buffalo is all full up. They cannot take anymore. They have already got a long wait list there. Basically, Buffalo sends it back to the outpatient clinic and says, you are going to have to find it elsewhere.

Inside VA, if you do not have a clinic, an endoscopy clinic where you are doing colonoscopies, then you do not have a place to turn to to schedule it. If you cannot schedule it, then you cannot access the Choice program. So, what happens is in that case, the veteran gets referred directly to non-VA care, never the opportunity for Choice, because we do not offer that service inside the facility.

That is part of the challenge that we have got to work through as an institution, reconciling these different alternatives, better explaining to people inside the organization how to make Choice available to our veterans. I would tell you, quite frankly, I think that is one of the reasons we do not see higher utilization of Choice right now. We will get that fixed within a matter of days.

We will continue our outreach to VA facilities leadership to improve employees' understanding of Choice and to address lingering cultural issues that may make our staff reluctant to send patients into the community for care. This is not about our choice, it is about the veterans choice and we understand that.

In April, we will be sending teams of experts, including staff from Health Net and TriWest to the 15 facilities in each of their two respective catchment areas that have long wait lists but low

activity on Choice to do a deep dive into their practices to understand why we are not seeing more referrals into Choice. What are the business practices on the ground that are keeping us from seeing more activity there?

Finally, we ask for your support to update our authorities to use provider agreements for purchasing non-VA medical care. In addition to our continuing work to improve the operation of Choice, this change would allow us to streamline and speed up how we purchase care for an individual veteran and simplify the burden on providers in the community.

Mr. Chairman, we will continue to work with veterans, with Congress, especially with this Committee, with non-VA care providers, with VSOs, and our own employees to ensure the Choice program is working well in delivering great health care outcomes for veterans on a day in and day out basis. That is our commitment.

We thank the Committee for the opportunity to testify and the opportunity to work together with you to make things better for all of America's veterans and we look forward to your questions.

[The prepared statement of Mr. Gibson follows:]

PREPARED STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to participate in this hearing and to discuss the Department of Veterans Affairs' (VA) implementation of the distance criteria in the Veterans Choice Program. I am accompanied today by Doctor James Tuchschmidt, Interim Principal Deputy Under Secretary for Health.

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) is helping VA to meet the demand for Veterans health care in the short-term. VA has put considerable focus and attention on ensuring the law is implemented seamlessly for Veterans, focused on creating the most positive experience for them. We are very appreciative of this temporary measure to improve access while we build capacity within the VA system to better serve those who rely on us for health care.

As you are aware, the 90-day timeline to establish a new health plan capable of producing and distributing Veterans Choice Cards, determining patients' eligibility, authorizing care, coordinating care and managing utilization, establishing new provider agreements, processing complex claims, and standing up a call center was particularly challenging. In fact, we received overwhelming feedback from the marketplace about the significant challenges of meeting the law's aggressive timeline. Despite the timeline, VA published regulations and launched the Veterans Choice Program on November 5, 2014, with a responsible, staged implementation with the goal of providing Veterans with the best possible care-experience, while also meeting our obligations to be good stewards of the Nation's tax dollars. By the end of January, 8.6 million Veterans Choice Cards had been distributed to eligible Veterans.

The Veterans Choice Program established by section 101 of VACAA requires VA to expand the availability of hospital care and medical services for eligible Veterans through agreements with eligible non-VA entities and providers. It is a program unlike any other. Veterans who meet certain eligibility requirements are able to elect to receive care from eligible non-VA entities and providers through this program. What makes it unlike other non-VA care is the Veterans' ability to select from among eligible non-VA providers. Inherent in this flexibility is the need for VA to ensure that Veterans' health care is coordinated and delivered timely through seamless operations.

As we continue to stand up the Veterans Choice Program and grow the number of providers delivering services to Veterans, eligible Veterans are continuing to receive care in the community from other existing non-VA programs and providers. As of March 18, 2015, 46,429 Veterans have received authorizations for care under the Veterans Choice Program, and non-VA providers have scheduled 44,461 appointments for care in the Program since it began in November. To put these Choice Program numbers in perspective, in an average month, 6.4 million appointments are completed in VA and 1.3 million appointments are completed using non-VA care programs.

IMPLEMENTING THE VETERANS CHOICE PROGRAM

VA's goal has been, and always will be, to provide Veterans with timely and high-quality care with the utmost dignity, respect and excellence. As we have long maintained, for the Veteran who needs care today, VA's goal will always be to provide timely, clinically appropriate access to care in every case possible. However, as we have shared with staff for the Senate and House Committees' on Veterans Affairs in over 16 telephonic and in-person meetings about the implementation of this program that have been held between Committee staff and VA personnel since September 2014, users of the Choice Program have identified aspects of the law that are presenting challenges, resulting in confusion for Veterans, or not working for Veterans as well as they need to. We also recognize that early utilization of the Choice Program has not been as robust as expected. We have been eagerly seeking feedback on the program from all our stakeholders—from Veterans, Veterans Service Organizations, our employees, and Congress, and we are working diligently to address these challenges. We want to turn these challenges into opportunities to improve our care and services, but in some areas, we will need assistance from Congress and stakeholders.

Veterans Choice Program Outreach Efforts

VA recognizes that some Veterans lack awareness or are confused by the Veterans Choice Program. When we initially launched the program, we mailed explanatory letters to over eight million Veterans. To increase Veterans' awareness of the program, VA will continue a comprehensive communications program. The Veterans Choice Program outreach efforts can contribute to correcting confusion about the program by building awareness and understanding, as well as improving public perception of the Veterans Choice Program as a program designed to improve Veterans' access to care.

Importantly, VA has completed an outbound call campaign to those Veterans who were initially eligible for the Veterans Choice Program under the 30-day wait criterion. This outreach effort was completed to ensure these Veterans were aware of their eligibility for the Veterans Choice Program if they had not already been informed through their local VA medical center. All Veterans who were enrolled prior to August 1, 2014, and any recent Combat Veteran who enrolled after that date were mailed a Choice Card with an informational letter explaining their eligibility for the Choice Program. VA has also provided a Choice Program fact sheet for Veterans that can be printed locally and provided to the Veteran upon notification of eligibility for the Choice program. Additionally, VA briefed a number of external groups and organizations about the Choice program. These include provider groups as well as Veterans Service Organizations, who assist in reaching out to both providers and Veterans.

To continue our outreach efforts, we recently launched a public service announcement for eligible Veterans, viewable at: https://www.youtube.com/watch?v=i9nnsRlX5b8. We hope all parties will share the video to aid in education efforts about the Choice Program.

In the next few weeks, we will continue our robust outreach strategy to help Veterans better understand their benefits under the Veterans Choice Program, by:

- Collaborating with VSO leadership to share newsletter inserts, talking points, social media content, etc. with their membership;
- Initiating a re-occurring survey of Veterans to gain an understating of their knowledge of the program (The results of this survey will be leveraged to identify gaps in communication and training among Veterans and VHA staff.);
- Developing a comprehensive social media strategy for Veterans and their families and caregivers;
- Placing Veteran Choice Program posters in public locations to increase awareness;
- Hosting town halls related to the program at the VAMCs; and,
- Finalizing a brochure of information that will be available to Veterans.

Veteran Choice Program Employee Training and Education

We acknowledge that there are gaps in understanding the Veterans Choice Program and related business processes among VHA staff. This is leading to Veterans receiving inconsistent information and outreach about the program. To date, VHA has provided training through a variety of modalities including but not limited to, in-person training, webinars, virtual training, teleconference and any other means available. Over 25 Webinar training events have been provided on a variety of topics related to the Veterans Choice Program and a question-and-answer session has been held for each VISN and the facilities that fall under them. VHA is also providing

specific training for portions of the program, for example, explanation of the appeal process for a grant of hardship under the Program's "geographic burden section." All of these training opportunities are available for employees to download or view on the web for refresher training or if they were unable to attend.

Moving forward, VA will target training for staff, tailoring the training needs to the type of employee delivering care to Veterans. For example, we will deliver additional training sessions to our clinical, administrative and purchased-care staff.

In addition to schedulers, clinicians and facility management, "Choice Champions" directly assist Veterans with questions about the Veterans Choice Program. The Choice Champion plays a key role at the facility level in implementing and operating the Veterans Choice Program. Choice Champions are specifically trained to be local subject-matter experts on the Choice Program who can explain and advise Veterans, other employees, and our stakeholders on the program. There currently are more than 900 VHA employees from a variety of functions who have been named Choice Champions. Training, resources, and support for Choice Champions are available through the VA Pulse Choice Champion Community of Practice Web site as well as the VA VACAA Intranet Site. Ongoing monthly training calls are conducted to keep the Choice Champions engaged.

Refining Business Processes

We are also focused on looking internally at the business rules and internal processes that govern the Choice Program. Stepping back to revise our own practices and focus on long-term work plans should create more efficient processes that will engender better and timelier care experiences for Veterans as well as better business relationships with our non-VA care partners. Managing the Choice Program effectively requires us to have broad visibility of data. We are refining our data analytics to develop more thorough management and oversight of the Third Party Administrators' (TPA) performance. In order to support the non-VA care providers that treat our Veterans, we are refining the oversight of payments for services provided. We are also continually working with the TPAs to help them develop their healthcare networks to support Veterans' health care needs. More broadly, following a legislative proposal included in the Department's Fiscal Year 2016 President's Budget, VA requests Congressional support for updating the Department's authorities to use provider agreements for the purchase of non-VA medical care. Updating them will streamline and speed the business process for purchasing care for an individual Veteran when necessary care cannot be purchased through existing contracts or sharing agreements.

Eligibility for the Choice Program

We are grateful for the transparent and close working relationship with Congress in implementing the Choice Program to provide Veterans with greater options for care. One issue that has caused much confusion for Veterans and stakeholders relates to the determination of a Veteran's eligibility based upon the distance to the nearest VA facility. In line with the Conference Report drafted for VACAA, VA implemented this provision using geodesic (straight line) distance. We have heard the feedback from Veterans and our stakeholders about this determination. This decision presents difficulty and frustration for some of our Veterans when this straight line test excludes Veterans who reside within 40 miles of a VA medical facility using a straight line measure but must nonetheless drive a significant distance to reach that facility. Additionally, this measure is not intuitive for Veterans because it is unlike the mileage calculations used for the beneficiary travel program. We are exploring options related to this provision.

A second issue causing challenge for Veterans, is that according to the Choice Act, the Veteran is eligible for hospital care and medical services if the Veteran resides more than 40 miles from a medical facility of the Department, including a Community-Based Outpatient Clinic (CBOC), that is closest to the residence of the Veteran. This criterion bases eligibility on the proximity of the nearest facility, irrespective of the availability of the needed care at that site. VA is a regionalized system; so we recognize that every CBOC does not deliver the services needed by every Veteran. Absent a statutory change, we do not believe that we have the flexibility to adopt an alternative approach. All of these issues speak to a larger structural question—the right balance between VA's role as a provider of care and as a purchaser of care. We are undertaking further careful study on this issue. Additionally, section 101 limits the considerations VA can take into account when determining if a Veteran living within 40 miles of a facility is eligible for the Choice Program. VA may only consider an "unusual or excessive burden * * * due to a geographical challenge" when determining eligibility for non-VA care under this criterion. The Department asked in September 2014 to remove the "geographical challenges" lan-

guage from VACAA in order to provide the Secretary with greater flexibility in providing health care for Veterans who face unusual or excessive burdens in reaching VA medical facilities. Presently, fewer than 100 Veterans have been determined eligible for the Choice Program because they face an unusual or excessive burden due to geographical challenges. While the Department is educating staff and Veterans about this provision, this formulation does require VA to adjudicate claims that are very context-specific in nature. We believe legislation providing greater flexibility on this issue would enable more Veterans to receive care closer to home.

Rationalizing All Non-VA Care Programs

Beyond the Choice Program, VA has, for years, utilized various authorities and programs in order to provide care to Veterans more quickly and closer to home. In fact, the Department spent over $5.5 billion on non-VA care in Fiscal Year 2014, and our partnerships with other health care providers enable us to deliver care to Veterans where and when they want it. In Fiscal Year 2014, VA completed 55.04 million appointments inside VA and 16.2 million appointments were completed in the community.

We recognize though, that the number and different types of non-VA care programs and authorities are confusing to Veterans, our stakeholders, and our employees. Navigating these programs to determine the best fit for a Veteran can be challenging. The Department is examining our various non-VA programs to strategically view how all the programs fit together. We hope that this review can help us rationalize the ways we purchase non-VA care in order to deliver the best experience for the Veteran, while also efficiently using appropriated funds. We look forward to discussing this review and the guidance of the Independent Assessments conducted under section 201 and Commission on Care established by section 202 as they relate to VA's use of non-VA care.

CONCLUSION

We appreciate the authority granted by VACAA. We know that today, the program is not working as well for Veterans as it should, but we are working to overcome the challenges, and we are committed to providing Veterans with the best possible care-experience by implementing legislation effectively to deliver timely access to high-quality care for Veterans.

We are grateful for the transparent and close working relationship with Congress as we work to ensure that we are making progress in implementing the Choice Program. We will continue to share with the Committee any issues to ensure we have a common understanding of the implications of the Veterans Choice Program. I thank the Committee again for your support and assistance, and we look forward to working with you in making things better for all of America's Veterans.

Chairman ISAKSON. Dr. Tuchschmidt, do you have anything to add or are you waiting to be the victim of a question or two?

Mr. GIBSON. He is going to handle all the really hard questions, Mr. Chairman.

Chairman ISAKSON. Well, here is a hard one. In your testimony, you said 17.5 percent of the last quarter appointments in the Veterans Administration were non-VA appointments, right?

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. It is true you have the statutory authority to do those right now, right?

Mr. GIBSON. That is a true general statement, yes, sir.

Chairman ISAKSON. And VA initiated those appointments, not the veteran, correct?

Mr. GIBSON. That is correct. Well——

Chairman ISAKSON. Then why do you need——

Mr. GIBSON [continuing]. We initiated those appointments when the veteran called in for care and we were unable to provide the care that was needed inside the VA.

Chairman ISAKSON. Then why do you need it? Why do you need statutory authority now if you are already giving 17.5 percent of the veterans coming in non-VA appointments?

Mr. GIBSON. I am going to—tough question. I am going to ask Jim to handle this one because he has done research into the specific provisions of Title 38, I am assuming, that gives us the authority to schedule appointments in the community.

Chairman ISAKSON. Dr. Tuchschmidt.

Dr. TUCHSCHMIDT. Yes. I think a couple of things. I think one, we do not believe right now that we have the authority in the Choice Act, particularly as it relates to the 40-mile benefit, to make those decisions. So, we will need help in specifically, I think, addressing the geographic burden clause to expand the Secretary's ability to do that.

Outside of Choice in our non-VA, normal purchase care environment, we have two statutory authorities that allow us to buy care. One of those authorities, 1703, is very specific in that it allows us to buy care on a episodic, infrequent basis where we cannot meet the specific need of a veteran.

It is not, I am told by our general counsel, designed or intended to let us just go buy care for large groups of people or specific services. It is meant to be an infrequent solution.

The other statutory authority that we have actually allows us to go buy care in pretty broad terms, but it requires us to essentially do FAR-based contracting, you know, to establish a Government contract with a provider. We do those with large groups, universities, large practice groups or clinics in areas.

But individual providers are not going to sign a great big Government contract, which is part of the reason that we believe very strongly that we need the authority, the provider agreement authority that we have been talking about, so that we can make those individual authorizations in a much more effective way.

Chairman ISAKSON. Well, let me tell you what we are going to do. I am going to get Ranking Member Blumenthal's chief of staff and my chief of staff in touch with you this coming week when the break starts, and during the 2-week break between our staff and your staff, we ought to be able to come up with the legislative language you need to authorize whatever you need.

I think the faster we act on that, the better off. I do not think there is any disagreement on the Committee, is there? I think the faster—while we are gone, we will leave the work with you Sloan. When we come back, we will try to get a Senate Rule 14, if that is what it takes to get it on the floor and get it done.

Mr. GIBSON. Thank you very much.

Chairman ISAKSON. Further, this is not an accusation, but a statement. We are where we are today because some people in the VA, a minority, manipulated numbers on appointments, underserved veterans, and everything blew up. It blew up in Phoenix, it blew up in other places. It appears to me, if you are already giving non-VA care to 17.5 percent of your appointments that we are using an excuse—I am making a general statement here—as to why we are not serving the veterans under Veterans Choice.

If there is a legislative impediment, let us fix it, let us get it done, because our intent is to see to it that veterans get needed services.

Mr. GIBSON. Yes.

Chairman ISAKSON. Now, I am saying this as one member of the Senate. I am not speaking for the Committee. But if the financial burden to the Senate burns the money that we appropriate out sooner than later, that is a good problem to have because we are getting our veterans the care they deserve. We will have to find that money because we have made a promise to the veterans that I want to see work.

As long as the VA is doing everything it can do to see to it that the veterans are not, as you said, Sloan, frustrated, but in fact they are pleased with the service and the communication they get, then I think we will all be better off.

If Richard agrees with that, we will get our chiefs together with the Department. I think we can come up with that legislative language by the time we return in April.

Mr. GIBSON. Thank you.

Chairman ISAKSON. Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I do completely concur. I hope that we will get our staffs together and review not only new legislative language, but maybe administrative action that can be taken without legislation language.

On the 40-Mile Rule, I will be very blunt. For a long time, folks told us, "You need new legislation." We pushed back and said, "No, it can be done administratively." And now, you have done it administratively. We waited a long time, and when I say a long time, perhaps longer than we should have and Congress bears some of the responsibility. But I think the more we can act without legislation the better off everyone will be. I hope that in that meeting we can look for non-legislative opportunities as well.

Let me talk about just one of them. You have mentioned, Mr. Gibson—and I want to make clear that the critical tone to my remarks is not personal. It is not directed at you personally. Like the Chairman, I think we share here a determination, which I know from our private conversations as well as the public discussions we have had: to serve our veterans as well as possible.

You have mentioned, Mr. Gibson: the Patient-Centered Community Care Program, known as PC3; and the project Access Received Closer to Home, also known as ARCH. These are what you have referred to as non-VA programs. The fact is, what we have heard, and the factual evidence confirms it, that many different VA facilities around the country have uneven, inconsistent, and different approaches in implementing these programs.

There is no need for legislation to make these policies consistent. So, what I would like for you to tell us, not necessarily today, if you can today all the better, but I think we need a study and a comprehensive approach here to making sure that the referrals are as robust as possible in meeting the needs of veterans when better care can be provided outside the VA facilities.

I am referring to it that way because I do not view it as non-VA care when a veteran is assigned the VA facility. The VA is as much responsible for that care as it is when it is done in a VA hospital.

Mr. GIBSON. We agree with that point precisely. It is our own unfortunate use of language. But it is the fundamental point that makes what we do different than a health plan.

Senator BLUMENTHAL. Right.

Mr. GIBSON. We are accountable for those health outcomes for veterans.

Senator BLUMENTHAL. So, I want to make this point as strongly as I can. The VA should not fear the Choice program or the PC3 program or the ARCH program. It is not non-VA care, it is not a threat to the VA. It is a different mode of serving the same health care needs with the best possible health care.

I think we also want to know—maybe you can answer this point as well—how long are the waits for health care outside the VA system. In other words, when there is a referral to a private doctor, is there more than a 30-day wait to see that doctor? Because the veteran, the individual veteran in need of health care is no better off waiting 90 days to see a private doctor than 90 days to see a VA doctor at a VA hospital.

So, I think we need to be as strong and aggressive in overseeing these other non-VA health care services as the VA directly provided services. I do not know whether you have data on the wait times or travel distances for what you have referred to as non-VA.

Mr. GIBSON. We have data around PC3. Three quick points here. First of all, we do have data around that. I need to make clear, PC3 is a relatively new program. At the time Choice was enacted, I do not think we had PC3 in place much more than a year. Correct me if I say something wrong here.

And understand, PC3 was a radical departure from the historic practice inside VA. The historic practice has been basically 150 different medical centers, pretty much what you described, doing their own thing. Does not mean that there are bad arrangements, but it was pretty much everybody putting in place the support in their community that they needed to develop to do that.

So, yes, we do need to reconcile those different channels. That was the fundamental point that I made in the opening statement an that related topic. The other thing, very quickly, you know, if you are looking for somebody to hold accountable for the decision on driving distance, I am the guy. I sat there and I tried my best to honor the intent of Congress. I am going to read to you from the conference report verbatim.

"In calculating the distance from a nearest VA medical facility is the conferee's expectation that VA will use geodesic distance or the shortest distance between two points." That is verbatim language out of the conference report.

Now, I will tell you, if I had it to do over again, I would have ignored that. I would have ignored Congress's intent. I would have gone ahead and done what we thought was the right thing for veterans anyway, and I guarantee you, we would have been criticized for doing it. But at least I could have looked myself in the mirror and said, well, we did the right thing for veterans in the process.

Senator BLUMENTHAL. Well, I think that is a very important statement and it reflects the reason why I said in my remarks that Congress bears some of the responsibility. I appreciate your remarks.

Thank you, Mr. Chairman.

Chairman ISAKSON. No, we are all in this together, which is why each member has got a coin at their seat. I told you all at the first

meeting we had that we were going to adopt Lieutenant Noah Harris, who lost his life in Iraq's IDWIC slogan, I Do What I Can. We are going to do what we can for veterans. You all keep that as a memento of our commitment.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair, and thank you, gentlemen, for being here. I want to go back to the 40-Mile Rule. I am brand new. I was not here last year. And it sounds to me like you did exactly what you were asked to do based on the statutes, and I, for one, appreciate it when agencies honor the intent of the Congress even when I disagree with it, and this is one where I do.

When we fixed the 40-Mile Rule, how do we also deal at the same time with the reality that a VA facility may be within those parameters, but not able to provide the care the veteran needs?

Mr. GIBSON. That is today's $64 question. The reason the legislation got written the way it got written was because opening the aperture to 40 miles from where a veteran could receive care scored at multiples of the $10 billion. So, it was really a compromise to basically say, write it this way because that is what we could kind of back in to the $10 billion number; which, as I understand it from all of my conversations with the different Chairs at the time of the two Committees, was the thought process and the approach.

That is the tough spot that we are in right now. You know, I am very attentive to the Chairman's comment to forget about how much it is going to cost, forget about what the burn rate is going to look like. That leads you very quickly to a conclusion that says, well, just make it 40 miles from everywhere. Yet, if you do that, it is, we believe, potentially multiples of the $10 billion that we have got here.

One of the things we are doing is we are doing analysis to try to understand, you know, what if it is 60 miles instead of 40 miles? Or what if there are certain procedures, such as routine optometry or audiology or colonoscopy or physical therapy, that we could open the aperture on those, but then if it is a more complex procedure, that maybe it is OK to travel 100 miles.

Senator TILLIS. That is the part—I have the utmost confidence in Chairman Isakson and Ranking Member Blumenthal's staff to work with you all to figure that out. But that is the sort of thinking that needs to be woven into the discussion over the next couple of weeks because it is just practical.

I do have a question about the cost of it that, as a numbers person, I am not able to get my head wrapped around. What is the reimbursement rate for non-VA providers? When someone goes through a procedure, what is the typical reimbursement rate for a typical procedure? Is it Medicare rates?

Mr. GIBSON. The short answer is Medicare.

Senator TILLIS. OK.

Mr. GIBSON. That is what it is for Choice.

Senator TILLIS. OK.

Mr. GIBSON. In PC3, rates below Medicare or up to Medicare can be negotiated by the administrator. In these other arrangements,

they are oftentimes more frequently Medicare rates, but other higher rates may be negotiated.

Senator TILLIS. How do we, on average, allocate the cost of providing care in a VA facility? I mean, what is a comparable cost of care? If we are reimbursing the provider at, on average, Medicare rates, what does it typically cost? Is it half for a VA provider, the same for a VA provider versus a non-VA provider?

Dr. TUCHSCHMIDT. I cannot tell you by procedure, but I can tell you that if you look at the data from last fiscal year, our cost, average cost per person, totally allocated cost, which includes all of our facility costs and everything else, is just below the average cost of Medicare. It is about on par.

Senator TILLIS. OK. Well, that is the part of the math that I do not quite understand. I understand that you may be shifting to—first off, I think we all agree, nobody that I know on this Committee wants the privatization of veteran' care. We need VA hospitals. We need a place where veterans feel comfortable and they feel like they can get the most comprehensive care.

But, I cannot understand the sort of hockey stick projections for added cost when it looks like it has more to do with where it gets disbursed and less to do with how much more it costs. So, as we are going through this process, can we get a better handle on that? Because it would seem to suggest that Choice is doubling or tripling the cost to provide the same sort of care. Yet, it is still at roughly the same reimbursement rates for Medicare or for what it would cost in a VA facility.

Dr. TUCHSCHMIDT. We are running a lot of those analyses now around the kinds of things that the Deputy talked about, and we are working with our actuarial from Milliman, which is probably one of the best in the world.

I think the challenge or the part of that that is kind of above and beyond is our effort to try to understand the change in reliance that will happen, the cost shift that will happen from Medicare, Medicaid, or indemnity insurance to VA because somebody has—you know, it is easier to get the care through us and through the Choice program and it is cheaper out of pocket.

Senator TILLIS. I know my time is expired. I am going to stick around, maybe ask another round of questions if time allows. But I am just trying to get my head wrapped around this. There could arguably be some stranded costs, but that does not even make sense because if there were stranded costs, that means the facility is not being used; so, I wonder why they would be going to a non-VA provider.

I really think we have to do a better job of normalizing these numbers because it is the first thing we have to do to make it clear that this is not a budget buster. It is a different way of providing more timely care.

Mr. GIBSON. Yes.

Senator TILLIS. Thank you. Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Tester.

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I would also echo what you said earlier, where the staffs of your Chairmanship and the Ranking Member get together and hopefully we can get it out of this Committee and use it to give you guys the flexibility you need for specific care that veterans need.

Could you tell me what the process is, Sloan, on a veteran? I assume they call into the veteran facility, whether it is a CBOC or hospital, and ask for an appointment. What happens at that point in time? If they do not have a doc at the CBOC or—just tell me how the process works.

Mr. GIBSON. I will roughly outline——

Senator TESTER. Yes.

Mr. GIBSON [continuing]. And I will ask Jim to fill in.

Senator TESTER. As briefly as you can.

Mr. GIBSON. Sure. First of all, if it is a 40-mile veteran that knows they are in 40 miles, they will call directly to the third party administrator to schedule an appointment.

Senator TESTER. OK.

Mr. GIBSON. Other veterans that are not part of that group would call their clinic, call their doctor's office. They would speak with a scheduler or with a clinician and say, I need this kind of care.

Senator TESTER. Right.

Mr. GIBSON. And they would work to, "When do you need to be seen, when do you want to be seen?" They would ask the basic questions and work them into the schedule.

Senator TESTER. OK.

Mr. GIBSON. If it could not be scheduled within 30 days, then they would be offered the opportunity to use Choice and go that way.

Senator TESTER. Then, would the VA make the appointment or would it be up to the veteran to make the appointment?

Mr. GIBSON. What then happens is the veteran connects directly with the third-party administrator and the third-party administrator is responsible for lining up that provider in the community and scheduling that appointment.

Senator TESTER. And in Montana, that third-party administrator is who; do you know?

Mr. GIBSON. I am pretty sure it is TriWest in that part of the country.

Senator TESTER. TriWest. So——

Mr. GIBSON. Is it Health Net in that part of the country?

Dr. TUCHSCHMIDT. I think it is Health Net.

Senator TESTER. So, Health Net would set up the appointment with somebody that would be fairly close?

Mr. GIBSON. Yes. There are stipulations. One of the advances, my view, in PC3 as well as in Choice, is that there are requirements built into this for the third party administrator around distance and timeliness of the scheduling process.

Senator TESTER. Well, I think—getting to Senator Tillis's point—part of why there would be non-VA care is there would not be a doctor there.

Mr. GIBSON. Correct.

Senator TESTER. Consequently, you would then connect them with the private sector.

Mr. GIBSON. Correct.

Senator TESTER. The question I have is, was the bill we passed last July, 2 years ago. What is the VA doing to make fundamental changes in long-term investments necessary to build the capacity of the VA?

Mr. GIBSON. The Choice program actually has a 3-year or $10 billion sunset.

Senator TESTER. OK. But still——

Mr. GIBSON. The question is a great question. Congress, I believe, very appropriately, also authorized $5 billion that we are investing almost entirely in both facilities and in staff. So, in virtually every facility investment we are making direct investments that enhance our ability to provide access to care.

Senator TESTER. So, the question is, have you determined—do you have a short- and a long-term plan on where the facility shortfalls are? I mean, we have had different folks in from the VA that talked about this—and how you are going to get folks, in my case, into rural America, doctors in particular?

Dr. TUCHSCHMIDT. We do have a plan. We took the $5 billion, roughly half of that is for space, half of that is for people, roughly 10,650 people. The funding for the people part of that is slightly skewed toward next year because it takes a year to recruit a doctor, and the rest of it this year.

So far we have obligated about $77 million for salary support for the new people that we have hired around the country.

Senator TESTER. The issue for me is that we have got two problems in Montana, which may be the same in Arkansas or anywhere, where we do not have enough docs. We have got some nurse shortages, but docs are the big deal. Yet, if you did hire enough docs, you would not have the space. It is a chicken and egg thing. How are you guys doing this?

I mean, I can give you Missoula as a prime example. They do not have the space. I can say the same thing in other areas of Montana, that they do not have the space. You can hire the docs; they would have no place to work. So, how are you going to solve—how do you solve this? By the way, I am not saying this to point fingers at anybody. I mean, it is kind of in your lap so you have got to tell me how you are going to do it.

Mr. GIBSON. No, no, no. The other reason that some of the spending, the staff spending is skewed to 2016 is because we have to get some of the space issues corrected.

Senator TESTER. OK.

Mr. GIBSON. So, this was really a process, and I do not know—I cannot tell you offhand what we have allocated into Montana, both on space and on staff, but basically, we worked down through this thing all across the entire system to be able to allocate the workforce.

Senator TESTER. The bigger issue, Sloan, and it is the bigger issue is that do you have a plan? That is the bigger issue. Do you have a plan for facilities and do you have a plan for docs so that the facilities and the docs match up when you bring them on?

Dr. TUCHSCHMIDT. We do. So, we have a plan for the space that was front-loaded and the space and the people money all actually went to the places with the largest waiting lists for primary care or specialty care or mental health. You already know, some of the challenges are not just VA. I mean, shortages are in the country in general.

Senator TESTER. No, no. It is inside and outside. You are right.

Dr. TUCHSCHMIDT. Yeah.

Senator TESTER. OK. I have got some other questions for the record that are more specific to Montana. Thank you, guys, for your service, and I would be remiss if I did not say, almost without exception, the veterans that I talk to like the health care they get once they get through the doors of VA.

Mr. GIBSON. Thank you.

Chairman ISAKSON. Thank you, Senator Tester.

Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman, and I do appreciate the approach that you and the Ranking Member are taking in asking that we move forward in an appropriate fashion to address the issues.

Mr. Gibson and company, we want you to succeed. We want this to work. And I sense the frustration that you have with regard to the 40-Mile Rule, the definitions that are found within statute, and the expectations of you in order to make this thing work. I am just curious if it would be appropriate, should we actually look at modifying the statutory guidelines that are found within the legislation to begin with, to change it so that you do not have that issue in the future and that the 40 miles is not going to be audited, written up, and challenged again in the future.

It may be something that we may want to look at. In South Dakota right now, we have got—you know, we have the East River and West River and we divide our State up that way, which everybody in our part of the country knows it that way. If you look at East River, SD, we have got 34,000 veterans, 250 of which have actually exercised their Choice option and made an appointment with a non-VA provider.

Out of 19,330 veterans in West River, 61 veterans have used the Choice program. I think there probably needs to be some additional outreach to these folks. We are a pretty good sized State. But one thing comes to mind and that is, if there are real challenges in terms of getting these other physicians to actually participate in the programs, you have got a real challenge with having five different VA programs that you are trying to manage on this.

Is there something we can do in terms of providing statutory authority so you can maybe cut through some of the red tape? Is it necessary to have five different programs right now? Would there be a better way to do this so you can simplify contracting so that it is easier not just on the Department, but on the providers and institutions that you are expecting to step up?

Mr. GIBSON. There has to be a simpler way.

Senator ROUNDS. Do you need statutory changes to do that?

Mr. GIBSON. The honest answer is I do not know yet. We know we need contractual changes. We have got—the longer term contracts that are locally negotiated; the PC3 contract, which we actually modified to slip Choice up underneath it. I think we are going to have to reconcile those two things, and those are going to be contracting actions——

Senator ROUNDS. Would it not just make—excuse the term, but would it not be just a whole lot easier for everybody to take a little common sense into this thing here and just decide that we are going to have a single rate out there that we can negotiate with docs and work it through, or at least to provide you with the ability to do that?

Mr. GIBSON. I think the answer is an unqualified yes. Medicare provides for some differences, particularly in rural areas or in particular States, and I think we want to accommodate that because of the challenges attracting providers into those particular locations.

Senator ROUNDS. It most certainly would simplify rates for the providers because if they are providing Medicare services now, if they have got a system set up to follow that rate-making process or those reimbursement rates, at least it would make it easier on them to have the same type of an approach with the VA.

Would you check? Could I ask that you find out what you would need to be able to make that sort of a change and bring it back to the Committee?

Mr. GIBSON. I will tell you, on further reflection, if we were going to come up with a single way to do this, a single program and a single approach, unquestionably yes; we would have to have legislative authority because Choice is one of those five or six channels. ARCH is one of those five or six channels. Both of those were specifically legislated. And then we have got contract actions to work through on the others.

Senator ROUNDS. You have got an issue where you have got a bureaucracy, which is pretty overwhelming, and part of it is because you are doing multiple programs. Let us simplify it.

Mr. GIBSON. Yes, we agree.

Senator ROUNDS. Let us get it down to where the dollars are actually going back down to the providers.

Mr. GIBSON. We agree.

Senator ROUNDS. If we can cut through a whole bunch of programs, simplify it, make one program out of it, save the dollars and actually put them back in, you may not have the burn rate that you have right now on the veterans that you are serving.

Mr. GIBSON. We agree.

Dr. TUCHSCHMIDT. If I could add, one of the things that we are doing is working with a large consulting firm. We have asked them to bring their commercial side in, which does really nothing but help health plans get set up to run, to help us and they are doing an evaluation right now. I think when that evaluation is done, what we want to do is get people together and have a conversation about what the future of the VA purchase care programs look like.

Senator ROUNDS. So, my understanding is that you would be able to at least look and find out what it would take to be able to simplify both reimbursement and contracting processes that are there?

Mr. GIBSON. Yes.
Senator ROUNDS. OK. Bring it back in and let us look at it?
Mr. GIBSON. Yes.
Senator ROUNDS. Thank you. Mr. Chairman, thank you.
Chairman ISAKSON. Senator Rounds, thank you.
Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you. Mr. Secretary, Doctor, thank you for being here. I want to make just a couple of comments and then try to get to questions as quickly as I can. I want to rehash the authority of the Department, and I do this not for having an argument about whether you have the authority to fix the 40-mile arena or not, but to set the stage for you to assure me that there is no intention toward preventing full and all-encompassing care for veterans under the Choice Act at the Department of Veterans Affairs.

The reason I describe this is because of some skepticism I have about that. You quoted, Mr. Deputy Secretary, the report language was talking about the so-called "as the crow flies" measure and you analyzed that and determined that this is what Congress intended.

Let me read to you the language about the issue that I have been most vocal about which is the inability or the unwillingness of the VA to provide care to a veteran who lives within the 40 miles, but cannot get the care that he or she needs because there is a VA facility there, even though that VA facility does not provide the service the veteran needs.

Here is what the language says in the Choice Act. "The conferees do not intend the 40-mile eligibility criteria included in this section to preclude veterans who reside closer than 40 miles from a VA facility from accessing care through non-VA providers, particularly if the VA facility the veteran resides near provides limited services."

Then it goes on to make certain that you know you have the authority. The report language intends to notify the VA that you have the authority to utilize Title 38. Title 38 authorizes the VA to contract with non-Department facilities—I am quoting the title—facilities and providers to furnish hospital or medical services to eligible veterans when the VA is not capable of providing economical care because of geographical inaccessibility or due to an inability to furnish such care or services required.

Title 38 of the VA facility to enter into a contract agreement with non-VA health care entities to secure health care services that are either unavailable or cost-effective at the VA facility. The report language, again, makes clear that there is nothing in the law that says you cannot utilize Title 38 as described in those two sections.

So, you use the report language initially to tell us that "as the crow flies" is the way it had to be, but then decided there was a way to solve that problem. The report language, in my view, gives the opposite conclusion. You ought to be able to reach the conclusion that you can use the Choice Act.

Again, I do not want to get involved in the legal battles. You will tell me your lawyers say you cannot do that. The point I want to make, and it comes from a conversation I had with the Secretary back in September, in which we were talking about the Choice Act.

My question to the Secretary was, Do you have everything you need to implement this and to solve the problem?

The Secretary's response—this is the hearing of September 9, 2014—let us look at it through the lens of the veteran. Does it make sense for the veteran to get a cortisone shot closer to home? You know, what makes sense? And one of the things we are asking is to give the Secretary that flexibility in technical changes to the Care bill.

We then passed the technical changes in which the Secretary indicated that if we did that, he would have the full authority to implement the 40 miles as he thought was in the best interest of the veteran. In fact, he said, I think it is just simply putting in a phrase. It would be very simple-handed and we have been working that with the Committee's staff.

The reason I raise this topic is that what I would like to feel certain about is that you fix the "as the crow flies" issues, we pass legislation that fixes the issue of whether or not the services are available within the 40 miles, the definition of a facility within 40 miles.

Is there anything else, any other features of the law or any resource arguments you are then going to make that will prohibit the VA from fully implementing this legislation, the Choice Act, in a way that benefits the veterans that are intended and need the care?

The background that I outlined is, again, not to have a legal discussion about who is right or who is wrong about what the VA can do, but what has been suggested to me, my sense is, the VA has found reasons not to implement this legislation in a way that benefits the veterans. I am worried that we fix this, you fix the crow fly, the Chairman and the Ranking Member, and we come up with legislation language to fix the facility issue.

Is there going to be something else? Are we just going to be chasing the VA one day at a time for another reason that you cannot implement the bill?

Mr. GIBSON. I see I have 9 seconds for my response.

Senator MORAN. The answer would be no and will fit within the nine seconds.

Mr. GIBSON. As I have said, VA is committed to making this work and we are going to do what we need to do to make it work. There are reasons why the legislation was written the way it was written. In the case of the 40 miles driving versus distance, because it sits in the conference report, that is the reason why I think I have some flexibility and why I could have ignored that, even though that reflects what I believe to be the intent of Congress.

I do not have that flexibility as it relates to 40 miles from the care. In the bill text, a veteran is an eligible veteran for purposes of this section if the veteran resides more than 40 miles from the facility—from the medical facility of the Department, including a community-based outpatient clinic that is closest to the residence of the veteran. That is in the bill text.

I do not have latitude to disregard that. That is the law. So, that is exactly what we implemented. No, I do not believe I have the discretion to decide something different about 40 miles from a facility where they can get the care. That is where I have said before

that we need help, and I want to do that in a thoughtful way and I am delighted to have the opportunity to work with the Majority and the Minority staff over the next several weeks to try to come up with sensible approaches that are veteran-centered to make that happen.

Senator MORAN. My question, Mr. Secretary, is there something else that will then arise, once this issue is fixed, that then causes the implementation of this bill to be burdensome?

Mr. GIBSON. I have already asked, in my opening statement, for additional support and additional changes. So, they are included in my opening statement.

Senator MORAN. My time is expired. Mr. Chairman, thank you.

Chairman ISAKSON. Thank you, Senator Moran. I think this meeting is a crossroads for us and a good crossroads. I think the leadership you all exemplified since the last hearing we had ,to try to embrace the concerns we had versus obfuscating them shows, that you want to move in the right direction.

I think what is being asked by Senator Moran is a bona fide question. We are here to help. Sometimes you are going to have to tell us where you need the help, which you did in terms of the statutory language. But there is also self-initiated help which we expect you to do to find those things that will make this Choice Act work for the veterans. I think that is what you were referring to; am I not right?

Senator MORAN. True.

Mr. GIBSON. I would tell you, Mr. Chairman, that we did that consistently as we worked to implement the Act in the first place. You know, Dr. Tuchschmidt—how many visits did you have with staff? Congressional staff, 20 visits?

Dr. TUCHSCHMIDT. Probably more.

Mr. GIBSON. Basically, once a week Jim was over here visiting face to face with staff having routine conversations, asking questions, getting clarification, providing updates in order for them to understand consistently. I will give you an example.

The law basically says that the veteran who gets his care outside of VA under Choice has to make his co-pay at the time care is delivered. Well, you know what? That is not the way we work non-VA care. So, you think veterans are going to want to use that instead of using non-VA? They are going to say, no, no, I do not want Choice. I want to go over here and do this other thing because I do not want to make my co-pay on the front-end.

We found a way administratively around that, to interpret that, because we knew that was going to be a point of friction for veterans. We do that routinely day in and day out. But there are some things we cannot work around.

Chairman ISAKSON. And that is a good thing. Thank you.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. Senator Heller.

HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Mr. Chairman, thank you. I thank you and the Ranking Member for your ideas. I think we have accomplished a lot in this hearing today, and your efforts during the recess to help with this flexibility issue for care at non-VA facilities, I think, will

go a long way. I want to thank the witnesses. Thank you for your service. Thanks for spending time with us today so that we can resolve some of these questions, important questions, such as what Senator Moran raises.

I want to talk a little bit about Nevada for a minute because, Mr. Chairman, this 40-Mile Rule means a lot to the veterans in my State. We have 300,000 veterans in the State of Nevada. If you look at the size of the State, it is 110,000 square miles. If you wanted to take a look at the State, it really is an urban State. 85 percent of the population in Nevada lives in 5,000 square miles.

So, between Las Vegas, Reno, and Carson City, 85 percent of the population. The other 105,000 square miles, has veterans spotted around. I have got a map here and I would be happy to share it with the Committee, with you, Mr. Chairman, the Ranking Member, perhaps yourself, Mr. Secretary, talking about how far and how much travel these veterans have to overcome.

One city is 7 hours round trip. They have got to go all the way to Salt Lake City, which is not Reno, it is in the other direction. The same in another city called Elko; it is a 6-hour round trip. We have to have 4½ hours to drive into Reno. So, you can see the implementation of a bill like this and the impact that it has on the veterans in my State.

Here is a question that I do raise: I mentioned we have 300,000 veterans in the State of Nevada, but only roughly about 1 percent of them have received the Choice card. It is a small number. Can you tell me why it is so difficult, if there are difficulties, as to why only 1 percent of the veterans in Nevada would choose a Choice card or the program?

Mr. GIBSON. Well, there is a big difference between how many veterans receive the Choice card and how many have chosen to use it. We mailed out 8.6 million Choice cards—if somebody can do the arithmetic—out of 22 million veterans across the country. The legislation stipulated who was eligible for consideration under Choice and that is who got the cards.

Senator HELLER. Six million veterans?

Mr. GIBSON. 8.6 million veterans have received Choice cards.

Senator HELLER. OK.

Mr. GIBSON. We started mailing them and we did in a tiered fashion. We began on November 5. Those in the 40-mile group got them first. Those waiting more than 30 days for care got them second. Then everybody else came out in waves. We were sending out more than a quarter of a million cards every day. The last of those were received in late January, about 60 days ago.

Senator HELLER. Can you tell me how many of those veterans have made appointments?

Mr. GIBSON. As I mentioned in the opening statement, there have been——

Senator HELLER. Sorry.

Mr. GIBSON. It is OK.—46,000 authorizations issued and 44,000 appointments made with providers in the community. You see, I am breaking the habit of calling it non-VA care. I listen.

Senator HELLER. I want to share a letter with you from a veteran out of Carson City. He spent 25 years in the Marines. And he ex-

pressed some concerns about the implementation of the Choice Act. If I can read a portion of that letter to you?

He says, I received my veterans Choice card only to realize after attempting to use it the Government had again inserted itself between myself and my medical care. I do not get to see a doctor of my choice. I have to call each time I need an appointment, which means I am not assured that I would see the same doctor each time, merely the first doctor that is available. The current program does me no good.

Is this what we wanted in the Choice Act? Or is there a——

Mr. GIBSON. I will tell you what you have described is not at all what we want. First of all, the veteran under Choice has the flexibility to choose his doctor. So, if the veteran went to see Dr. Smith for that first appointment, I would expect that automatically the third party administrator would schedule with Dr. Smith again, and if they did not, the veteran would say, I want to go see Dr. Smith again; I need another appointment.

The other provision under Choice is that veterans are authorized for 60 days. So, the authorization for a particular purpose, for a particular medical purpose, extends for a 60-day period of time. So, there can be multiple authorizations or multiple appointments scheduled under that single authorization.

So, that is not at all—but the other point I would make very quickly is, this is a key distinction in terms of the Choice not being a health plan. It is not like—people are familiar with how a health plan works. You get, I got my Blue Cross/Blue Shield card in my pocket. I just show up at a doctor's office and I hand over the card. That is not how Choice works.

Senator HELLER. OK, OK. One quick question. I apologize. My staff gave you the heads up on Pahrump, a small rural town in Nevada. I talked to the Secretary about it. It was a month ago today. He said, in a month, I will be making a grand announcement on that clinic in Pahrump. Do you want to make a grand announcement today?

Mr. GIBSON. I do not have a grand announcement to make on Pahrump, but I will get some folks scurrying to get some information for you, the latest information on Pahrump.

Senator HELLER. You have been very patient.

Mr. GIBSON. Yes, sir.

Senator HELLER. Mr. Chairman, thank you.

Chairman ISAKSON. On that point, I should have given credit earlier, but I think the VA announced on Monday the first of the 27 approved clinics in the veterans Choice bill, which is the one in Lafayette, LA. Is that not correct?

Mr. GIBSON. I have been up to my ears in that particular facility. I have been to Lafayette in the last 2 weeks. I am proud to tell you, yes, we did.

Chairman ISAKSON. So, that is the first step. We have got 26 more to go, but that is a good sign.

Senator HELLER. Let us get you up to your ears in Pahrump. How is that? [Laughter.]

Mr. GIBSON. I do not know if I like the sound of that.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all for being here. We do appreciate your hard work. Tell me a little bit about, you know, one of the concerns that we have all had on the forefront is veterans that are having problems with mental illness, having difficulties for various reasons.

A veteran that lives out beyond the 40 miles, can you kind of walk through how he gets care if he is not able to do that? But the thing I am really concerned about is if they—if a mental health care provider locally sees him and gets him on a medication and then he comes back, it is not on the formulary, are there any provisions?

Are we doing anything to try to prevent those kind of problems? As you know, in a matter of weeks you could kind of get somebody stabilized, get them used to something, then he comes back in a very fragile condition, and all of a sudden somebody is saying, we do not carry that. Then you have got real problems.

Mr. GIBSON. I am going to let our clinician here answer that question.

Dr. TUCHSCHMIDT. So, our mental health providers should be able—we have routine formulary exception procedures. They should be able to do a formulary exception. I think most of them probably would until they got to know that patient and then would make decisions about whether to continue or change that medication.

So, I think there are procedures in place and I cannot say that everything works perfectly every time in a system this size, but I would hope that that is what would happen.

Senator BOOZMAN. I would really encourage—you know, as we visit with families that have gone through this, that seems to be kind of a common denominator in the sense of the transition from DOD where the formularies are different.

Mr. GIBSON. We have done some very specific work associated with the transition from DOD and promulgated very clear guidance about maintaining continuity of medication, particularly for mental health treatment during that transition period. I am not going to remember the number, but we spend hundreds of millions of dollars every year on prescription medications that are not in our formulary for exactly the circumstance that you are describing.

Senator BOOZMAN. I appreciate that. It is something that you might consider, again, we are not talking about great numbers. I mean, you know, we are not talking about the equivalence of diabetes, hypertension, things like this. These are pretty specific individuals, but it is such a big deal.

You might consider then—and I appreciate you working hard on the DOD issue. Something you might consider is maybe perhaps putting out a similar thing, because the numbers are so small, it really should not affect, with this 40-Mile Rule, and then we will not see problems associated with that.

Dr. TUCHSCHMIDT. I think the guidance we put out actually is generic guidance, but it was prompted by the DOD issue.

Mr. GIBSON. We will go back and look.

Senator BOOZMAN. Good. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

One comment I would make. You know, what you all really ought to do is you ought to send a memo to each of the Senate offices. A hundred of us have veteran full-time coordinators in our office. I am sure you do, John. I do. They ought to be a regular recipient of any advisory VA puts out on veterans Choice because that is one of the best places to get the information. I do not know if you do that or not. It just occurred to me. It would certainly be helpful to our office. You might just try and do that.

Mr. GIBSON. Yes, Senator. If not already doing it, we will do that.

Chairman ISAKSON. Senator Tillis, did you have an additional question?

Senator TILLIS. Yes, I did. Just, I want to go back again to some of the math. But before I do that, Senator Tester prompted me to reflect on a conversation we had with the Secretary in Chairman Isakson's office a month or so ago. We were talking about the kind of peaks that we have for care right now. He was suggesting that a significant amount of our veterans or VA facilities are providing care to veterans of the Vietnam War, I believe, and that if you look historically there have been these peaks and valleys in terms of the demand.

When we are talking about long-range planning for facilities, are we looking at how we kind of cut through a line there that, you know, will not necessarily satisfy the peak demand and that is why we will have the relationships like non-VA providers or Choice. But is that very much weighing into the long-term strategy? That is one area.

Then, in areas where we have needs that may be of a unique nature, rather than building out a VA capability, we are looking at this sort of scope of practice that maybe is never appropriate for a VA hospital because of the need to keep the facilities and the skillsets current. Is that weighing into the long-term thinking?

Mr. GIBSON. I think on both cases the answer is yes, clearly.

Senator TILLIS. Now, the question I had, again just going back to the math, you were saying that 17 percent, I guess, of the population is being provided care from a non-VA provider.

Mr. GIBSON. 17 percent of the appointments. On average, we run between 1–1½ million appointments in the community each month.

Senator TILLIS. OK. How much of that, if we get the Choice right, how much of that would migrate to—will that be a constant or will that migrate more toward the Choice population? Are they very different scenarios?

Mr. GIBSON. I think my expectation has been that what we would see would be an increase in the number of appointments completed in the community and that Choice would be a very meaningful component of that.

Senator TILLIS. OK.

Mr. GIBSON. That is sort of the expectation.

Senator TILLIS. Now, the other question again, I am just trying to get the math right and it may not be a proper connection, but I think you mentioned something to the effect of somewhere around $7 billion provided in non-VA care. What period of time?

Mr. GIBSON. It was in 1 year.

Senator TILLIS. In 1 year, $7 billion?

Mr. GIBSON. It was $6.6 to be precise.

Senator TILLIS. And that was 17 percent of the appointments?

Mr. GIBSON. 17 percent of the appointments.

Senator TILLIS. OK. Again, I hear these estimates on Choice and for some reason the math does not seem to add up. If 17 percent of the appointments went to Choice, why would it seem like there is a disproportionately higher number? Am I reading those numbers wrong?

Mr. GIBSON. 17 percent went to care in the community.

Senator TILLIS. OK.

Mr. GIBSON. In fiscal year 2014, none of that was Choice because the law did not——

Senator TILLIS. No, I understand that. It is just when I have seen some of the estimates for the—because some of the people that were concerned about the 40-Mile Rule were saying this is how we kind of create a cap on the potential cost just to manage exactly what this was going to cost. I was trying to get some way to crosswalk how that care is being provided by non-VA providers outside of the Choice plan.

I am still at a loss for seeing how some of the estimates and the math works for the downstream potential cost for care that we need to provide, whether it is a non-VA provider, a VA facility, or through the Choice plan. I would really be interested. When we get to the long-term solution, we figure out to what extent Choice plays a role.

I am just trying to get a better estimate of numbers, because to me, it seems like we may have over-estimated the net incremental cost to have Choice as a part of the safety valve to provide veterans care.

Mr. GIBSON. Part of the challenge that I think we had and I think the Congressional Budget Office had on the front end, was not—we were going someplace we had never gone before in many respects, and the point that Jim made earlier about what happens with optionality when veterans have a chance to access care at a lower cost with lower co-pays.

For example, 70 percent of our veterans use VA for prescriptions because it is cheaper than getting their prescriptions filled elsewhere. It is the highest category of utilization for VA, more than inpatient, more than outpatient, more than other categories, and it is because it is financially advantageous.

So, once we move this way, part of what we have to look at is two-thirds of our veterans are over 65. They are Medicare eligible and they are already getting half of their care outside of VA. We were talking earlier about continuity of care issues and how do you manage veteran health. That is already a big challenge.

Senator TILLIS. That explains the delta between some 21 million veterans and 9 million of them using——

Mr. GIBSON. Yes.

Senator TILLIS [continuing]. The system.

Mr. GIBSON. Yes.

Dr. TUCHSCHMIDT. If you look at our patient population today, 81 percent of them have some form of insurance other than VA. Two-thirds have Medicare. So, I think the caution is, if the out-of-pocket costs are different, lower in the VA, and the transactional costs are lower because you are not driving someplace, and VA will pay for

it, what is—and that is the big question we are asking: what percentage of that care will shift from some other payer to VA?

In the end, it might actually be cost-neutral across the board for the Federal Government if the shift is from Medicare to VA. But there clearly is a difference in terms of where that care is going to get paid.

Senator TILLIS. Mr. Chair, thank you for your indulgence. I only have one other question and it has to do with long-range planning. I am from North Carolina. We have got a veterans population that exceeds the population of some of our States, which is approaching 900,000 on a path to a million.

And 51 percent of our population lives in urban areas, but we are spread out over almost 600 miles from the coast to mountains. As you are looking at long-term planning, are you looking—I sat next to a medical geographer on a flight from Reagan National to Chapel Hill. He works in a research center in Chapel Hill.

Are you spending time trying to get ahead of the curve in terms of your long-range planning to try to identify these care deserts that exist, that become the stories that Senator Heller or somebody else will talk about as part of your long-term planning? Are we getting to that level of sophistication for long-term planning?

Mr. GIBSON. I am going to start and you jump in here. We have a capital planning process we call SCIP (Strategic Capital Investment Planning Process Directive 0011), which uses a 10-year planning horizon. We are looking at demographic trends out that length of time. So, we are trying, in fact, to anticipate that. But part of the challenge is—and I am not throwing any stones here at all, but we have a massive capital deficit in terms of being able to keep up.

Part of our challenge is, we see the number of veterans that are using VA for care. It may grow by 1.5 percent a year, roughly. But you go to Fayetteville, NC, and last year, it was up—I am going from memory here—6 percent, either 6 or 7 percent at Fayetteville.

In Wilmington, NC, where I was about a month ago, 14 percent year-over-year growth and you need patients accessing care. And we are not fleet of foot. We do not make adjustments quickly. We have to rely on multi-year funding streams. So, that presents a challenge and, quite frankly, we get behind and we do not catch up.

Senator TILLIS. Thank you, Mr. Chairman.

Chairman ISAKSON. In fairness to our second panel, I am going to go ahead. Senator Blumenthal has a quick comment to make and then I want to get right to our second panel. But good questions, Senator Tillis. I appreciate it.

Senator Blumenthal.

Senator BLUMENTHAL. Just to complete the questions on the 17 percent, that is 17 percent of all appointments——

Mr. GIBSON. Correct.

Senator BLUMENTHAL [continuing]. Are with community providers?

Mr. GIBSON. Correct.

Senator BLUMENTHAL. Can you give us the number of that which is under the Choice?

Mr. GIBSON. Correct.

Senator BLUMENTHAL. That is post-Choice?

Mr. GIBSON. No, no, no, no. That is total——

Senator BLUMENTHAL. Pre-Choice?

Mr. GIBSON. Well, the number that I gave you was from the first quarter, first fiscal quarter of 2015. So, it was October, November, December. We started Choice on the 5th of November, but the number of appointments completed during October, November, and December for Choice would be minuscule. So, you are looking at——

Senator BLUMENTHAL. We will see a different—do you have more recent data as to what that 17 percent—the equivalent of that 17 percent would be for the next quarter?

Mr. GIBSON. I do not have that data, and the reason I do not have that data regarding completed appointments in the community is the information lags.

Senator BLUMENTHAL. How long does it lag?

Mr. GIBSON. 30 days, 45 days, sometimes even longer.

Senator BLUMENTHAL. When will you have some trend data for us?

Chairman ISAKSON. Probably the end of the fiscal year. [Laughter.]

Dr. TUCHSCHMIDT. We have—I mean, we have month over month data about how many appointments we are scheduling through our normal purchase care process.

Mr. GIBSON. In other words, purchasing care in the community.

Dr. TUCHSCHMIDT. The non-VA care, which is PC3.

Senator BLUMENTHAL. Contracts or——

Mr. GIBSON. Long-term contracts or individual arrangements and individual authorizations.

Senator BLUMENTHAL. My understanding—I know that ARCH may have been authorized by statute, but what about PC3? There are contracts with Health Net Federal Services and TriWest to carry out the PC3 program that were concluded in September 2013. It was not really started until May 2014.

Mr. GIBSON. Correct.

Senator BLUMENTHAL. Was there a statute that authorized PC3? I do not know of any.

Mr. GIBSON. I do not think so.

Dr. TUCHSCHMIDT. There is a contractual——

Senator BLUMENTHAL. My understanding is that there was a statute for ARCH, Public Law 110–387.

Mr. GIBSON. Correct.

Senator BLUMENTHAL. I guess what I am suggesting here is that there needs to be an effort to rationalize all of these community-providing health care services because right now, it is a little bit like Secretary McDonald noticed while still at Proctor & Gamble—they were making the same detergent and packaging it in five different types of packages and five different marketing programs and advertising budgets for different regions.

I mean, coming into that situation, you would say, my goodness, we are really——

Mr. GIBSON. We are in violent agreement with you.

Senator BLUMENTHAL. Maybe as part of——

Mr. GIBSON. We understand we need to do that. There are tens of thousands of providers out there across the country that are operating under existing contracts or agreements providing care to

veterans. So, part of what we have to make sure we do as we work these changes is we do not break things that are delivering care to our veterans currently.

So, that is why we agree with you completely, but what we have got to do is do this in a form and fashion so that we do not disrupt care.

Senator BLUMENTHAL. Right. And I am completely in agreement. I am hoping that beginning, during the recess, I do not know that we can complete it during the recess, but I am going to be committing kind of my own, not just our staffs, to try to develop a framework for some more rational and common sense framework here.

And I want to emphasize two concepts, common sense and choice. The veteran ought to have choices. And the rule ought to be one of common sense, as you have applied now on the 40-Mile Rule. Thank you.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. Secretary, thank you. Dr. Tuchschmidt, thank you very much for your service. We appreciate your time.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. PROVIDER AGREEMENTS

Deputy Secretary Gibson's testimony mentioned the need for legislation to allow the Department of Veterans Affairs (VA) to engage with private providers by establishing provider agreements rather than relying only on currently available Federal contracting authorities. Utilizing provider agreements rather than Federal contracts would hopefully encourage independent private practitioners to establish a relationship with local VA facilities and to see veterans as a part of their practice. I plan to follow up on the commitment made at the hearing to work with VA on developing the legislation necessary to address this change, and respectfully request your response to the following questions.

a. What have been the primary complaints that VA has heard from private providers about why they are reluctant to contract with VA?

Response. VA approved care in the community is used to augment VA provided health care in order to meet clinical demand as well as to address wait times for providing medical services. When hospital care or medical services are required the need is usually immediate. In such cases, demand may be for infrequent use, or the required care would not be at a volume sufficient for a private provider to support a formal contract. In the preceding instances it is counterintuitive to the overall scope and delivery of health care to potentially postpone the delivery of health care in order to negotiate and award a formal contract with an individual provider to supply the necessary health care.

VA is under contract with Health Net and Tri-West to build health care provider networks across the country. As the contractors work to build these networks common complaints from private providers that represent barriers to their participation include; reimbursement, administrative requirements that direct the return of medical documentation, prescription fulfillment and coordination of care. Specific examples of these factors include: lower than Medicare rates for reimbursement, although some negotiated rates may be higher. Reluctance would be on the part of provider who does not want to join the existing Contracts given the lower rates, approval for care process and prescription fulfillment requirements and lack of autonomy in directing patient care.

Provider agreements provide more opportunities to offer services for Veterans from their local providers when care is urgent, a contract does not already exist and time does not allow one to be developed. Provider agreements may serve to furnish vital and often life-sustaining medical services, potentially broadening the spectrum of care available to the geographical displaced Veteran population in the rural and highly rural areas. VA has put forward a proposal that would ensure that it is able to provide local care to Veterans in a timely and responsible manner, while including explicit protections for procurement integrity, provider qualifications, and price reasonableness.

b. What steps will VA take to ensure that it maintains the same level of oversight of patient care as it would for patient care that is provided within VA rather than purchased from the community?

Response. VHA works to ensure that all purchased care from the community have oversight of quality related to certain standards including but not limited to provider credentialing, access to care/timeliness, patient safety, and patient satisfaction.

For care purchased outside of the national contracts (primarily Health Net and TriWest), the Non-VA Care Medical Care Coordination (NVCC) model is VHA's system of business and clinical processes which standardize front-end business procedures, improve patient care coordination and support future state solutions within its Non-VA Medical Care programs.

Under the NVCC program model, non-VA medical care providers are instructed to send VHA the supporting clinical documentation within 14 days of completion of date of service/visit. Once the referring VHA medical facility receives the supporting clinical documentation for the care provided, it is then uploaded into the Veteran's electronic health record. The uploaded supporting clinical documentation is then linked to a consult, alerting the Veteran's VHA provider and care management team that the documentation is uploaded and available to review. This process ensures the non-VA provider's clinical documentation is reviewed and that any additional follow up care that is needed or requested by the non-VA provider is addressed by the VA provider.

NVCC staff monitors and reviews open consults to ensure the non-VA provider has submitted the supporting clinical documentation. If the documentation is not submitted, the NVCC staff will follow up with the non-VA provider and work to retrieve the non-VA clinical documentation.

To increase governance and oversight of quality and patient safety in the field for VA Care in the Community, the Patient-Centered Community Care Program (PC3) has adopted a multi-committee structure. There are two collaborative committees, one focused on Quality Oversight and Safety, and the other is focused on Patient Quality and Safety; which have been established by each PC3 contractor to cover all the regions under their purview.

The PC3 regional contractors were required to establish a Joint Quality Oversight and Safety Committee that includes clinical staff from both contractors as well as select VA clinical staff within each region. This Committee reviews and evaluates areas such as:

- Complaints, grievances, and results from patient satisfaction surveys;
- Appointment timeliness;
- Medical documentation return;
- Provider listings, to include network provider recruitments, re-credentialing, and terminations;
- Commute time;
- Summary reports of patient quality and safety trends that are submitted by the VHA/Network Patient Quality and Safety Peer Review Sub-committee; and
- Refer as necessary items to the Contracting Officer Representative for presentation to the appropriate Regional Steering Committee.

The Joint VHA/Network Patient Quality and Safety Peer Review Sub-committee is a contractor-led group, comprised of Clinical Lead Health System Specialist, Contracting Officer, Medical Director, Medical Management Clinician, and Chief Medical Management Officer, focused primarily on the review of patient clinical safety events, recommending contractual remedies, and providing summary reports to the Joint Quality Oversight and Safety Committee. The subcommittee is responsible for:

- Reviewing patient clinical safety events;
- Reviewing issues of physician standards of practice;
- Making recommendations to the Contractor for contractual remedies with summary reporting to the Joint Quality Oversight and Safety Committee;
- Reviewing data related to health care safety and quality;
- Evaluating issues identified through tracking and trending;
- Defining, measuring, analyzing, improving and/or controlling identified issues;
- Performing peer reviews of Veteran health care delivery; and
- Recommending corrective actions within the context of the respective health plan contract with the provider in collaboration with the Contracting Officer to ensure the actions are within the scope of the PC3 contract.

c. How does VA currently engage directly with providers about policies relating to how VA purchases care from the community and how would VA communicate any changes to existing policy with private providers?

Response. When it is determined that VA is unable to provide medical services requested by the Veteran's VA provider, VA coordinates the medical care with the Veteran's preferred non-VA providers through telephonic communication. The coordination consists of scheduling the appointment for the Veteran and advising the non-VA provider of the specific care required, VA reimbursement, and the supporting clinical documentation required and ends when it has been confirmed that Veteran completed their appointment. During this coordination, VA will give the non-VA provider's office contact information, should additional questions arise after the referral.

During this initial contact with the non-VA provider's office, NVCC will advise the provider of specific care required and other pertinent information related to the claim processing for reimbursement. The initial contact for referral to a non-VA provider office is completed through many different avenues and communication methods. The varying communication methods greatly depend on the working relationship developed between the local referring VA facility and the non-VA provider; many of these relationships have been developed over years in the pursuit of quality care for our Veterans.

When a Veteran has been authorized care under the PC3 Contracts or the Choice Program, the NVCC staff will work with contractor to ensure all information needed to provide the care is available. VA also works with the contractor to ensure the providers, caring for our Veterans, adhere to the terms and conditions of the contract requirements.

VA strives to provide the highest quality care for our Veteran, and VA can only be successful in doing this by keeping open lines of communications with non-VA providers during the treatment of its Veteran patients. NVCC will stay in contact as needed with the non-VA provider's office until the episode of care has been completed, thus ensuring the Veteran's medical needs are addressed.

VA also ensures that communication is available to providers and Veterans. One avenue of such communication is the VA Web site, http://www.va.gov/PURCHASEDCARE. The Web site provides information for non-VA medical care providers on the submission of claims and other pertinent information for their offices and also contains many references for Veterans, including how to request non-VA medical care. The Web site provides a link where non-VA medical providers can subscribe to a distribution list that emails monthly information specific to conducting business with VA. The Web site also provides a link to historical messages if any have been missed by a provider. Additionally, VA facilities have pamphlets and brochures that also describe non-VA medical care options.

Question 2. GEOGRAPHIC CHALLENGES

Deputy Secretary Gibson's testimony included a request to alter the current eligibility criteria for the Veterans Choice Program to include veterans who face any unusual or excessive burden to accessing a medical facility rather than an unusual or excessive burden that is due to a geographical challenge.

a. How would VA anticipate determining the unusual or excessive burdens if not by wait time or geography?

Response. On May 22, 2015, Public Law 114–19 (H.R. 2496), the Construction Authorization and Choice Improvement Act, was signed into law. This provides VA with the authority to expand eligibility for the Veterans Choice Program based on unusual or excessive burden in traveling to a VA medical facility. VA appreciates this expanded authority which will allow those Veterans who live less than 40 miles from a VA medical facility but may face unusual or excessive challenges in travel to be eligible. This authority allows VA to consider factors such as geography, weather, traffic, or medical conditions to determine eligibility for the Veterans Choice Program as any other residence-based eligibility criteria.

b. How does VA expect that such a change to the eligibility criteria for the Veterans Choice Program would impact utilization of other non-VA care options, such as PC3 or Project ARCH?

Response. VHA recently released a memorandum to VHA staff providing mandatory requirements outlining the hierarchy of purchasing Veteran Community Care. The memorandum directs that when VA or other Federal agencies, to include DOD, Indian Health Service (IHS), or Tribal organizations, are unable to provide the care within VHA's timeliness standard, then the Veteran must be referred to a non-VA provider under the Veterans Choice Program (VCP). On the other hand, if a referring VA facility can schedule that service within VHA's timeliness standard, the Veteran is not eligible for VCP, specifically, or for non-VA medical care in the community in general. When a Veteran is not eligible for VCP or the medical services are not covered by VCP (e.g., non-skilled home nursing care, durable medical equipment (DME), including eyeglasses, non-urgent/non-emergent medications, compensa-

tion and pension (C&P) examinations, or unscheduled emergency non-VA care), VA may then utilize other non-VA care options such as PC3 or Project ARCH. Project ARCH is a limited, special project which is intended to improve access to eligible Veterans to receive medical services closer to home and is only available in five (5) VISNs. When a Veteran is eligible for VCP but declines to participate in the program, then VA may also utilize other non-VA care options such as PC3 or Project ARCH to ensure timely care.

Under the new hierarchy of purchasing Veteran Community Care, utilization of other non-VA care programs may be reduced. This potential reduction is attributed to the expanded number of Veterans being provided care under VCP. However, there is a possibility that Veterans with private third-party insurance will be more reluctant to seek care under VCP to avoid any potential out-of-pocket expenses, and those Veterans will either choose to wait for an appointment in a VA facility or request referral through other non-VA care programs available to them.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JERRY MORAN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 3. Provide the current utilization data and analysis of non-VA care under the Choice Act, specifically explaining or categorizing the health care services, procedures, and treatments that are being administered to veterans by non-VA providers and where geographically said health care is being provided.

Response. The data in the attached chart reflects utilization rates for only February 2015. As of April 11, 2015, there were 43,971 total authorizations under the Choice Act.

CBOPC Department of Informatics

CHOICE Utilization by Rendering Provider Location

Triwest Claims by Provider	
State	# of Auths
AK	91
AL	52
AR	214
AZ	829
CA	952
CO	36
FL	112
GA	9
HI	199
ID	311
IL	32
IN	23
KS	301
KY	101
LA	254
MN	1
MO	282
MS	113
MT	33
NC	1
NM	118
NV	278
OH	1
OK	223
OR	1,344
TN	267
TX	937
UT	7
VA	13
WA	1,151
WV	6
Total	**8,291**

Healthnet Claims by Provider	
State	# of Auths
AL	147
AZ	3
CO	266
CT	5
DE	1
FL	839
GA	472
IA	91
ID	121
IL	183
IN	70
KS	11
KY	8
MA	51
MD	68
ME	43
MI	229
MN	200
MO	7
MS	2
MT	70
NC	303
ND	24
NE	112
NH	310
NJ	22
NV	15
NY	78
OH	151
PA	95
PR	7
RI	5
SC	149
SD	73
TN	1
TX	1
UT	247
VA	126
VT	8
WA	1
WI	149
WV	26
WY	61
Total	**4,851**

Data Source: TPA Monthly Report - February 2015

Data Disclosures

Data reflects total number of authorizatons reported by the TPA where the care of the rendering non-VA provider is located, where care was either appointed to be scheduled or appointment completed

Data reflects top 10 categories of care being rendered by TPA in the various reported locations

Data reflects authorizations and appointment activity during the month of February 2015 only

Data Transaction Dates: February 1, 2015 - February 28, 2015

Top 10 Health Net	
Category of Care	Count
PRIMARY CARE	1062
ORTHOPEDIC	602
OPTOMETRY	450
PODIATRY	266
OPHTHALMOLOGY	265
PHYSICAL THERAPY	233
NEUROLOGY	174
UROLOGY	170
DERMATOLOGY	167
PAIN MANAGEMENT	163

Top 10 TriWest	
Category of Care	Count
PRIMARY CARE	1291
ORTHOPEDIC	705
OPTOMETRY	628
PHYSICAL THERAPY	443
OPHTHALMOLOGY TESTS, PROCEDURES, STUDIES	388
PODIATRY	349
DERMATOLOGY TESTS, PROCEDURES, STUDIES	346
AUDIOLOGY	221
RADIOLOGY MRI/MRA	198
NEUROLOGY	183

Question 4. What is the dollar amount that the VA has expended on non-VA care under the Choice Act?

Response. Choice Act obligations and expenditures as of March 31, 2015, are displayed in the following table:

Choice Act Obligations and Expenditures		
As of March 31, 2015		
Purpose	Obligations	Expenditures
Section 802		
Hiring Medical Staff	$100,492,821.81	$100,492,821.81
Supplies and Equipment associated with Hiring Medical Staff	$8,785,902.89	$7,197,442.32
Health Professionals Educational Assistance Program (Section 302)	$36,944.00	$0.00
Emergency Leases	$83,160.00	$20,790.00
Leases in the Pipeline	$906,783.31	$229,496.00
Legionella	$1,371,000.00	$390,955.57
Non-Recurring Maintenance	$87,280,810.52	$299,738.99
Subtotal Section 801	$198,957,422.53	$108,631,244.69
Section 802		
Implementation Costs	$300,168,417.00	$79,561,084.10
Care in the Community Payments	$384,000,000.00	$77,677.38
Pharmacy	$1,385.10	$1,385.10
Prosthetics	$0.00	$0.00
Beneficiary Travel	$9,748,664.57	$78,758.89
Subtotal Section 801	$693,918,466.67	$79,668,855.47
Total Choice Act	$892,875,889.20	$188,300,100.16

Question 5. What is the dollar amount that the VA anticipates will be expended on non-VA care under the Choice Act as a result of the VA's new interpretation of 40-mile criteria as calculated by driving distance?

Response. If all newly eligible Veterans participate in the Choice Program, VA estimates an increase in expenditures of $2.4 billion in FY 2015 and a total increase in expenditures over three years of $7.6 billion. If less than 100% of newly eligible Veterans participate, VA anticipates a total increase in expenditures over three years ranging from $921 million to $6.2 billion.

Question 6. Please confirm that the Congressional Budget Office (CBO) scored the Choice Act at $10 billion considering the 40-mile criteria as calculated by driving distance.

Response. VHA does not have the Congressional Budget Office's scoring documents regarding the 40-mile criteria as calculated by driving distance.

Question 7. Please confirm that under the calculation of geodesic distance for the Choice Act, approximately 300,000 veterans would be eligible for the Choice program. If this is inaccurate, please explain the variance.

Response. Yes, approximately 300,000 veterans were eligible for the Choice Program based on residence when VA used a geodesic measure of distance to determine eligibility. VA adopted a driving distance measure on April 24, 2015, when it published a second Interim Final rule.

Question 8. Please confirm that under the calculation of driving distance for the Choice Act, approximately 600,000 veterans would be eligible for the Choice program. If this is inaccurate, please explain the variance.

Response. Yes, VA estimates that approximately 600,000 veterans are eligible for the Choice Program based on residence under the new driving distance measure adopted on April 24, 2015.

Question 9. In a December 11, 2014 meeting with Senate Moran, in response to the Senator's request for cost analysis to permit veterans' access to non-VA care when a VA facility within 40 miles of a veterans is not capable of offering the care sought by the veteran, the Deputy Secretary Gibson referred to VA's internal analysis and cost estimate of approximately $30 billion to offer non-VA care to veterans who live within 40 miles of level 1 and 2 VA medical facilities. This seems consistent with the December 4, 2014 response letter that mentioned automatic referral for veterans within 40 miles of VA medical facilities could possibly cost tens of billions in non-VA care. Please furnish a copy of the analysis and cost estimate the Deputy Secretary referenced in the December letter and meeting. Also, were level 3 VA medical facilities, such as CBOCs, assessed as part of this cost estimate and analysis?

Response. As you may be aware, VA originally provided data to the Congressional Budget Office when they were scoring the Veterans Access, Choice, and Accountability Act of 2014. We partnered with our actuarial firm, Milliman, to do a similar assessment that provides a range of the potential impact. Performing the specific analyses that you have requested would require complex assessments at the individual patient level, and VA does not house all the data elements required to conduct these detailed analyses.

The analysis discussed in this response was addressed in the December 2014 meeting with Senator Moran. Subsequent to that analysis, VA produced additional analyses on potential impacts of changes to the 40-mile eligibility rules which incorporated different assumptions which resulted in different cost estimates.

There are several factors that must be considered when modeling the financial implications of a policy that would cover all services at VA expense that could not be provided within 40 miles of a Veterans residence. There have been other analyses done using existing data, and this response attempts to summarize the factors inhibiting detailed analysis, while providing synthesis of the information VA does have. Much of the analysis required to determine the financial implications of a policy that would cover all services at VA expense that could not be provided within 40 miles of a Veteran's residence turn upon enrollee behaviors that may change as a result of such a policy shift.

First, some Veterans currently using VA, who reside more than 40 miles from the services they need, would opt to receive care in the private sector instead of at a VA facility. We lack historical experience to confidently predict how often and to what degree Veterans would elect to receive care outside of VA. Many factors will influence the decisions Veterans make regarding where they chose to receive care. We believe the most important of these include the Veteran's existing relationships with their clinicians, the nature of the services the Veteran needs, and the availability of services in the private sector. Modeling the last factor becomes even more complex because in VA's experience, these services may not be available more timely in the community than within VA.

Second, there is the degree to which Veterans rely upon VA as their health care provider of choice. VA estimates 81 percent of enrolled Veterans have some other form of insurance, whether it be Medicare, Medicaid, TRICARE, or private health insurance. As a result, enrollees only get approximately 37 percent of their total health care needs covered by VA. Enrollee reliance on VA varies significantly across the country, from a low of approximately 14 percent to a high of approximately 60 percent. Additionally, there are significant differences in the copayments between VA, Medicare, and private health insurance that must be considered when estimating the transactional costs to the Veteran. A logical assumption is that if Veterans could receive all their care at VA expense and at a lower personal cost, there will be an increase in reliance on VA services acquired in the private sector. Consequently, our methodology attempted to estimate the economic impact of this shift in reliance.

Finally, VA believes it likely that Veterans not currently enrolled in VA would find such a new benefit very attractive for the reasons stated above. Presently, VA does not have the historical experience to model the level of increased enrollment that might be stimulated by such a change in policy.

Turning from the factors impacting use of VA services, another concern is the availability of services at VA facilities and the location of Veterans relative to those services. In an effort to estimate the economic impact of such a policy, VA assumed

that most specialty care was only available at Level 1 and Level 2 facilities. However, some Level 3 facilities do have limited specialty services, while not all specialty care is available at all Level 2 facilities. The net result is that this approach probably underestimates the true economic impact to VA. That is, in most places more complex specialty care is only available at Level 1 facilities or even, at times, on a more regional basis, such as transplant services.

In FY 2015, approximately 3.3 million enrollees (35%) lived more than 40 miles from a Level 1 or Level 2 VA center. At their current level of reliance (approximately 37 percent), these enrollees represent $15.5 billion in VA health care expenditures for services that are potentially available in private sector.[1]

We do not have data on private sector market capabilities and some service may not be available in all communities. Again, it is worth noting that a majority of these Veterans have other forms of insurance and receive care outside VA, the majority under Medicare. Under the expanded eligibility criteria, these enrollees could choose to shift more of their care to VA but receive it in the private sector.

In the absence of historical experience to estimate the expected level of patient reliance on the VA for care, VA has provided cost estimates at two levels of increased reliance to provide an order of magnitude of the potential change. The following table summarizes the potential additional costs should these enrollees increase their reliance from the current level of 37 percent to 70 percent or 100 percent; the analysis also assumes that all of this additional care will be delivered by private sector providers at VA expense. This analysis does not consider any stimulated interest in enrolling in VA to take advantage of this new benefit.

In accordance with our current authorities, we assumed that VA could purchase these services in the private sector at either (1) Medicare rates or (2) at VA's current cost of purchasing care. Note that VA often must pay higher than Medicare rates to secure needed services in some geographic locations and the VA Fee Unit Costs estimates use our actual purchased care experience.

	Additional Expenditures Required** (Dollars in Billions)			
VA Unit Costs RX VA Unit Costs	**MEDICARE Unit Costs RX Community Unit Costs**		**VA Fee Unit Costs RX Community Unit Costs**	
Current VA Reliance	***70% Reliance***	***100% Reliance***	***70% Reliance***	***100% Reliance***
$15.4	**$9.9**	**$21.3**	**$16.2**	**$30.7**

** VA Unit Costs–Projected VA unit costs from the 2014 Model (BY13)
MEDICARE Unit Costs–100% Medicare allowable unit costs
VA Fee Unit Costs–Based on preliminary analysis of 2013 VA fee care unit costs at 105% and 185% of Medicare Allowable for Inpatient and Ambulatory Care Services, respectively.

Lacking specific data on how Veteran preference might change, we had to make certain assumptions about the shift in reliance. Using the VA Enrollee Health Care Projection Model, Milliman estimates the total medical expenditures for the population of Veterans enrolled in VA based on demographic and diagnostic information, using VA data and actuarial data sets available to them. They then model the reliance on VA to assign a share of that total cost to VA care. For this analysis, we used those total cost estimates.

While the lowest estimate might be based on the $15.5 billion VA currently spends to provide care to this population, we firmly believe limiting this benefit to some level of historical services would not be operationally possible. With these very large limitations, a more reasonable estimate would be somewhere between $25.3 billion and $46.1 billion annually, depending on one's assumptions about the shift in reliance and ability to cap costs at the Medicare allowable rates.

Furthermore, to implement such a policy, VA would have to reduce the significant investment in staff and infrastructure associated with providing the $15.5 billion in care in order to move care to the private sector under such a policy. To the extent that VA could not contain costs from its own national infrastructure and operations, total costs of the policy would be even higher.

[1] Note: This analysis considered all health care services that are available for purchase in the private sector and excluded services unique to VA (mental health residential rehabilitation, spinal cord injury, etc.). Dental services were excluded because of the limited eligibility criteria, and Long Term Services and Supports were excluded because they are not included in Title 38.

Finally, this analysis does not consider any stimulated interest in enrolling in VA to take advantage of this new benefit. It also does not take into account any second order impact on the efficiency of existing operations at VA medical centers, our educational and research programs, nor our emergency preparedness missions.

Question 10. Under Choice Act, is the referral process and veterans' choice to access non-VA care determined by a veteran and a VA medical facility and/or a third-party provider (TriWest/Health Net)?

Response. Under the Veterans Choice Program, eligible Veterans may request non-VA care through the Third Party Administrator (TPA). The TPA only schedules care under Choice when an eligible Veteran has contacted them to request care under Choice.

Question 11. Does the VA calculate and analyze cost for automatic referral in the same manner as a cost analysis that factors the capabilities of VA medical facilities within 40 miles of a veteran's home and the veteran's choice (VA or non-VA)? Please explain the VA's methodology and factors in its cost analysis to permit veterans' access to non-VA care when a VA facility within 40 miles of a veteran is not capable of offering the care sought by the veteran.

Response. Veterans eligible under the 40 mile criteria may contact the applicable Third Party Administrator (TPA) to schedule care in the community under the Veterans Choice Program. When these Veterans are scheduled for care, they are eligible for a 60-day episode of care. During that time, the community provider will bill the applicable TPA in accordance with their agreement. VA will then reimburse the TPA in accordance with the contractual rates or Medicare rates if the provider is providing care under a non-network agreement. VA tracks and trends the billing and paid data related to this population of Veterans to ascertain usage and average cost of care

When a Veteran is identified as eligible for the Choice Program as a result of VA wait times, they are informed of their eligibility and their responsibilities related to accessing care from the Program. If the Veteran chooses to opt in and receive care, they contact the applicable TPA to schedule their appointment. Similar to the 40 mile eligibility, these Veterans are eligible for a 60 day episode of care and the TPA pays the community provider and bills VA accordingly. VA then tracks and trends the billing and paid data related to this population of Veterans to ascertain usage and average cost of care.

Question 12. In VA's potential assessment and cost analysis factoring capabilities at VA facilities, how does the VA- a.) Forecast the services that each veteran might require; b.) Determine whether the VA facility within 40 miles of where each veteran lives is capable of offering the service(s) they require; and c.) Whether each veteran chooses to pursue VA care from another VA facility that does offer such service(s) or they choose to seek non-VA care? Please explain.

Response. The Department of Veterans Affairs (VA) uses the VA Enrollee Health Care Projection Model (Model) to project enrollment, utilization, and expenditures for the enrolled Veteran population for 83 categories of health care services for 20 years into the future. The Model uses actuarial methods and approaches consistent with those employed by the Nation's insurers and public providers, such as Medicare and Medicaid.

First, VA uses the Model to determine how many Veterans will be enrolled each year and their age, priority level, and geographic location. Next, VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA. Finally, total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

Projections are supported by over 15 years of extensive research and analyses of the Veteran enrollee population and drivers of demand for VA health care, including:

- Enrollee age, gender, income, travel distance to VA facilities, and geographic migration patterns
- Significant morbidity of the enrolled Veteran population, particularly for mental health services
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Economic conditions
- Enrollee reliance on VA health care versus the other health care options available to them, i.e., Medicare, Medicaid, TRICARE, and commercial insurance
- Unique health care utilization patterns of Operation Enduring Freedom/ Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), female, and new enrollees

• New policies, regulations, and legislation, such as the OEF/OIF/OND combat enrollment eligibility period
• VA health care initiatives and a continually evolving VA health care system, e.g., quality and efficiency initiatives
• Changes in health care practice and technology such as new diagnostics, drugs, and treatments

Finally, where a Veteran receives care is based on clinical needs, the availability of services within VA, and the Veteran's preferences. VHA has developed a model to help with the coordination of non-VA medical care; the Non-VA Medical Care Coordination (NVCC) model is a system of business processes which standardize front-end business processes, improve patient care coordination, and support future state solutions within Non-VA Medical Care Programs VHA-wide.

In the NVCC model, the Veteran is notified of the approval of non-VA medical care and contacted to identify availability, preferences, and needs. Once this information has been obtained, the non-VA medical care provider is contacted by NVCC staff to schedule an appointment for the Veteran. The appointment is then captured in the Veterans Health Information Systems and Technology Architecture (VistA). The Veteran and non-VA medical care provider are sent the authorization and the appropriate release of information form(s), to ensure the medical records are received by VA for continuation of care.

Question 13. Please explain the VA's limitations in utilizing other VA statutory authorities, such as Title 38, to offer veterans the choice to access non-VA care when a VA medical facility within 40 miles of a veteran is not capable of offering the care sought by the veteran?

Response. When a VA facility is unable to provide medical care to a Veteran, there are several statutes VA can use to assist in meeting the Veteran's health care needs. However, these authorities have limitations for authorizing and reimbursing for non-VA medical care, which are based on a Veteran's enrollment and eligibility status to receive VA health care. The authorities are 38 U.S.C. 1703 (Contracts for hospital care and medical services in non-Department facilities), 38 U.S.C. 1725 (Reimbursement for emergency treatment), 38 U.S.C. 1728 (Reimbursement of certain medical expenses), 38 U.S.C. 8111 (Sharing of Department of Veterans Affairs and Department of Defense health-care resources), and 38 U.S.C. 8153 (Sharing of health-care resources).

More broadly, on May 1, 2015, VA sent to the Congress an Administration legislative proposal entitled the "Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act." This bill would make critical improvements to the Department's authorities to purchase non-VA medical care—specifically, to streamline and speed the business process for purchasing care for Veterans when necessary care cannot be purchased through contracts or sharing agreements. We urge your consideration of this bill, which will provide VA the appropriate legal foundation on which to reform its purchased care program. This proposal would ensure that VA is able to provide local care to Veterans in a timely and responsible manner, while including explicit protections for procurement integrity, provider qualifications, and price reasonableness. And that is critical for Veterans' access to health care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE HIRONO TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 14. HOMELESS VETERANS & THE CHOICE CARD PROGRAM

While a majority of the focus of this hearing has been on veterans whose residential addresses are outside distance requirements in current law, could you give an example on how homeless veterans who don't have a residential address are treated under the Choice Card program?

Response. VA cannot calculate the distance between the nearest VA facility and a Veteran's place of residence without a residential address. Accordingly, under VA's implementing regulations, a residential address is required to be eligible under the residence criteria. Therefore, homeless Veterans without a residential address on file are not eligible based on the residence criteria. However, they are eligible to be seen through the Choice Program if they experience a wait time greater than 30 days for an appointment at their local VAMC.

Question 15. VA'S COMMUNICATION EFFORTS

One of the biggest issues is that there are still veterans that aren't aware of the Choice Card and how it works and some have received conflicting information from

VA staff. What is VA doing to improve its communication strategy on the Choice program and train employees specifically on the process for veterans to appeal VA decisions denying eligibility under the Choice Program?

Response. To increase Veterans' awareness of the Program, VA will continue a comprehensive communications program and outreach efforts to correct confusion about the program, as well as improve public perception of the Veterans Choice Program.

VA has completed an outbound call campaign to those Veterans who were initially eligible for the Veterans Choice Program based on VA's inability to provide an appointment within the wait time goals of VHA. This outreach effort was completed to ensure these Veterans were aware of their eligibility for the Veterans Choice Program if they had not already been informed through their local VA medical center. All Veterans who were enrolled prior to August 1, 2014, and any recent Combat Veteran who enrolled after that date were mailed a Choice Card with an informational letter explaining their eligibility for the Choice Program. VA has also provided a Choice Program fact sheet for Veterans that can be printed locally and provided to the Veteran upon notification of eligibility for the Choice Program. Additionally, VA briefed a number of external groups and organizations about the Choice Program. These include provider groups as well as Veterans Service Organizations (VSO), who assist in reaching out to both providers and Veterans.

To continue our outreach efforts, we recently launched a public service announcement for eligible Veterans, viewable at: https://www.youtube.com/watch?v=i9nnsRlX5b8. We hope all parties will share the video to aid in education efforts about the Choice Program.

Moving forward, VA will target training for staff, tailoring the training needs to the type of employee delivering care to Veterans. For example, we will deliver additional training sessions to our clinical, administrative and purchased-care staff.

In addition to schedulers, clinicians and facility management, "Choice Champions" directly assist Veterans with questions about the Veterans Choice Program. The Choice Champion plays a key role at the facility level in implementing and operating the Veterans Choice Program. Choice Champions are specifically trained to be local subject-matter experts on the Choice Program who can explain and advise Veterans, other employees, and our stakeholders on the program. There currently are more than 900 VHA employees from a variety of functions who have been named Choice Champions. Training, resources, and support for Choice Champions are available through the VA Pulse Choice Champion Community of Practice Web site as well as the VA VACAA Intranet Site. Ongoing monthly training calls are conducted to keep the Choice Champions engaged.

When we initially launched the Veterans Choice Program, we mailed explanatory letters to over eight million Veterans, with their Choice Cards. This month, we are planning to send a mailer regarding the Veterans Choice Program to the same group of Veterans. The mailer assists Veterans in determining if they are eligible for the Veterans Choice Program and provides guidance on how to confirm their eligibility and schedule their next appointment. We will continue to focus on outreach and communicating with Veterans to ensure they understand the Choice Program, to include: establishing a reoccurring Veterans survey to measure their knowledge of the program; strengthening and expanding our social media strategy for Veterans, families, and caregivers; and, conducting program-related town halls at VAMCs.

In the next few weeks, we will continue our robust outreach strategy to help Veterans better understand their benefits under the Veterans Choice Program, by:

- Collaborating with VSO leadership to share newsletter inserts, talking points, social media content, etc. with their membership;
- Initiating a re-occurring survey of Veterans to gain an understating of their knowledge of the program (The results of this survey will be leveraged to identify gaps in communication and training among Veterans and VHA staff.);
- Developing a comprehensive social media strategy for Veterans and their families and caregivers;
- Placing Veteran Choice Program posters in public locations to increase awareness;
- Hosting town halls related to the program at the VAMCs; and,
- Finalizing a brochure of information that will be available to Veterans.

Chairman ISAKSON. We will go immediately to our second panel. So, would the panelists please come forward?

We would like to welcome all of our panelists for the second panel and I am going to move quickly so we can be sure and get

everybody's testimony in before votes start on the floor of the Senate.

In order of appearance, first we will have Roscoe Butler, the Deputy Director for Health Care for the American Legion; Peter Hegseth, Chief Executive Officer at Concerned Veterans for America; Joseph Violante—is that the correct pronunciation?

Mr. VIOLANTE. Yes, it is.

Chairman ISAKSON [continuing], National Legislative Director for Disabled Veterans of America; Mr. Bill Rausch, Political Director for Iraq and Afghanistan Veterans of America; and an alumni of this Committee, Carlos Fuentes—Carlos, welcome back—Senior Legislative Advisor to the Veterans of Foreign Wars. We are glad to have all of you here. We will start with Mr. Butler. Please try to keep your remarks within 5 minutes.

STATEMENT OF ROSCOE BUTLER, DEPUTY DIRECTOR FOR HEALTH CARE, THE AMERICAN LEGION

Mr. BUTLER. Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee. On behalf of our National Commander, Michael Helm, and the 2.3 million members of the American Legion, we thank you for this opportunity to testify regarding considerable possible changes to the distance criteria as well as attempting to gain an understanding of the issues veterans are facing first-hand.

Ultimately, all of the stakeholders exploring the implementation of the Veterans Access, Choice, and Accountability Act want the same thing, for veterans to be able to receive timely care without undue burden. Getting those veterans to the care they need is everyone's focus. If I were a veteran living in the Chesapeake Bay area of Virginia, I would face obstacles to reaching a treatment facility that straight-line distances on a map cannot show.

Veterans living on the eastern shore of Virginia live approximately 60 road miles from the Hampton VA facility and a direct line is only 24 miles. However, veterans need to travel over the Chesapeake Bay Bridge and tunnels which costs veterans $24 round trip and $26 if they do not have an E-Z Pass.

The problem is not unique in Virginia. In a 2012 report on rural health care for veterans, the American Legion noted, Veterans who reside on Martha's Vineyard have to take a 45-minute boat ride to the mainland, followed by a 25-mile drive to the CBOC located in Hyannis, MA, to receive care, and if the care needed is not provided, the veteran must drive another 80 miles to the medical center in Providence, RI.

Today, VA has announced that they will take regulatory action to fix part of this problem. Rather than using the "as the crow flies" standard, they will now consider actual road miles traveled. This is a good start. It is a common sense solution to getting access to veterans and the American Legion is glad the VA is stepping up and taking action to get this done.

But there are more common sense solutions that could be implemented. Sometimes the problem revolves around what treatments are available close to the veterans. The American Legion had veterans tell us, in the Yakima, WA, region, that they are being told they must travel over 2 hours to obtain audiology services at a VA

facility when there are facilities right there in town that could provide the same service and without waiting 90 days or more because of over-burdened facilities.

The purpose of the Choice card program was to supplement VA care by enabling veterans who were finding obstacles to getting care within the VA system, whether by time or distance, to get care either closer to home or faster than the VA could provide.

Denying veterans access to care closer to home because there is a VA facility that does not offer the service they need seems to be a problem of following the letter of the law rather than the spirit of the law. If veterans are struggling to gain access to care, get them access to care. Common sense needs to prevail.

Right now, these deniers are only creating ill will in the veterans community. If the Choice card program is currently under-utilized, as Secretary McDonald states, then there should be no obstacle interpreting this law in the veterans' favor. Before the VA looks to respond to re-purpose those funds elsewhere, they should explore all options to make sure the veterans who struggle to get care are better served.

The American Legion believes some common sense reform could help make this program effective, delivering care to veterans in need. VA has already looked at the 40-mile straight line rule and realized it was not helpful in determining how difficult it was to get veterans to care they need.

Now Congress should look at the facility definition to make sure a facility only counts as being close to a veteran if it actually provides the treatment the veterans need. VA must communicate clearly and effectively with the veterans, make sure the message for every vision is the same message coming out of central office.

This program came about to help bridge the gap where VA struggles to deliver care. Whether because of distance or volume of veterans, with a few simple tweaks it could be quite effective in doing so.

Thank you again, Chairman and Ranking Member Blumenthal, for turning the Committee's attention to getting this right. I appreciate the opportunity to share The American Legion views and look forward to any questions you may have.

[The prepared statement of Mr. Butler follows:]

PREPARED STATEMENT OF ROSCOE BUTLER, DEPUTY DIRECTOR FOR HEALTH CARE, VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee, on behalf of Commander Helm and the 2.3 million members of The American Legion, we thank you and your colleagues for conducting this hearing and considering possible changes to the distance criteria as well attempting to gain an understanding of the issues veterans are facing first-hand. Ultimately, all of the stakeholders exploring the implementation of the Veterans Access, Choice and Accountability Act want the same thing—for veterans to be able to receive timely care without undue burden. Getting those veterans to the care they need is everyone's focus.

The American Legion supported the passage of the "Veterans Access, Choice, and Accountability Act (VACAA) of 2014" bill that was signed into law on August 7, 2014 as Public Law 113–146; as a means of addressing revelations that veterans struggled to receive access to care within the Department of Veterans Affairs (VA) system. The American Legion believes all veterans need to be able to depend on

equal access to care [1] and that veterans should not be punished for living in a rural area, or even an area with a high volume of veterans where demands on the healthcare system make timely appointments difficult to schedule.

When The American Legion reached out to veterans recently to determine the level of success the veterans were having accessing the VA Choice Card program, we received the following response from a female veteran in Virginia:

> I am a 90% disabled Air Force veteran. Last November the VA set me up an appointment to see a physiologist at the end of January, but told me to call this 1–800 number and I could get an appointment in my home town within 30 days. I called. I was told someone would call me back. No one did. I called 3 times in December. First they told me that I had permission for physical therapy. I said, "This isn't physical therapy." The lady told me she would get back to me. They never did. I called one last time the first full week in January and spoke to a man named John. He told me he would put a rush on this. The VA called me on February 6th to set me up an appointment. My appointment was January 20th and I had already been seen. I asked to speak to a supervisor. I explained what happened and her response was, "Well, it happens."

Secretary of Veterans Affairs Bob McDonald recently noted that the Choice Card program was being underutilized, with only 27,000 veterans having made appointments since the program rolled out in November.[2] At the time, VA stated a desire to be able to "repurpose" portions of the $10 billion in allocated funds to other programs within VA. The American Legion believes it is premature and short sighted to reallocate those monies so early into the implementation of this program. The Choice Card program was implemented to ensure veterans who struggle to receive care have improved access to care. A better solution would be to examine the current flaws in the implementation of the system, and see if there are ways it could be enhanced to improve access to care.

The American Legion believes improving the implementation of the Choice Card program for rural veterans and veterans not located close to a VA facility requires addressing three critical concerns:

1. Revision of the current "as the crow flies" standard for measuring distance
2. Reevaluating the current policy that does not take into account whether the VA facility within 40 miles offers the treatment the veteran needs
3. Ensuring that the appeals process is clearly communicated to veterans who question whether their denial of eligibility for the Choice Card program is appropriate

REVISING THE "AS THE CROW FLIES" STANDARD:

Despite the best of intentions, veterans are being denied enrollment into the Veterans Choice Program, due in part to how the bill specified the mileage calculation using "geodesic" or "as-the-crow-flies" to determine if a veteran lives more than 40 miles from VA care. Under VA's interim final rule [3] VA calculates the distance between a veteran's residence and the nearest VA medical facility using a straight-line distance, rather than the actual driving distance. The American Legion believes this straight-line calculation is appropriate for calculating the distance for airline travel or as the "crow flies," but to use this method of calculation for determining the distance for driving from a veteran's home to a VA medical facility is problematic and does not accurately take into account real driving conditions. As a result, veterans who would otherwise be eligible if real driving distances were considered are being denied enrollment into the Veterans Choice Program.

For many veterans they have to travel across mountains, bridges, highways, and water to access care at a VA medical facility. Veterans who reside on Martha's Vineyard for an example, have to take a 45 minute boat ride to the mainland followed by a 25 mile drive to the CBOC located in Hyannis, Massachusetts to receive care and if the care needed is not provided veteran's must drive another 80 miles to the medical center in Providence, Rhode Island.[4]

Veterans living on the Eastern Shore of Virginia live approximately 60 road miles from the Hampton VA facility and a direct line is only 24 miles. However, veterans

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[1] Resolution No. 160 "Veterans Receive the Same Level of Benefits"—AUG 2014

[2] Federal Eye "Far fewer veterans use choice card and private health than expected, VA says" *The Washington Post* February 13, 2015

[3] 38 CFR § 17.1510(e)

[4] 2012 System Worth Saving Report on Rural Health Care: http://www.legion.org/sites/legion.org/files/legion/publications/sws-rural-healthcare-report-2012-web.pdf

need to travel over the Chesapeake Bay Bridge and Tunnel which costs veterans $24 round trip. A member of The American Legion from the Chesapeake region recently expressed their frustration with the situation they face in that region:

> While the Pocomoke CBOC is a well run and professional VA medical facility, the problem that exists for the shore veteran is that the Pocomoke CBOC is under the Baltimore Veterans Administration [sic]. That means any in-depth medical treatment or special testing etc. that a shore veteran requires results in additional travel to Baltimore or Cambridge, MD. Just last week one of our combat veterans at Post 56 was denied a local medical appointment because he lived within this 40 mile radius of the Hampton VA. The fact is that he lives 50.2 miles away from the Hampton VA and he doesn't own a hang glider to make that appointment.

The 40 mile rule is misleading because of the geographic challenges that veterans who live in rural and/or highly rural areas face regarding accessing VA health care. Approximately 41 percent or 3.4 million veterans live in rural and/or highly rural communities with the majority living in southern or central portions of the country.[5] The American Legion discovered that one of three veterans who are enrolled in the VA resides in a rural and or/highly rural area of the country and that number is expected to rise as more servicemembers transition out of the service. Veterans living in rural areas of the country are faced with many challenges to include the lack of primary and specialty health care services and treatments as well as increased time and distance that veteran's experiences in traveling to VA health care facilities.[6]

Veterans in these rural communities are concerned that the "as the crow flies" standard doesn't recognize the challenges involved in actually traveling the road miles to reach a facility. The American Legion believes the current interpretation of the distance standard should be modified to reflect actual distances traveled, as well as other intervening factors such as the high tolls faced in some regions. This provision was meant to improve access for veterans in rural regions who had difficulties accessing VA care. To be truly within the intent of the legislation, the rulemaking needs to reflect an attempt to overcome the challenges rural veterans face when trying to access that care.

REEVALUATING THE POLICY REGARDING TREATMENTS OFFERED AT VA FACILITIES:

The American Legion's National Commander Michael D. Helm stated before the Senate and House Veterans' Affairs Committees that one of the biggest challenges he has seen with the implementation of the Veterans Choice Card Program is the confusion over VA's definition of a VA medical facility. VA regulations defines a "VA medical facility" as a VA hospital, a VA community-based outpatient clinic (CBOC), or a VA health care center, with no consideration as to whether the VA medical facility can provide the health care or services the veteran requires. In many cases, veterans are being referred from a CBOC to the parent VA medical center which can be over 150 miles without taking into account travel times and road conditions. This can significantly impact veterans the ability to maintain their appointments, which directly impacts VA's appointment cancellation and no-show rates.

Commander Helm related stories of veterans in Kansas being sent over 270 miles to a hospital for treatment because they were close to a CBOC, but the CBOC didn't offer the treatment they needed, he called the practice "crazy."

The American Legion queried our network of over 3,000 accredited service officers to hear their accounts of veterans accessing the Choice Card program. As service officers, they are the first line of contact for many veterans when they run into problems at VA, so collecting information from this web of contacts is helpful for determining the pulse of how veterans are really faring when interacting with VA, whether in the claims and benefits system or the healthcare system.

In Washington State many of the local veterans cannot get the service they need at their CBOC so they need to travel over 170 miles to the parent facility in Spokane. One veteran The American Legion spoke to stated "I have an appointment that was scheduled on May 5, 2015, so I called the number on the choice card to see if I can get an appointment sooner and received a call nine days later."

One service officer attended a Town Hall in Yakima, WA and related the following:

> The audience was veterans in their late 80"s and early 90's all the questions were about the wait to get appointment to fix their hearing aids.

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[5] Ibid
[6] Ibid

> Some said they have been waiting for over 90 days for an appointment and when they got the choice card they were still waiting 90 days for an appointment to get the hearing aide fixed. I know there are other facilities that do hearing tests and give hearing aids beside the contract facility that VA is using in the Walla Walla catchment area. These veterans are driving over two hours one way for hearing aids or appointment which they can get in the community if VA would look into it.

The purpose of the Choice Card program was to supplement VA care by enabling veterans who were finding obstacles to getting care within the VA system, whether by time or distance, to get care either closer to home or faster than the VA could provide. Denying veterans access to care closer to home because there's a VA facility that doesn't offer the services they need seems to be a problem of following the letter of the law rather than the spirit of the law. If veterans are struggling to gain access to care—get them access to care. Common sense needs to prevail. Right now, these denials are only creating ill will in the veterans' community.

If the Choice Card program is currently underutilized as Secretary McDonald states, then there should be no obstacle to interpreting this law in the veterans' favor. Before VA looks to repurpose those funds elsewhere, they should explore all options to make sure the veterans who struggle to get care are being served.

ENSURING VETERANS HAVE A CLEAR PATH TO APPEAL DENIALS OF ELIGIBILITY:

When a veteran is determined to be ineligible for the Choice Card program, there are questions regarding the proper avenue of appeal. The American Legion contacted VA Central Office (VACO) regarding the appeals process and were informed there is an appeals process the veteran is informed of when they are notified of a formal denial of eligibility. A veteran has a right to request that VA reconsider their decision.[7] In accordance with VA's regulation, an individual who disagrees with the initial decision denying the claim in whole or in part may obtain reconsideration by submitting a reconsideration request in writing to the Director of the healthcare facility of jurisdiction within one year of the date of the initial decision. The reconsideration decision will be made by the immediate supervisor of the initial VA decisionmaker. The request must state why it is concluded that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for the dispute will be returned to the sender without further consideration. The request for reconsideration may include a request for a meeting with the immediate supervisor of the initial VA decisionmaker, the claimant, and the claimant's representative (if the claimant wishes to have a representative present). Such a meeting shall only be for the purpose of discussing the issues and shall not include formal procedures (e.g., presentation, cross-examination of witnesses, etc.). The meeting will be taped and transcribed by VA if requested by the claimant and a copy of the transcription shall be provided to the claimant. After reviewing the matter, the immediate supervisor of the initial VA decisionmaker shall issue a written decision that affirms, reverses, or modifies the initial decision.

In communication with VACO the appeals process was clearly defined. Whether the process is being clearly explained or implemented in the field is still in question.

A service officer in New York explained:

> I have had numerous veterans contact me at my office or speak to me at various meetings regarding their denial of eligibility for using their Choice Card. To the best of my knowledge none of them have been offered an opportunity to appeal the denial. We have 5,253 Veterans in Otsego County, NY. Additionally, I know of no one in our county that has been approved to use their Choice Card.

A service officer from Alabama responded by stating many of the issues raised by the veterans he spoke to were in regards to the denial of services. In each of those discussions there has been no mention of an appeal process or the ability to appeal.

The information The American Legion has at this time is still anecdotal, and requires additional research to make a more definitive decision as to whether the process is working as intended in the field. Right now, there are too many questions to determine whether VA is, or is not, explaining the process as intended. The American Legion continues to conduct field visits to VA medical facilities across the country, and questions regarding the implementation and effectiveness of the appeals process are now a standard part of the field research conducted by staff of The American Legion.

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[7] 38 CFR 17.133

At this time, there is a process in place, but it is important to ensure implementation of the process is happening consistently and that the process is being clearly explained to veterans in the field. The American Legion is committed to ensuring that this is the case through careful consideration during field research and site visits.

CONCLUSION

The American Legion still strongly believes the VA is the best method for delivering care to veterans, however we also recognize there are constraints VA must overcome, such as geography and workload that sometimes make this difficult. The Choice Card program, like many authorities extended to VA to address areas where they are falling short of meeting veterans needs, has great potential to ensure veterans get seen in a timely manner, and without undue travel requirements. In time, when we study the implementation of the Choice Card program before its authority expires, data on how the program was used can be helpful in determining where VA must expand to meet veterans' needs, and where there are still gaps in service.

However, the program cannot be implemented by half measures, and with one hand seemingly tied behind its back. To be effective, The American Legion believes the Choice Card program needs to be implemented in a manner consistent with the spirit in which it was passed—as a tool to ensure veterans get the care they need, when and where they need it. To do this, The American Legion urges VA to adopt rule changes that eliminate the straight-line "as the crow flies" rule, to make common sense corrections that interpret "facility" to mean a facility that actually has the treatment the veteran needs available, and to develop a simple but effective means for veterans to resolve their ineligibility questions. If VA cannot or will not make these changes of their own volition to serve the veterans who need these changes, The American Legion urges Congress to amend the laws to make things right.

The American Legion thanks this Committee for their diligence and commitment to examining this critical issue facing veterans as they struggle to access care across the country. Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861–2700, or wgoldstein@legion.org.

Chairman ISAKSON. Thank you, Mr. Butler. You are going to get the Blumenthal award for the best use of common sense. That term has been used a lot today and I think it is exactly true. If we apply common sense to these problems, we could solve them all. Thank you for your testimony.

Mr. Hegseth.

STATEMENT OF PETER B. HEGSETH, CHIEF EXECUTIVE OFFICER, CONCERNED VETERANS FOR AMERICA

Mr. HEGSETH. Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, thank you for this opportunity. Last year's reform law established a temporary Choice card program that we are discussing here today. The law was not a silver bullet, but it was a good first step. The Choice card, as we all know, extends the possibility for private care for veterans who wait more than 30 days or live more than 40 miles from the VA facility.

But ask any veteran and they will tell you, Rather than choice and better access, the Choice card process is confusing, frustrating, and still unacceptably long. There are currently millions of so-called Choice cards in the pockets of veterans yet there is still very little choice.

Understanding the closed-door give and take the conference committee undertook with consideration for CBO scoring, the primary problem has still been VA's execution of the law, specifically their commitment to restricting the use of the Choice program to those within 40 miles of any VA facility even if that facility does not provide the care that is needed.

VA has chosen to execute the law quite strictly, drawing 40-mile circles, crow or no crow, around every single VA facility choking out Choice in the process. A 100-percent-disabled veteran from rural California recently contacted our organization. His story illustrates the point.

He lives ten miles from a CBOC. However, that clinic cannot provide the care that he needs, ranging from an eye doctor to podiatry. For these services, he still travels over 100 miles to get his care. Common sense and good faith would tell us that he should qualify for the Choice program, but he does not.

Now, when he calls the information line and waits on hold, he is inexplicably told he does not qualify. Finally, because there is no clear cut appeal process, he has no recourse for appeal. He waits. He is stuck. No explanation, no customer service, no common sense, no appeal.

Instead, a VA-scheduling gatekeeper tells him what he gets, when he gets it, and where he will get it. He has a Choice card, but he has no choice. For him, absolutely nothing has changed. His story is the norm. Every day VA gatekeepers tell thousands of veterans that live more than 40 miles away from where they actually receive care that they do not have a choice.

Now, technically, VA's implementation is in line with the parameters of the law, as we have heard. Something our organization, CVA, warned about when the reform law was first passed. Without clearer implementation guidelines, we believed VA would execute the rules in their favor, undermining the intent of the law.

Bureaucracies reflexively serve their own self-interests, and in the case of the Choice card, that is exactly what VA has done. Now, only 26,000 veterans have yet to use the program, 26,000 veterans. Why such under-utilization? According to Helen Tierney, Assistant Secretary for Management at VA, the VA has, "a strong indication that private care is not veterans' preferred choice," and that, "veterans would prefer to remain in the VA for their care."

Ms. Tierney, a 2014 appointee with little previous health care or veterans experience, offered no supporting evidence for these sweeping assertions. Of course, the opposite is true. Veterans want Choice. A recent VFW survey found that 80 percent of their members who should qualify for the Choice program were not afforded that choice when they called.

Almost all of their 2,500 respondents were interested in getting private care. Our nationwide polling shows the exact same desire. 90 percent of veterans want a choice or a private option; 77 percent want that choice even if they have to pay more out of pocket for it.

The Department's incentive is to keep veterans inside the VA hospitals regardless of the needs of the veteran. The Choice program did not fundamentally shift VA's misaligned incentives. It merely nipped at the margins of a self-serving system.

VA remains VA-centric, rather than veteran-centric. That is why, in our recently released, *Fixing Veterans Health Care* task force report, which we are happy to share with everyone on the Committee, we propose to truly put the veteran at the center of their own health care choice option through the Veterans Independence Act.

[The task force report can be found on the World Wide Web at http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf)]

In our proposal, the veteran is empowered to truly choose the health care products that serve them best. No more gatekeepers. Senator Tillis, 40 miles, 500 miles, or 2 miles, the veteran has the choice. Central planning is a very difficult task no matter how smart those charged with doing it. When a veteran chooses, it makes that complication much simpler.

Our plan builds a premium support mechanism, the same one that VA employees have, that would allow eligible veterans to make the best health care choices for them. How ironic is it that VA employees have health care choices, but not veterans? Or, for that matter, Senators here today have health care choices, but veterans do not.

Veterans chose to serve. Why can they not choose their health care? This hearing is about a card and our report is about transforming the VA to provide real choice which can be done in a cost-effective way, which we dug into in the report. That concept is long past due. The 21st century health care delivery model demands choice.

I hope you will review our bipartisan report which I submit for the record (see URL above) humbly. Our report was authored by Republican Senator Bill Frist, Democratic Congressman Jim Marshall, former VHA Director Mike Kussman, and health care expert Avik Roy. We believe it deserves stand-alone consideration.

In closing, the Choice card could be a good first step for choice for veterans, provided VA is held accountable to deliver it. Until then, the Choice cards millions of veterans have in their pocket are barely worth the card stock paper they are printed on.

Thank you for this opportunity and I welcome your questions.

[The prepared statement of Mr. Hegseth follows:]

PREPARED STATEMENT OF PETER B. HEGSETH, CEO,
CONCERNED VETERANS FOR AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Senate Veterans' Affairs Committee, thank you for the opportunity to be here today and testify on this important topic.

My name is Pete Hegseth and I am the CEO for Concerned Veterans for America, an organization of veterans and military families dedicated to fighting for our Nation's veterans; specifically—today—by pushing for reforms to the way healthcare is delivered to America's veterans.

Our organization represents a growing number of veterans and military families who refuse to accept the broken status quo. For too long, promises have been made, and too few have been kept. Implementation of the Choice Card is a perfect example. There are currently millions of so-called choice cards in the hands of America's veterans; but rest assured—for a myriad of reasons—there is still little choice. Hence, today's hearing.

In August of last year, President Obama signed the Veterans Access, Choice and Accountability Act that established a temporary "choice card" program. We understood then, and fully recognize now, that the law was never designed to be a panacea. It was a first step. But rather than take that step, the VA has stumbled. Worse, it's barely tried to walk—undermining the intent of the choice law through what we believe has been confusing and disingenuous implementation.

No need today to re-litigate the litany of VA scandals over the past year—and much longer. As you know, many of those revealed scandals had to do with access and appointment scheduling practices that masked real, egregious, and in many places criminal wait times for America's veterans.

The Veterans Access, Choice and Accountability Act—specifically the Choice Card—was intended to address this access problem, extending the possibility of private care to veterans who wait more than 30 days for an appointment and/or reside more than 40 miles from a VA facility—including a Community Based Outpatient Clinic (CBOC). But ask any veteran here, in my organization, or across the country, and they'll tell you that, rather than access and appointments getting easier—the process is confusing, frustrating, and still unacceptably long.

The primary implementation impediment has been VA's interpretation of the law; specifically their decision to restrict the use of the Choice program to those within 40 miles of a VA facility, even if that facility does not offer the care needed. The law states that veterans are eligible if they reside "more than 40 miles from the medical facility of the Department, including a community-based outpatient clinic [CBOC], that is closest to their residence." VA has taken this quite literally—drawing 40 mile, "as-the-crow-flies" circles around every single VA facility, thereby chocking out choice.

But, as we all know, many CBOC and small VA facilities do not offer a full range of medical coverage. As such, it is often the case that veterans are denied the use of the Choice Card because they are less than 40 miles from a CBOC, despite the fact that they are unable to receive the care they need from that facility. Instead, they still must drive hundreds of miles to receive care—even though, if the Choice Card was used properly, they could get it in their local community.

This is illustrated well by a recent call my organization received from a 100% disabled veteran from rural California. This veteran lives less than 10 miles away from a CBOC, which he often utilizes. However, that clinic is unable to provide some of the more substantial health care services he requires—ranging the eye-doctor to podiatry. For these services, he still travels well beyond 40 miles—often over 100 miles one way.

Common sense—and good faith—would tell us that he should qualify for the choice program. But he does not. When he calls the Choice Program information line, after waiting on hold, he is repeatedly told he doesn't qualify. Finally, because there is no clear-cut appeal process—he has no recourse for appeal. So, he gave up—and still drive long distances and waits too long.

No explanation. No customer service. No common sense. No appeal. Instead, the VA scheduling gatekeeper tell him what he gets, where he gets it, and when he gets it. He has a Choice Card, but no choice. Nothing has really changed.

His story is powerful because it's the norm. It's powerful because it's the same as hundreds of thousands of other veterans in America. They thought they had choice because they know they live more than 40 miles away from where they actually receive care—but VA's "choice gatekeepers" on the other end of the phone line determine otherwise.

Technically, VA's implementation is in line with the letter of the law—something CVA warned about when the reform law was first passed. Without strict guidelines, we believed VA would bend the rules in their favor—which is exactly what has happen. As a result, VA has undermined the clear intent of the law. They have met the technical requirements of the law while fundamentally undermining the spirit and intent of the law. As I said, lots of choice card—but no choice.

Moreover, VA's attempts to strip—excuse me, reprogram—funding away from the Choice Program have come almost immediately. Why? Because, as VA has pointed out, only 26,000 veterans have yet to use the program. Why such underutilization? According to Helen Tierney—assistant secretary for management at VA—they have "a strong indication that this [private care] is not veterans' preferred choice" and they "would prefer to remain in the VA" for their care. Ms. Tierney—a 2014 appointee with little previous health-care or veterans' experience—offered no supporting evidence for these sweeping assertions.

The opposite is true—veterans want to use the program, because they want choice. A recent VFW survey on the Choice Program found that 80 percent of their members who should qualify for choice said they were not afforded the choice to receive non-VA care. Almost all of their 2,500 respondents were interested in getting private care. Our nationwide polling of veterans also shows the exact same desire. Veterans want health care choices—in fact, 90% do. 77% want options outside the VA system—even if they have to pay more out of pocket.

So, while individual veterans want choice, the powerful VA bureaucracy does not. Rather than implement Choice Program reforms diligently, VA has delayed implementation and erected technical barriers to private choice. As a result, few veterans have been able to yet exercise that choice, which is when VA publicly claims veterans actually don't want choice. Finally, under the guise of "doing what veterans want," VA leadership is now attempting to strip the funding—and we know what

that means. Using classic bureaucratic tactics, VA is attempting to write its own self-fulfilling prophecy in order to keep veterans inside the system.

History tells us that no bureaucracy can be trusted to reform itself. Only strenuous oversight of the current law by codifying reasonable and common-sense distance and time parameters—and further reforms that expand choice by truly empowering veterans to choose—will ensure that veterans get what they crave.

In a larger context, we see these problems as part of misaligned incentives and priorities at VA. The choice program did not fundamentally shift these incentives; it merely worked around the edges of a system that has much deeper problems. The Department's incentive is to funnel veterans toward VA hospitals, regardless of the needs of the veteran. VA is VA centric, rather than veteran centric. The interests of VA are not necessarily the same as the interests of veterans.

This is why, in our recently released the Fixing the Veterans Health Care task force report, we proposed to put the veteran at the center of their own health care choices through the Veterans Independence Act. In our proposal, the veteran is empowered to choose the health care products that serve them best. Our plan would build a premium support mechanism—the same one VA employees have—that would allow eligible veterans to make their choices in health care. How ironic is it that VA employees have health care choices, but not veterans? Or, for that matter, Senators here today have health care choices—but veterans do not?

Our idea is simple, and long overdue: allow the healthcare dollars to follow the veteran while recognizing what VHA does best—and liberating it to do those things. I hope you will all take a look at our bipartisan report, which I will submit for the record.

The Veterans Access, Choice and Accountability Act remains a good first step toward real choices for veterans—provided VA is held accountable to deliver real choice. And that starts with codifying what 40 miles really means, and for that matter, what really constitutes a 30 day wait. Until then, the choice cards millions of veterans have won't be worth the government paper it was printed on.

Thank you for the opportunity to testify on this important issue, and I look forward to working with this Committee to advance real choice for our veterans. I welcome any questions. Thank you.

Chairman ISAKSON. Mr. Violante.

STATEMENT OF JOSEPH VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, on behalf of DAV and our 1.2 million members, all of whom were wounded, injured, made ill from their wartime service, I am pleased to discuss the distance criteria contained in the Veterans Access, Choice, and Accountability Act.

The law established two primary access standards for the Choice program: Waiting longer than 30 days or traveling more than 40 miles. However, due to cost considerations, Congress wrote the 40-mile standard in a way that was more restrictive than common sense would dictate.

The 40 miles is measured to the nearest VA medical facility in a straight line from point to point, or as the crow flies. In addition, the measurement is made from the veteran's residence to the nearest VA medical facility even if that facility cannot provide the service required.

DAV believes that 40 miles must be measured as humans travel, not as crows fly. Typically, that would be done by measuring road mileage, though an argument could be made that driving time ought to be considered as well. DAV is pleased VA has decided to revise its policy.

Mr. Chairman, it also makes no sense to measure the distance to a facility that is unable to provide the needed service. That must also be changed. Even with these changes, the 40-mile standard for the program is not a panacea for VA's access problems. For some

disabled veterans, five miles might be too long to travel for primary care, particularly if that veteran has severe disabilities. On the other hand, for some veterans having to travel 100 or more miles might not be too far to receive highly specialized care.

The most important access standard must always remain what is clinically appropriate for each veteran. Mr. Chairman, DAV supports these common sense changes only within the broader context of how this temporary program was structured.

First, Congress established a separate mandatory funding source to ensure VA would not have to make a choice between providing care to veterans at VA or through the Choice program. Congress and VA must ensure that funding for non-VA health care, however that program is reformed, remains separate from funding for the VA health care system.

Another principle central to our support is coordination of care, which is vital to the quality of veterans' care. VA's use of third party administrator networks helps to assure medical records are returned to VA there are quality control on clinical providers, and neither veterans nor VA are improperly charged or billed for services.

Finally, and most importantly, the law included a new resource to rebuild VA's capacity to provide timely health care. A systemic lack of resources has prevented VA from hiring enough medical and clinical professionals or to maintain usable treatment space to meet the demand for care by veterans. Congress must assure adequate funding for both VA and non-VA health care programs.

Mr. Chairman, it is still far too early to make any judgment about whether this new Choice program will function as intended, whether it has enough or too much funding, whether it will improve access for veterans, or, more important, whether it will improve health care outcomes for veterans.

That is why Congress required the creation of a commission on care to study how best to deliver health care to veterans. Unfortunately, the law allows the commission only 90 days to produce an interim report, and then only 90 additional days to submit its final report. That is not enough time for the newly-constituted commission to examine the issues and come to agreement on specific recommendations that would change how health care would be delivered to millions of veterans over the next two decades.

We 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. Mr. Chairman, we would also expect that permanent changes to the VA system would not be considered until after this Congressionally-mandated commission has completed its work and allowed other stakeholders to engage in a debate worthy of the men and women who served.

Mr. Chairman, that concludes DAV's testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

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 publicly 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 cutoff 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 cutoff 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 judgments 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 judgment, 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 judgment.

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.

Chairman ISAKSON. Thank you very much. Mr. Rausch.

STATEMENT OF BILL RAUSCH, POLITICAL DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. RAUSCH. Chairman Isakson, Ranking Member Blumenthal, distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America, and our nearly 400,000 members and supporters, thank you for the opportunity to share our views with you today on a hearing examining the distance criteria in the Veterans Access, Choice, and Accountability Act of 2014.

IAVA was an early supporter of and partner with this Committee on crafting the Choice Act last year as it became apparent that the VA could not fulfill its obligation to provide timely access and quality care to the veterans under its charge.

While we fully support the VA and want to see it properly resourced, we also believe that no veteran should have to wait to receive the care they need and deserve. I came here today fully pre-

pared to make two recommendations regarding the distance criteria in the Choice Act, as my written testimony reflects.

But as you know, the VA announced this morning that it will change the calculation used to determine the distance between a veteran's residence and the nearest VA medical facility from a straight line distance to driving distance. IAVA strongly supports this announcement and we applaud the Secretary for having a strong pulse on what veterans are thinking and experiencing at the ground level.

While today's announcement is welcomed, initial implementation is exposing an important aspect of the Choice program that, based on our members' feedback, also needs addressing. We urge this Committee to amend the law to allow the VA to measure the distance from the nearest VA medical facility that offers the specific treatment or care the veteran requires rather than the current 40-mile restriction measured by the VA from any facility.

Currently, the nearest VA medical facility or CBOC may not offer the care the veteran needs. Based on a recent poll of our members focused on distance eligibility requirements, only 9 percent have used the program, while 25 percent stated they tried to utilize the program, but were denied access.

From those who were denied access, over half were turned away because of distance issues. One example includes a member who travels an hour and a half to a VA medical facility for urology appointments. This veteran tried to use the Choice program to see a urologist in their home town but was denied because they lived 40 miles—excuse me—within 40 miles of a VA clinic that does not have a urology department.

Another member told us, "Because there is a CBOC in my area, I was denied. The clinic does not provide any service or treatment I need for my primary service-connected disability. The nearest medical center in my network is 153 miles away."

Now, we are encouraged by the commitments made earlier today by the Chairman and Ranking Member and their staff to work with the VA and IAVA stands ready to commit and support as needed.

On a related topic, our members report there is confusion and a lack of consistent and reliable information being provided by VA schedulers concerning the Choice program. In recognition of this, we urge the VA to aggressively educate their staff to ensure veterans are consistently being informed of the Choice program.

Additionally, efforts need to continue to—excuse me. Additionally, efforts need to continue in educating the veteran population or members of the program in its eligibility requirements. Given its infancy, we believe this is a shared responsibility amongst all stakeholders. We cannot lose sight of the fact that everyone represented here today should be focused on the same goal: doing what is best for our Nation's veterans.

Reforming the distance requirement and ensuring that veterans have all the information needed regarding the Choice program takes positive steps to meeting this obligation.

Mr. Chairman, we look forward to working with the Secretary, our VSO partners, and this Committee to provide the best access and quality of care for all veterans. Thank you again for allowing

IAVA to be part of this hearing and for considering our views and recommendations regarding how to improve the Veterans Access, Choice, and Accountability Act of 2014.

[The prepared statement of Mr. Rausch follows:]

PREPARED STATEMENT OF BILL RAUSCH, POLITICAL DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Statement of Iraq & Afghanistan Veterans of America
Senate Committee on Veterans' Affairs
March 24, 2015

Statement of Bill Rausch
Political Director
at
Iraq and Afghanistan Veterans of America
before the
Senate Committee on Veterans' Affairs
for the
Hearing Examining "The Veterans Choice Act: Exploring the Distance Criteria"

March 24, 2015

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

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our nearly 400,000 members and supporters, thank you for the opportunity to share our views with you at today's hearing examining the distance criteria in the Veterans Access, Choice and Accountability Act (VACAA) of 2014, Public Law 113-146.

IAVA was an early supporter of and partner with you on crafting the Choice Act last year as it became apparent that the Department of Veteran Affairs (VA) could not fulfill its obligation to provide timely access and quality care to the veterans under its charge. While we fully support the VA and want to see it properly resourced, we also believe that no veteran should have to wait to receive the care they need and deserve.

For this reason, IAVA worked diligently with the staff of this Committee and with many of your offices to craft solutions that would open up options for veterans to receive quicker care in more convenient locations. The resulting bill established two criteria for determining which veterans are eligible to use the Choice Program; those who must wait longer than 30 days for an appointment and those who live more than 40 miles from a VA medical facility, which is the topic of today's hearing.

Although there were many factors that went into determining the distance criteria, including cost concerns, initial implementation has exposed two areas for improvement based on the feedback we have received from our membership. IAVA urges this committee to consider amending the legislation to measure the 40 mile distance criteria based on driving distance rather than point-to-point or geodesic measurement.

Further, we urge a change in the law to measure the distance from the nearest VA medical facility that offers the specific treatment or care the veteran requires rather than the current 40 mile restriction measured from any VA medical facility. Currently, the nearest VA medical facility or CBOC may not be the facility that offers the care the veteran needs.

Based on a recent poll of our members who are eligible for the program, only 9% have used the program while 25% stated they have tried to utilize the program but were denied access. From those who were denied access, over half (58%) were denied because of distance issues.

One example includes a member who travels 1.5 hours to a VA medical facility for urology appointments. This veteran tried to use the Choice Program to see a urologist in their hometown, but was denied because they lived within 40 miles of a VA Clinic that

doesn't have a urology department.

Another member told us, "because there is a CBOC in my area I was denied. The clinic doesn't provide any service or treatment I need for my primary service connected disability. [The] nearest medical center in my network is 153 miles away."

On a related topic, a recent poll of our members show that there is confusion on who is eligible for the Choice Program and that the information being provided by VA schedulers is inconsistent. In recognition of this, we urge the VA to aggressively educate their staff to ensure veterans are consistently being informed of the Choice Program. Additionally, efforts need to continue in educating the veteran population of the program and its eligibility requirements. Given the infancy of the Choice Program, we believe this is a shared responsibility among all stakeholders.

We cannot lose sight of the fact that everyone represented here today should be focused on the same goal; doing what's best for our nations veterans.

Reforming the distance requirements of the Choice Program takes positive steps in meeting this obligation and we look forward to working with the Secretary, our VSO partners and this Committee to provide the best access and quality of care for all veterans.

Mr. Chairman, thank you again for allowing IAVA to be a part of this hearing and for considering our views and recommendations regarding how to best improve upon the distance criteria within the Veterans Access, Choice and Accountability Act of 2014.

Chairman ISAKSON. Mr. Fuentes.

STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, VETERANS OF FOREIGN WARS

Mr. FUENTES. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, on behalf of the men and women of the VFW and our auxiliaries, I thank you for the opportunity to present our views on the Veterans Choice program. Last year, this Committee's hard work, with the support of the VFW, led to the enactment of the comprehensive and bipartisan Veterans Access, Choice, and Accountability Act of 2014.

This important law commissioned a new veterans Choice program which now offers veterans the opportunity to receive non-VA care in their communities if VA health care is inaccessible. The Choice Act required VA to implement the veterans Choice program by November 5th, 2014, meaning VA and its partners had 90 days to establish a new veterans health care infrastructure, a timeline that most health care experts recognize as implausible.

As a result, the VFW knew that there would be implementation challenges that would need to be addressed. In an effort to mitigate problems and to gauge veteran experiences, the VFW has continued to publicize our national Veterans Help Line, 1–800–VFW–1899, and our VA Watch Web site where veterans can learn about the Veterans Choice program and seek assistance.

The VFW has also commissioned direct surveys to evaluate the experiences and determine if veterans are being served by this important program. Based on more than 2,500 survey responses and direct feedback from our members, the VFW compiled a report analyzing the Veterans Choice program. Our initial report includes six specific recommendations to improve the delivery of health care for veterans, as well as detailed analysis of participation, wait time standard, geographical eligibility, and non-VA care issues that must be addressed to ensure this important program succeeds in increasing access to health care for America's veterans.

Given the focus of today's hearing, I will limit my remarks to what our members believe is the program's biggest flaw: Geographic eligibility. Under the Veterans Choice program, geographic eligibility is defined in several ways, including residing more than 40 miles from the closest VA medical facility, which includes community-based outpatient clinics.

Eligibility for the program has been based on geodesic distance, or straight line distance. However, the use of straight line distance to calculate geographic burden is not aligned with the realities of traveling to a VA medical facility. Our members have vehemently opposed the use of straight line distance and want it to change.

The VFW is glad to see our members' concern and advocacy have yielded results. We applaud VA for changing the way it calculates distance from straight line distance to driving distance. This is a step in ensuring that eligibility for non-VA care is veteran-centric.

Another common concern we hear from our members is that their local CBOCs are unable to provide them the care that they need, so VA requires them to travel more than 40 miles to other VA facilities.

One veteran who receives his care at the Jackson, TN, CBOC tells us he can no longer make the more than 160-mile trip to the Memphis VA medical center for his neurology appointments and would prefer to visit a non-VA neurologist closer to home. Unfortunately, he is not eligible for the Veterans Choice program. However, VA does have the authority to provide this veteran and others like him non-VA care options.

VA must properly utilize all its non-VA authorities and programs to ensure veterans are afforded the opportunity to obtain care closer to home if VA care is not readily available, especially when veterans face an urgent medical need that could be more quickly addressed through non-VA care.

The VFW's report also found that veterans want the ability to make health care decisions that are best suited to their particular circumstances. Nearly all of the 850 survey participants who believe they were eligible for the Choice program but were not given the opportunity to participate indicated that they were interested in non-VA care options. Yet, half of them elected to stay with VA care when given the option despite facing access challenges.

This indicates that private sector care is not always the best option for veterans. Many of them acknowledge that the care they receive from VA cannot be easily replicated in the private sector, especially when the care they receive is veteran-centric and not available in the private sector such as spinal cord injury disorder, polytrauma treatment and services, and specialized mental health care.

As this Committee considers changes to the distance criteria for non-VA care eligibility, we urge you to consider the long-term sustainability of the VA health care system and its purchased care model. The VFW has found that veterans are generally satisfied with the care they receive from VA and believe the VA health care system must be preserved.

It is vital that the VA health care system of the future be able to expand capacity when needed, share space and services with its community and interagency partners when it can, and purchase care when it must to effectively provide timely and high quality health care for generations to come.

Mr. Chairman, this concludes my testimony. I am prepared to answer any questions you or the Committee Members may have.

[The prepared statement of Mr. Fuentes follows:]

PREPARED STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Isakson, Ranking Member Blumenthal and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I thank you for the opportunity to present the VFW's thoughts on the current state of the Veterans Choice Program.

Last year, whistleblowers exposed rampant wrong-doing at Department of Veterans Affairs (VA) medical facilities throughout the country, through which veterans were alleged to have died waiting for care, while VA employees manipulated waiting lists and hid the truth. The ensuing crisis forced the then-Secretary of Veterans Affairs and many of his top health deputies to resign. As the crisis unfolded, the VFW intervened by offering direct assistance to veterans seeking VA health care, working with Congress to pass significant VA health care reforms, publishing a detailed report on ways to improve VA care, and working directly with VA to implement reforms.

In August 2014, Congress passed and the President signed into law the *Veterans Access, Choice, and Accountability Act of 2014* (VACAA) with the support and insight of the VFW. This critical law commissioned the new Veterans Choice Program, which now offers much needed non-VA care options to veterans who cannot be seen within VA's wait-time standard (30-dayers) or live more than 40 miles from the nearest VA medical facility (40-milers).

To facilitate implementation of the Veterans Choice Program, VA is working with two health care contractors, Health Net and TriWest, which have established community networks of doctors willing to accept non-VA care patients and operate 24-hour call centers to help veterans verify eligibility and schedule appointments.

VACAA required VA to implement the Veterans Choice Program by November 5, 2014 – 90 days after its enactment. Meaning VA and its partners had a limited timeline to stand up a new veterans' health infrastructure – a timeline that most health experts recognized as implausible. As a result, the VFW knew there would be implementation issues that would need to be addressed. Regardless, VA and its partners were able to deploy the program on time, and have candidly acknowledged the issues that accompanied the roll-out.

In an effort to mitigate problems and to gauge veteran experiences, the VFW has continued to publicize its national veterans' help line, 1-800-VFW-1899, and its web page where veterans can learn about the Veterans Choice Program, www.vfw.org/VAWatch. The VFW has also commissioned direct surveys, to evaluate veteran experiences and determine if veterans are being offered the choice to receive non-VA care when VA care is not accessible.

Based on more than 2,500 survey responses and anecdotal feedback from VFW members, the VFW compiled a report analyzing the Veterans Choice Program, during the first three months of its implementation. The report includes six specific recommendations to improve the delivery of health care options for veterans, as well as a detailed analysis of participation, wait-time standard, geographic eligibility, and non-VA care issues that must be addressed to ensure this important program succeeds in increasing access to health care for America's veterans. The VFW has sent a copy of the full report to the Committee and I kindly request it be included in the record for this hearing. It can also be found on the VFW's VA Watch website, www.vfw.org/VAWatch.

The VFW acknowledges that VA and the program's contractors have made progress in addressing many of the challenges highlighted in our initial report. Responses to our second Veterans Choice Program survey, which went live on February 6, 2015, reflect those efforts. The initial report found that only 19 percent of survey participants, who believed they were eligible for the program, were offered the opportunity to participate. Initial results from the current survey show that more than a third of survey participants, who believe they are eligible, are being offered non-VA care options. However, there is still more work to be done to ensure every veteran who is eligible for the program is afforded the opportunity to participate.

Given the focus of today's hearing, I will limit my testimony to what VFW members believe is the Veterans Choice Program's biggest flaw, geographic eligibility. Under VACAA, geographic eligibility is defined in several ways, including residing 40 miles from the closest VA medical facility, which includes a community-based outpatient clinic (CBOC). In VACAA's Joint Explanatory Statement, the Conferees asked VA to use the geodesic distance, or straight line distance, to calculate the distance between a veteran's residence and the nearest VA medical facility.

However, the use of straight line distance to calculate geographic burden is not aligned with the realities of traveling to a VA medical facility. VFW members have vehemently opposed this practice and believe it needs to change. Veterans are accustomed to reporting their driving distance in terms of miles traveled when applying for beneficiary travel benefits – one of VA health care's most popular benefits. Thus, it is illogical to veterans that they can qualify for beneficiary travel of 40 miles, but cannot qualify for the Veterans Choice Program as a 40-miler.

The VFW urges this Committee to amend VACAA by changing the Veterans Choice Program's geographic eligibility from geodesic distance to driving distance. In so doing, Congress would truly ensure veterans are not burdened with excessive travel to VA medical facilities. Another common concern we hear from VFW members is that their local CBOCs are unable to provide them the care they need so VA requires them to travel more than 40 miles to other VA medical facilities for such care. One veteran, who receives his care at the Jackson, TN, CBOC tells us he can no longer make the more than 80 mile – one way – trip to the Memphis VA Medical Center for his neurology appointments and would prefer to visit a non-VA neurologist closer to home. Unfortunately, he is not eligible for the Veterans Choice Program. However, VA has the authority to provide this veteran, and others who live within 40 miles of a VA medical facility, non-VA care options.

VA must properly utilize all its non-VA care authorities and programs to ensure veterans are afforded the opportunity to obtain care closer to home if VA care is not readily available, especially when veterans have an urgent medical need that can be addressed more quickly through non-VA care.

If the intent of establishing geographic eligibility for the Veterans Choice Program was to ensure veterans are not required to travel unreasonable distances to receive the health care they need, changes must be made to accurately capture their travel burden. Such changes will also increase patient satisfaction, which was one of the goals of the Veterans Choice Program. In fact, our first Veterans Choice Program survey found that survey participants, who were offered the opportunity to obtain non-VA care, were 24 percent more likely to be satisfied with the care they received from VA and 23 percent more likely to recommend VA care to their fellow veterans than survey participants who were not given the option to receive non-VA care. This indicates that veterans want the ability to make health care decisions that are best suited to their particular circumstances.

The VFW's report also found that nearly all of the survey participants, who believed they were eligible for the Veterans Choice Program, but were not given the option to receive non-VA care, indicated they were interested in non-VA care options. Yet, half of them elected to stay with VA care when given the option to receive care from private sector doctors. This indicates that non-VA care is not always the optimal option for veterans. Many of them acknowledge that the care they receive at VA cannot be easily replicated in the private sector. Especially when veteran are receiving veteran-specific services that are not readily available in the private sector, such as spinal cord injury and disorder care, polytrauma treatment and services, and specialized mental health care.

One of the biggest accomplishments of the Veterans Choice Program has been the establishment of standard – system-wide – non-VA care eligibility requirements, which give veterans the choice to receive non-VA care when VA care in not accessible. Now, Congress and VA must ensure such standards are veteran centric and clinically based. As a veterans service organization the VFW will continue to work with VA, the program's contractors, and other stakeholders to ensure that goal is accomplished.

As this Committee considers changes to the distance requirements for non-VA care eligibility, I urge you to consider the long-term sustainability of the VA health care system and its purchased care model. The VFW has found that veterans are generally satisfied with the care they receive from VA and believe the VA health care system must be preserved. However, they would like non-VA care options when VA care is not accessible due to lack of available specialists, long wait times, or geographic inaccessibility. It is vital that the VA health care system of the future be able to expand capacity when needed, share space and services with its community partners when it can, and purchase care and services when it must, to effectively provide high-quality health care for generations to come.

For more than a century, the VFW has been VA's greatest champion and sometimes harshest critic, especially when its lack of leadership, management, or accountability fails veterans. Still, we are committed to working together with our many partner organizations to ensure VA does not fail to meet its obligations to the brave men and women who have worn our nation's uniform.

Mr. Chairman, this concludes my testimony, I am prepared to take any questions you or the Committee members may have.

Chairman ISAKSON. Thanks to each of you. A question. I think it was Mr. Hegseth who talked about the execution of the VA in your comments, and I think that Sloan deserves credit as well as the Secretary for the execution, because a week ago, all of you wrote your testimony thinking you were coming here to try to make a case for the 40-Mile Rule change. Now you have all, we have all been caught because VA executed.

I want to acknowledge that, Sloan. We appreciate that. Hopefully, that will be the same result with our first hearing when we come back after the break, because after you all contact my chief of staff and Richard's chief of staff and we work with VA, hopefully we will get the care that you need item worked out so that veterans do have access to the care they need and the 40-Mile Rule as well. I congratulate the VA on what they did and thank all of you on your input.

My only comment is this: do not let your enthusiasm nor your appreciation for the changes made dim your communication or your energy in working with the VA. The VA needs your support. We need your help in communicating Veterans Choice issues to your members.

I have told a lot of VSOs the following: when I ran my company for years, I used to hire mystery shoppers. Those were people who posed as customers that I sent as my agents to find out if my people were providing the quality services they ought to.

You should be the mystery shoppers for the VA. You should be the ones telling the VA the good stories and telling the VA the bad stories; or not bad stories, but the difficult stories. Give them the best information they can have to make the best decision they can.

I know sometimes you cannot please anybody no matter what the situation. But good communication between the VSOs and their members and the VA and good communication between the VA and the VSOs to be the megaphone to get this information out will be of tremendous help. I encourage all of you to work and consider

that a part of your role. With that said, I will turn to Richard Blumenthal.

Senator BLUMENTHAL. Thank you and let me second the Chairman's remarks, that you came here thinking you would testify against a rule which now, fortunately, has been eliminated. But I think your points about the importance of Choice are absolutely right.

Let me ask Mr. Hegseth, what do you envision that specific changes in the current system would enable greater choice?

Mr. HEGSETH. I think there is an expectation from many veterans who are receiving a Choice card that they are receiving an insurance card. The VA has a big perception problem on their hands. There is talk of a Choice card and of Choice. In reality, the strict parameters, some for costs, some for other reasons, do not allow veterans to exercise that choice.

So, even though things were done in good faith in conference committee, in this Committee, and throughout the VA, in many places the veteran does not see that, does not experience that. The veteran believes, whether they are waiting more than—if they live more than 40 miles away, that this is something that they now have as an opportunity.

We did not talk about the time requirement. It is not just 30 days. VA's implementation has been 30 days of what is deemed, "medically necessary" by the VA. That is, again, another opaque standard that the veteran does not understand from when they attempted to schedule an appointment and when they have not been seen for 30 days, but they are still told they cannot wait. So, I think——

Senator BLUMENTHAL. I think this is the point that both Senator Moran and I and others here have made regarding not just waiting 30 days for treatment. It is whether treatment is available at that particular facility, which maybe is a change that has to be made.

But what we see is under-utilization of the Choice program, and maybe I can ask you and others whether you have on-the-ground perceptions as to what the reasons are that veterans simply are not using the Choice program.

Mr. FUENTES. Senator, the VFW has been very involved in the implementation process and I thank you for the suggestion, Mr. Chairman, and you as well, Mr. Ranking Member. We have been that partner ensuring VA's implementation of the Choice program is aligned with veteran perceptions.

Our report found that there are certain parameters that do not necessarily align. One of those that my colleague here alluded to is the clinically indicated date. When VA, for example, says—or when my provider says I have to be seen within 60 days, if I can only receive an appointment at VA at 75 days, I am not eligible for the Veterans Choice program.

We feel that if I cannot receive an appointment within 60 days, I should be able to receive that appointment within the private sector if I choose to. But if I choose to wait those 75 days, then I can do so. Right now I would have to wait 90 days in order to receive that option.

There are other issues that need to be addressed in terms of participation, but, you know, I would like to say that VA has been very

receptive to any issues that we have identified, and we have been working hard with TriWest and Health Net to identify solutions. So, I do want to thank Dr. Tuchschmidt for allowing us to participate in the discussion.

Senator BLUMENTHAL. Mr. Rausch.

Mr. RAUSCH. Senator, just to echo on that, I mean, I think we would all agree that this program is in its infancy and so, any insight that we can provide from our members is anecdotal, at best. Even the law's commissioned report has not been published. In fact, I would suggest that if you spoke to the individuals in that report, like many of us have, they are also looking for additional data out there. So, I would make that point initially.

But also, just the inconsistency of the program. It is a new program, it is a large program. We have a staff member, an Iraq War veteran, who called up and was not told about the opportunity to utilize the Choice program, or as we have other individuals, members, who have been informed. So, there is a lot of inconsistency.

But to the Chairman's point, you know, we view this—and there was a military phrase that I used to embrace and many of us know—one team, one fight. This is too big for any of us to pawn it off on another entity, which is why in my remarks I said that we believe that all of us, all stakeholders really have to get out there, inform our members, and do the due diligence.

I think I have called the phone number myself probably five or six dozen times to do that fishing to make sure that the due diligence is being done. But the bottom line is, you know, the program is in its infancy. Thank you.

Senator BLUMENTHAL. Thank you.

Chairman ISAKSON. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chair. Mr. Hegseth and Mr. Fuentes, you all made reference to something I would like to drill down on a little bit. We have had several Veterans' Affairs Committee meetings. We have had VSOs speak. And it runs the gamut from we want Choice to we want to make absolutely certain that our first choice for being in a VA facility is held.

Mr. Hegseth, I think you said that there was a survey where some 90 percent of those surveyed wanted Choice. Mr. Fuentes, I believe that you said that among, I guess, the membership of your VSO, that some 50 percent would prefer care in a VA facility.

When we get this right, we look at the long-range plan. How do we get to the right balance and how do we also—there seems to be some inconsistency amongst the VSOs which may be the unique needs of the members of those VSOs. But how do we get to a sort of holistic view of what is the best approach for the future for health care for the VA, including the significant presence of the brick-and-mortar VA hospitals and clinics, but then private choice options? Start with you, Mr. Hegseth.

Mr. HEGSETH. I would say we oftentimes hear—and it is true in many cases—when veterans get inside the VA, they like the care they get. If that is indeed the case, then veterans facilities should not be scared or averse to Choice, because veterans given quality access will stay at VA facilities.

The poll that I referenced is something we did as part of our task force to inform our thinking on the subject. What do veterans—ev-

eryone talks about what veterans want. What do veterans really want? Because we can do surveys that have preferences based on our memberships, we did a nationwide poll of veterans that was bulletproof on sort of representative of services and age and genders. Over 90 percent want Choice; 89 percent want private choice; 77 percent want Choice, even if they have to pay a little bit more out of pocket on co-pays up front. They just want the option to access outside care if they cannot get it from a VA facility.

We talk about a Choice card and choice implies you can actually make the decision. There is a gatekeeper making the decision for you based on criteria you cannot see, which is not, in fact, real choice. There is a way to do it in a fiscally responsible way so veterans are able to make that choice for themselves as opposed to someone telling them what is best for them.

Senator TILLIS. Thank you.

Mr. Fuentes.

Mr. FUENTES. Senator, we consistently hear from veterans that they are satisfied with the care that they receive, and I just want to expand a bit on that 50 percent. So, that is 50 percent of the veterans who face an access challenge. These are veterans that have to wait longer than 30 days or travel more than 40 miles and they still choose VA health care.

That is because they recognize that the care they receive at VA is not easily replicated in the private sector. I will give you an example. In Elko, NV, a veteran that contacted us said she was interested in seeing her options in the private sector.

But, when she was referred to private sector providers in Elko, she found that none of them were viable options because she wanted to receive face-to-face mental health care, as she was receiving telehealth from VA through Salt Lake. But there were no available private sector mental health providers in the community that would be able to see her.

I think, overall VA must remain the guarantor and coordinator of care for veterans. That is because VA leads the health care industry in many respects. One of them is providing a holistic approach to medicine and providing a continuum of care that you cannot find in the private sector.

What it does need to do is better assess where it needs to increase capacity, and there are certain instances where it will never need to increase capacity because of seasonal or temporary spikes in demand. For example, when veterans travel down south during the winter VA is going to have to rely on non-VA care in those instances. It will not need to increase capacity.

But, VA needs to better assess its future needs and be able to determine where the demand is and where it needs to increase capacity.

Senator TILLIS. Thank you. And in the interest of time, I will just submit follow-up questions. I should have started by thanking you all for your past service and continued service for our veterans. I look forward to having more discussion.

Congratulations. Because I think a part of your work, along with some good leadership from the VA, is leading to a good outcome for the 40-Mile Rule. Now let us go tackle all the other things we need to get done. Thank you. Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you very much. Gentlemen, thank you very much for your testimony. Thank you for your service to our country. I appreciate what you are saying. We have focused on "as the crow flies" and we are pleased that the Department has reached a solution that corrects that problem. We focused a lot of attention on the facility and it does not provide the service that a veteran needs.

It caused me to think. I was reading an email from a veteran just now and the answer that they received from the VA, "You do not qualify because there is a CBOC. Even though it is only open 1 day a week, you still do not qualify," which caused me to try to determine in the Act, is the word facility defined. Maybe the VA could define what a facility is.

We had staff at a meeting in which they were told because a mobile van of the VA goes through the area, that would qualify as a facility. Therefore, veterans within that 40 miles of where the van drove would not qualify. But the list is longer than that.

We focused really on these two. You have mentioned the number of times veterans call, they get the card, or a veteran who did not get a card wants to know how to get the card. Do they qualify? You call and no one can tell you what to do if they tell you they do not qualify. We have tried to get health care providers to be qualified by the VA to provide the services. That is a challenge.

The early co-payment, the Secretary talked about that. I am pleased to see that they are correcting that, where the veteran had to pay the co-payment up front. That is a problem. My point is, there is a long series of issues that create a circumstance in which a veteran may just shrug their shoulders, throw up their hands, become angry, be done and fed up with the program.

What I wanted to ask you is, what do you make of the budget recommendation in the President's budget that says, In the coming months, the Administration will submit legislation to reallocate a portion of the Veterans Choice program funding to support essential investments in the VA system priorities?

If we have all these problems where we do not yet know what is going on, we have not solved many of the problems that the veteran faces in accessing the care, why would a decision be made that we ought to reallocate money in advance of figuring out what all the problems are and how many veterans are ultimately going to be interested in using the Choice card? What is going on that somebody would reach the conclusion, Let us take some money out now because we have different priorities?

Mr. HEGSETH. I—go ahead.

Mr. BUTLER. I would say from The American Legion perspective, in our testimony we said before the VA looks at re-purposing any money, they need to make sure that the VA Choice program is working the way it was intended. You are right; they are right. There are a lot of barriers and obstacles to overcome, but working together with Members of Congress and the VSOs is the option to ensure that all of the barriers are eliminated.

Then once you work through all the barriers, then you can evaluate the effectiveness of the program. I will close in saying that, you

know, VA has a number of authorities that allows VA to contract outside the VA. And you need to take into account all of those existing authorities and they need to work hand in hand and together.

You cannot just use one authority. Oftentimes when you say you are not eligible for the Choice card, then what about 17.03 authority and so forth. You have to take all of those things into account to make sure that everything that Congress has provided to VA is working hand in hand to ensure that the health care needs of veterans are being met.

Mr. HEGSETH. I think we would say it is a reflection of priorities and incentives. There is a priority for the VA—there are other priorities for the VA system and they want flexibility in transferring those funds. There is also incentive for the VA to keep the funds inside the existing system.

What is frustrating for us as I mentioned, 26,000 veterans have used the program, and I may have this number not completely correct. But about 500,000 have attempted to call in and use the program, and the reason is the parameters are opaque. Very few veterans can actually use it. Then VA turns around and says, See, veterans do not want it. Because they are not able to get in the gate because the gatekeeper did not let them in.

Then, when they say that they do not want it by the gatekeeper not letting them in, well, we can just de-fund the program, and that is where temporary programs go to die. I am not impugning the motives of any individual here from the VA. I am saying the institutional bureaucracy has a different set of incentives than a veteran does who wants care rapidly and does not, in that moment, quite care if it is from a VA facility or a private facility.

Senator MORAN. Mr. Rausch—I am sorry. Mr. Violante.

Mr. VIOLANTE. Senator, short answer to your question is, DAV thinks it is too early now to de-program that money. We would like to see how this program is going to work out, especially with the changes that are being made and that we have talked about. So, it is too early in its infancy.

Senator MORAN. Thank you.

Mr. Rausch.

Mr. RAUSCH. Senator, just briefly, I do not think anyone is saying that veterans do not like it. I think, again, we all believe it is too early to tell and that is not an area that we have heard each other say or the VA say. As far as the flexibility piece, I think we were all in this room when the Secretary mentioned the checking account with the gas versus the food. It is a very interesting analogy.

As we understand it, we support the flexibility piece for the 71 line items. In theory, that would potentially provide the opportunity to move money into the Choice program, potentially.

Again, we believe that it is way too early to tell and we want to make sure that the data that is not being collected gets collected and that we can actually have a better understanding of who is using it and why they are using it. But, I do not think anyone is saying that people do not like it. It is way too early to tell.

Senator MORAN. Thank you.

Mr. FUENTES. I would just like to add that yes, it is too soon. Right now, there is a large gap between the number of veterans who are eligible for the Choice program and the amount of veterans who are actually receiving appointments through the program. Before you consider changing or moving around any money, we have to address that gap, and there are a lot of different ways to do it.

One of those is to provide detailed training to the local level VA staff that interact with the veterans every day, the schedulers, because they are the linchpin, if you will, into veterans participating in the program. What we hear now is that when veterans call and they have an appointment beyond 30 days, many of those schedulers are not aware of the program or, say it has not been implemented yet or give another type of response that should not be.

Senator MORAN. Thank you all very much.

Chairman ISAKSON. Thanks to the Members. Let me ask the VA if you will do something, Sloan and Dr. Tuchschmidt. Obviously, in the next couple of weeks, hopefully not any longer than that, you will have all the parameters done on the 40-Mile Rule and the change that is going to take place.

I think each one of these VSOs and our Committee need to know how you are going to notify those veterans who have been turned down in the past would be eligible, now that the policy has changed. I do not know if you have a record of those turn-downs.

Mr. GIBSON. We are actually already generating a list of those veterans whose availability will be changed and we intend to communicate directly to each and every one of them.

Chairman ISAKSON. That is the right answer. Thank you very much.

Thanks to all of you for your service to the country. We finished exactly when the votes were called. That is pretty good.

[Whereupon, at 4:31 p.m., the hearing was adjourned.]

A P P E N D I X

VFW ATTACHMENT—INITIAL REPORT ON VETERANS CHOICE IMPLEMENTATION

Veterans Choice Program

Initial Report

Compiled by the Veterans of Foreign Wars of the U.S.

March 2, 2015

VETERANS OF FOREIGN WARS
NO ONE DOES MORE FOR VETERANS.

BACKGROUND:

Last spring, whistleblowers in Phoenix exposed rampant wrong-doing at their local U.S. Department of Veterans Affairs hospital through which veterans were alleged to have died waiting for care, while VA employees manipulated waiting lists and hid the truth. In the months that followed, similar problems were exposed across the country, and the ensuing scandal forced the VA secretary and many top health deputies to resign.

As the crisis unfolded, the VFW intervened by offering direct assistance to veterans seeking VA care; working with Congress to pass significant VA health care reforms; publishing a detailed report on ways to improve VA care; and working directly with VA to implement reforms.

In August, Congress passed and the President signed into law the *Veterans Access, Choice, and Accountability Act of 2014* (VACAA) with the support and insight of the VFW. This critical law commissioned the new Veterans Choice Program, which now offers critical non-VA care options to veterans who cannot be seen by VA in a timely manner (30-dayers) or who live more than 40 miles from the nearest VA medical facility (40-milers).

In order to allow veterans to take advantage of the new Veterans Choice Program, VA continues to issue Veterans Choice Cards to veterans who were enrolled in VA care as of August 1, 2014. VA is also working with two health care contractors, Health Net and TriWest, to stand up community networks of doctors who will accept patients for non-VA care, as well as operate 24-hour call centers to help veterans verify eligibility and schedule appointments.

The program became operational on November 5, 2014, meaning VA and its partners only had three months to stand up a new veterans' health infrastructure – a timeline that most health experts recognized as implausible. As a result, the VFW knew there would be issues for veterans who sought to take advantage of this new program. Regardless, VA and its partners were able to deploy the program on time, and have candidly acknowledged the issues that accompanied the roll-out.

In an effort to mitigate problems and to gauge the pulse of the veterans' community, the VFW not only continued to publicize its national veterans' help line, 1-800-VFW-1899, but also built a new web page where veterans could learn about the program, www.vfw.org/VAWatch, and commissioned a direct survey where affected veterans could share their experiences.

The following report includes highlights and data trends that the VFW identified over the first three months of Veterans Choice Program's implementation. In an effort to continue to hold VA accountable and to keep the VFW's pulse on the Veterans Choice Program, the VFW launched its second Veterans Choice Program survey on February 6, 2015 via www.vfw.org/VAWatch.

The VFW acknowledges that VA and the contractors have made progress in addressing the challenges veterans faced during the first three months of the Veterans Choice Program's implementation. Initial responses from the VFW's third survey reflect those efforts. As the program's implementation progresses and veteran experiences change, the VFW will continue to issue reports on what is working and how VA and Congress can improve this important program.

FINDINGS:

One month after VA launched the Veterans Choice Program, the VFW conducted a survey of its advocates via the VFW Action Corps, asking about their individual experiences with the new program. The VFW also made the survey available on the VFW website via www.vfw.org/VAWatch.

As expected, the VFW recognized that the program was experiencing initial implementation problems, to include clear guidance for veterans on which veterans would qualify for the program.

Fortunately, the Veterans Choice Program has succeeded in helping thousands of veterans receive timely access to care. As of February 5, 2015:

- 8.6 million Veterans Choice Cards have been issued
- 458,769 calls have been place by veterans to the call centers
- 26,662 veterans have requested non-VA care
- 24,288 veterans have received appointments

As of February 5, 2015, the VFW received 2,511 responses to the initial survey. The initial survey was logic-based, meaning veterans were directed to the next series of questions based on their initial responses. This means that only select veterans to whom each question applied were prompted to respond. Below is a by-the-numbers summary of responses from veterans who reported being enrolled in VA health care:

- 34 percent of 2,157 survey participants reported living more than 40 miles from the nearest VA medical facility
- 35 percent of the 746 survey participants who attempted to schedule an appointment after November 5, 2014, reported waiting more than 30 days for a VA appointment
- 19 percent of the 1,069 survey participants who either live more than 40 miles from the nearest VA medical facility or could not be seen by VA within 30-days were offered the option to receive non-VA care
- 92 percent of the 850 survey participants who reported that they either live more than 40 miles from the nearest VA medical facility or that they could not be seen by VA within 30-days, but were not offered the choice to receive non-VA care, indicated they were interested in non-VA care options
- 47 percent of the 198 survey participants who were offered the choice to receive non-VA care, reported that they chose to receive their care from VA
- 78 percent of 2,002 survey participants reported that they were satisfied with their VA health care experience
- 82 percent of 1,919 survey participants reported that they would recommend VA care to their fellow veterans
- 57 percent of the 97 survey participants who chose non-VA care, reported that they were satisfied with the Veterans Choice Program
- 58 percent of the 97 survey participants who chose non-VA care reported that they would recommend the Veterans Choice Program to their fellow veterans

ANALYSIS:

To the VFW, the results of this initial survey were not surprising. VA and its contractors had to quickly deploy a new program to deliver care to veterans in a timely manner. However, the survey identified several issues that the VFW immediately worked to address with VA, Health Net, and TriWest.

Participation: Prior to the roll-out of the Veterans Choice Program, the VFW was concerned that veterans would not necessarily understand the stringent criteria through which they would qualify for care – especially veterans who believed that they lived more than 40 miles from a VA medical facility. Unfortunately, the veterans who responded to the VFW's survey reported these kinds of issues. The VFW expected this, since VACAA insisted that all veterans who were enrolled in VA care as of August 1, 2014, receive a Veterans Choice Card, but not all who received cards would be eligible for care.

Next, the VFW was concerned about the time in which 30-dayers would be referred to the contractor for non-VA care. In implementing the Veterans Choice Program, VA has chosen to rely heavily on local medical facility staff. When VA schedulers are unable to schedule a veteran within VA's wait-time standard – 30-days from the time a VA provider deems an appointment clinically necessary, or the clinically indicated date, or if no such date exists, the date a veteran prefers to be seen – such veteran is then placed on the Veterans Choice List (VCL). During the first weeks of the program, VA facilities would only transfer VCL data to the contractors once each week. In this initial phase, veterans were being told they were eligible for the Choice Program by their facilities, but unable to schedule non-VA care appointments when they contacted the Veterans Choice Program call centers because the contractors were unable to verify their eligibility. Understandably, this was a source of great frustration for veterans who felt they were receiving conflicting information from VA and the contract call centers.

After looking into these incidents, VA and the contractors realized that the lag time between when veterans were being informed of their eligibility and when the contractors received their records was causing this confusion. The contractors have since informed the VFW that they receive records from VA facilities at least three times each week, and that facilities are instructed to inform veterans of this potential data delay before contacting the call center. However, the VFW remains concerned about possible inconsistencies in the way VA medical facilities report VCL data to the contractors.

The VFW was also concerned about VA's ability to inform 30-dayers of their eligibility to receive non-VA care. The VFW learned that one of the major obstacles in implementing the Veterans Choice Program has been ensuring local VA medical facility staff is familiar with the program's intricacies. Since the contractors are prohibited from conducting outbound calls to inform veterans of their eligibility, VA has relied on its local schedulers to inform veterans of their eligibility and instruct them to contact the call center. Unfortunately, limited resources for local facilities mean that this kind of proactive outreach is inconsistent across VA facilities.

The VFW survey shows that 80 percent of the 1,068 survey participants who reported that they either lived 40 miles from a VA medical facility or could not be seen by VA within 30 days said

they were not afforded the choice to receive non-VA care. The VFW is still concerned that these veterans may continue to be denied access to timely care due to VA's lack of capacity for delivering consistent training to its staff responsible for properly informing veterans of their eligibility and placing veterans on the VCL.

To mitigate this issue VA has initiated the Veterans Choice Program Outreach Campaign to contact veterans currently on the 30-day Electronic Wait List or the VCL. As of February 5, 2015, VA's Health Resource Center, Purchased Care, and Health Eligibility Center have resolved more than 104,000 calls, 37,193 of which were resolved by direct contact with a veteran. Of those calls, 21,636 veterans said they did not need an appointment, 4,667 of them had already scheduled an appointment and 10,601 of them were referred to the Veterans Choice Program call center. The VFW is encouraged to see that more than 70 percent of veterans contacted indicated they were happy with their existing appointment, whether it was with VA or through the Veterans Choice Program, or did not need an appointment. However, nearly 30 percent of the veterans who indicated they wanted an appointment were unaware of their ability to obtain non-VA care.

Data from VA's Veterans Choice Program Outreach Campaign does not allow us to determine the ratio between veterans who were eligible and those who were interested in receiving non-VA care or how many veterans chose non-VA care when given the option. The VFW's survey determined that more than 90 percent of veterans who were eligible for the Veterans Choice Program, but were not given the choice to participate, said they were interested in non-VA care options. However, only 53 percent of the veterans given the choice to participate elected to receive non-VA care. Knowing they were presented with all available options lets veterans feel like they are making informed decisions that are best for them. The VFW feels that this is critical to increasing patient satisfaction, which was one of the main goals of establishing the Veterans Choice Program.

Wait-time Standard: While basing wait times on a clinically-indicated date is a step in the right direction, VA's wait-time standard still requires veterans to wait unreasonably long and remains susceptible to data manipulation. VA's current wait-time standard requires a veteran to wait at least 30 days beyond the clinically-indicated date before being considered eligible for the Veterans Choice Program. For example, if a VA health care provider deems it clinically necessary that a veteran receive a colonoscopy within 60 days, such veteran will be required to wait for a minimum of 90 days before being given the option to see a non-VA provider through the Veterans Choice Program. The VFW is concerned that veterans' health may be at risk if they are not offered the ability to receive care within the timeframe their VA providers deem necessary, regardless if it is through the Veterans Choice Program or VA care.

The VFW has also learned that the preferred date metric VA uses when a clinically indicated date has not been identified is identical to a deeply flawed metric called desired date. The desired date metric was used by VA to measure wait times for existing patients, before it changed the wait-time standard to the preferred date metric. The desired date metric was the subject of numerous Government Accountability Office and VA Office of the Inspector General reports and intensive Congressional oversight for being easily susceptible to data manipulation. VA's own access audit, which it launched mid-April 2014 to evaluate system-wide access issue, discovered that VA medical facility staff had been using several prohibited practices to manipulate desired date data, some were ordered to do so by managers to make wait-time reports appear more favorable.

During a House Committee on Veterans' Affairs hearing last year entitled *"Oversight Hearing on Data Manipulation and Access to VA Healthcare,"* Acting VA Inspector General Richard J. Griffin said that VA schedulers were inputting the medical facility's next available appointment date as the date a veteran desired to be seen in order to zero out the veteran's wait time. The preferred date metric is equally susceptive to this prohibitive practice. Although VA has asked its local medical facilities to cease the use of prohibited scheduling practices, such practices may still be used if VA's scheduling system does not preclude them from doing so. When veterans call to schedule an appointment and are asked when they prefer to be seen, the first question they logically ask is, "when is the next available appointment?" If VA schedulers are not required to input a preferred date before accessing the next available appointment, they would have the ability to input the medical facility's next available appointment as the veteran's preferred date.

Geographic Eligibility: The VFW was concerned that the eligibility requirements established under VACAA for 40-milers do not align with the realities of traveling to a VA medical facility. VACAA requires VA to use the geodesic, also known as "as the crow flies," distance between a veteran's residence and the nearest VA medical facility when determining geographic eligibility. Veterans are accustomed to reporting their driving distance in terms of miles traveled when applying for beneficiary travel benefits – one of VA health care's most popular benefits. Thus, it is illogical to veterans that they can qualify for beneficiary travel of 40 miles, but cannot qualify for the Veterans Choice Program as a 40-miler. The intent of this provision was to ensure veterans do not travel unreasonably long distances to receive VA health care. However, the geodesic distance a veteran lives from a VA facility does not accurately capture the travel burden that veterans may face. Furthermore, using a metric that veterans feel is misleading only serves to diminish overall patient satisfaction, defeating one of the main goals of the Veterans Choice Program.

Non-VA Care Authorities: The VFW is also concerned that VA may not be leveraging all of its authority to offer non-VA care. The Veterans Choice Program has been a much needed boost to VA's ability to provide non-VA care. However, the Veterans Choice Program is temporary and is not the only authority VA has to provide purchased care. Veterans must be afforded the opportunity to obtain care closer to home if VA care is not readily available, especially when veterans have an urgent medical need that can be addressed more quickly through non-VA care. This is a particular concern for veterans who live within 40 miles from a VA medical facility, but such facility does not provide the care the veteran needs. Veterans who do not qualify for non-VA care through the Veterans Choice Program may still qualify for non-VA care through VA's numerous non-VA care authorities and programs, such as the Patient-Centered Community Care, or PC3, program. PC3 is a system-wide program that should allow veterans, who do not qualify for the Veterans Choice Program, but still face wait time or travel challenges accessing VA care, to receive care closer to home.

RECOMMENDATIONS:

Fortunately, the Veterans Choice Program is succeeding in offering options to veterans. The problem, however, is that many veterans who have been determined as eligible have yet to be given the opportunity take advantage of the program. A program of this magnitude is likely to encounter these kinds of issues in its initial roll-out, which is why the VFW makes the following recommendations to ensure consistent delivery of health care options to veterans:

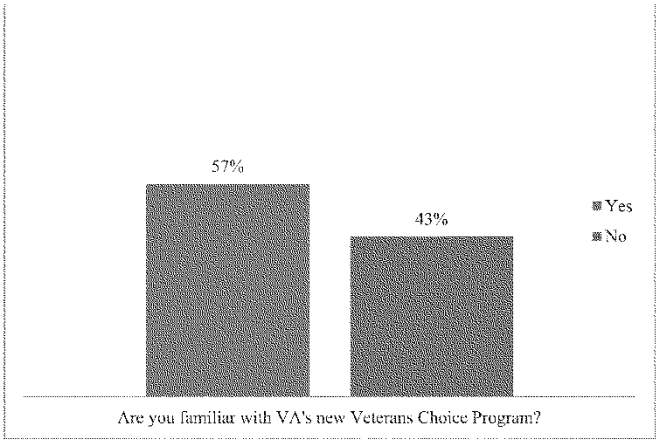
- VA must provide frontline personnel the training they need to ensure veterans who are eligible for the Veterans Choice Program are afforded the opportunity to participate.
- VA's wait-time standard must be modified to allow veterans to seek care through the Veterans Choice Program if such care cannot be provided at a VA medical facility within the clinically indicated date.
- VA must ensure the proposed Medical Appointment Scheduling System has a compliance aspect to preclude schedulers from using prohibited scheduling practices.
- Congress must amend VACAA by changing the Choice Program's geographic eligibility from geodesic distance to driving distance. In so doing, Congress would truly ensure veterans are not burdened with excessive travel to VA medical facilities.
- Congress must exercise proper oversight to ensure VA is properly utilizing all non-VA care authorities in cases where VA cannot readily provide care due to lack of available specialists, long wait times, or geographic inaccessibility.
- VA must ensure that Non-VA Care Coordination teams at all VA facilities are adequately staffed with professionals capable of handling the influx of work.

The VFW has been monitoring the Veterans Choice Program from day 1, and we will continue to monitor the program's success to identify shortcomings and work for reasonable solutions. This report is only the second in our series of reports on the state of VA health care and the implementation of the Veterans Choice Program.

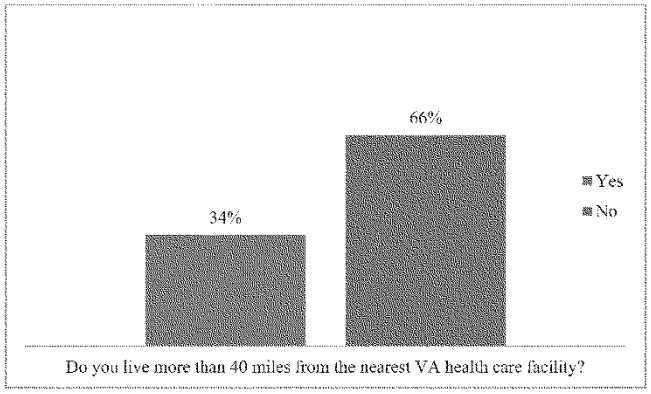
In order to continue holding VA accountable, we will need more input from veterans who interact with the VA health care system and who may be eligible for the Veterans Choice Program. To help the VFW hold VA accountable, take a few moments to complete the latest iteration of our survey at www.vfw.org/VAWatch.

APPENDIX:

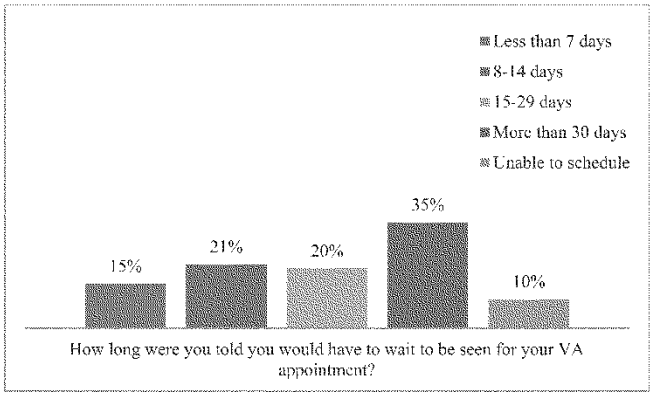
Charts of the responses the VFW received from the first Veterans Choice Program Survey. The initial survey was launched on December 5, 2014, and was closed on February 5, 2015. VFW received 2,511 responses. Enrollment in the VA health care system is a prerequisite for eligibility under the Veterans Choice Program, thus the charts below are controlled for enrollment.



Responses: 2,178 Yes: 1,243 No: 935

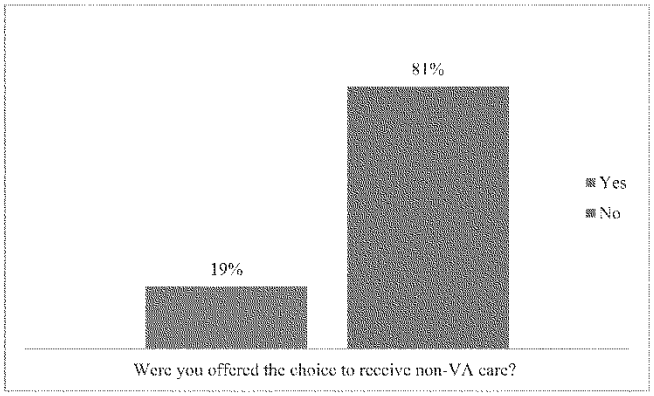


Responses: 2,157 Yes: 744 No: 1,413



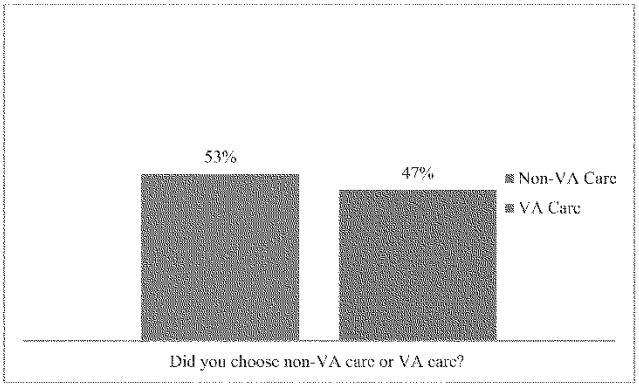
Only veterans who reported they attempted to schedule an appointment after November 5, 2014 were prompted to answer this question.

Responses: 746 < 7 days: 110 8-14 days: 157 15-29 days: 147 >30 days: 260 Unable:72



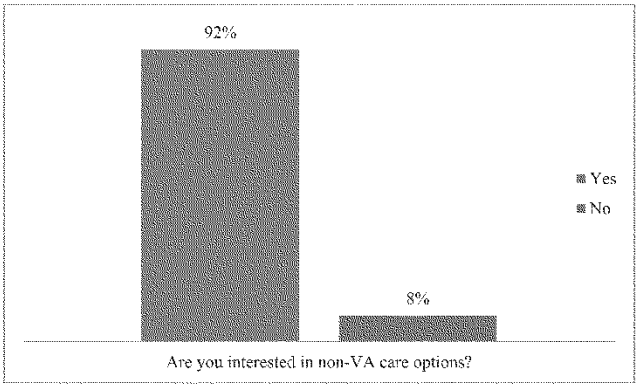
Only veterans who reported living more than 40 miles from a VA medical facility, waiting beyond 30 days for a VA appointment, or being unable to schedule a VA appointment were prompted to answer this question.

Responses: 1,069 Yes: 205 No: 864



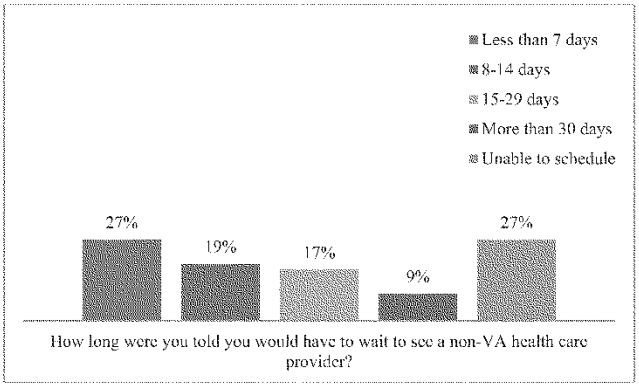
Only veterans who reported being offered non-VA care were prompted to answer this question.

Responses: 198 Non-VA: 104 VA Care: 94



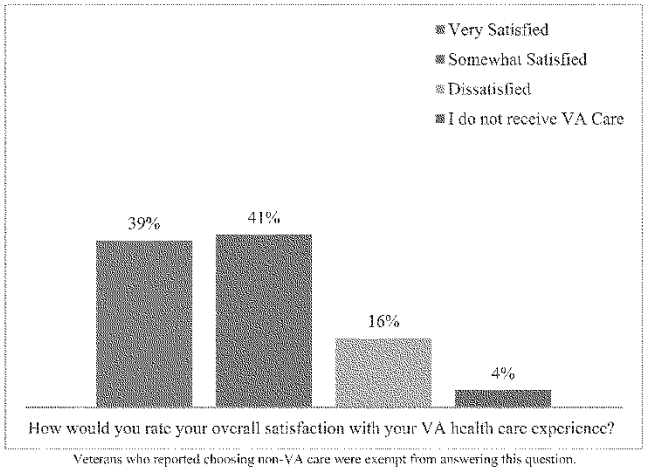
Only veterans who reported living more than 40 miles from a VA medical facility, waiting beyond 30 days for a VA appointment, or being unable to schedule a VA appointment and not offered non-VA care were prompted to answer this question.

Responses: 850 Yes: 781 No: 69



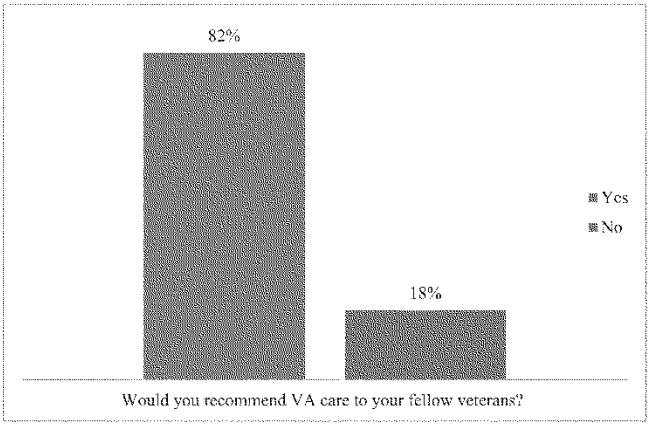
Only veterans who reported choosing non-VA care were prompted to answer this question.

Responses: 99 < 7 days: 27 8-14 days: 19 15-29 days: 17 >30 days: 9 Unable: 27



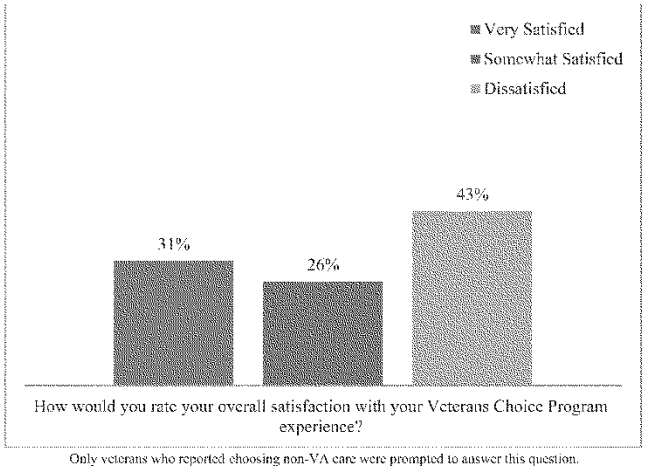
Veterans who reported choosing non-VA care were exempt from answering this question.

Responses: 2,002 Very: 785 Somewhat: 811 Dissatisfied: 325 Do not receive: 81



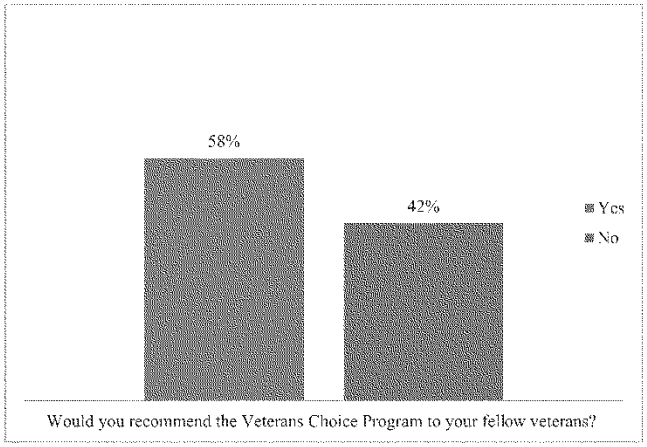
Veterans who reported choosing non-VA care were exempt from answering this question.

Responses: 1,919 Yes: 1,583 No: 336



Only veterans who reported choosing non-VA care were prompted to answer this question.

Responses: 97 Very: 30 Somewhat: 25 Dissatisfied: 42



Only veterans who reported choosing non-VA care were prompted to answer this question.

Responses: 97 Yes: 56 No: 41



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