



**Robert McDonald, Secretary of Veterans Affairs**  
**Opening Statement before the House Committee on Veterans' Affairs**  
**July 22, 2015**

Thanks to the Chairman and Ranking Member for joining your Senate counterparts at our most recent Four-Corners meeting at VA's Central Office Thursday morning.

And I appreciate this opportunity to continue our dialogue publicly so Veterans and all Americans can understand these important issues.

Representing Veterans and Servicemembers this morning are senior leaders of our some of our most important partners—Veterans and Military Service Organizations, and I want to thank them for being here.

~

A year ago today—at my Senate confirmation hearing—I was charged to ensure VA is refocused on providing Veterans “with the high quality service that they've earned.”

I welcomed that opportunity.

For the last year, I've been working with a great and growing team of excellent people to fulfill that sacred duty.

Because of their hard work, VA has increased Veterans' access to care and completed seven million more appointments this year than last—2.5 million at VA, 4.5 million in the community.

We've increased VA Care in the Community authorizations – including Choice—by 44 percent since we started accelerating access to care a year ago – that's 900,000 more authorizations than the previous year.

While Choice has been just a small proportion of that 4.5 million, it's on the rise, and utilization has doubled in the last month.

Today, because of growth in access, the Department is struggling to meet Veterans' needs through the end of the fiscal year.

We need your help.

You have already appropriated funds to meet these needs, but you haven't given me the flexibility and authority to use them.

Without flexibility, we'll have no option at the end of July but to defer all remaining *non-Choice* Care-in-the-Community authorizations until October, provide staff furlough notices, and notify vendors that we cannot pay them as we begin an orderly shutdown of hospitals and clinics all across the country. . . unfortunate conclusions to an otherwise productive year of progress.

In fact, we've doubled the capacity required to meet last year's demand by focusing on four pillars—staffing, space, productivity, and VA Community Care.

We have more people serving Veterans. Since April 2014, we've increased net staffing by over 12,000, including over 1,000 new physicians. And we've used Choice Act funding to hire over 3,700 medical center staff.

We have more space for Veterans. We activated over 1.7 million square feet last fiscal year and increased the number of primary care exam rooms so providers can care for more Veterans each day.

We're more productive – identifying unused capacity, optimizing scheduling, heading off “no-shows” and late appointment cancellations, and extending clinic hours at night and on weekends.

We're aggressively using technology like telehealth, secure messaging, and e-consults to reach more Veterans.

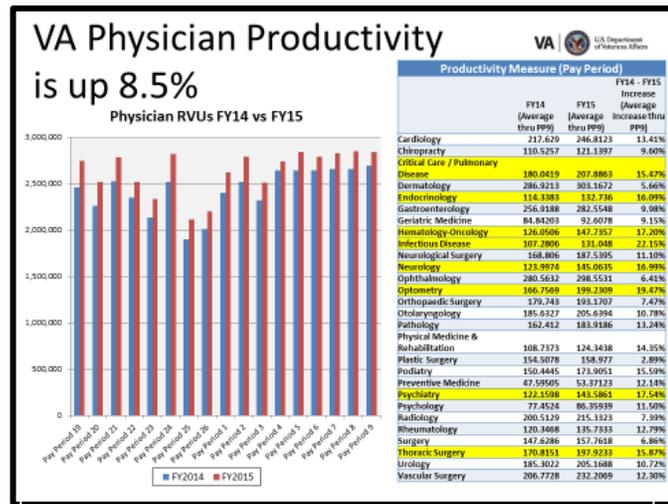
Clinical output has increased 8.5 percent while our healthcare budget has increased only 2.8 percent.

We're aggressively using care in the community. The Choice Program and our Accelerating Access to Care Initiative increased Veteran options for care in the community.

We provided VA Care in the Community authorizations – including Choice – for 36 percent more people than we did over the same period last year – a total of 1.5 million individual VA beneficiaries.

In short – we're putting the needs and expectations of Veterans and beneficiaries first, empowering employees to deliver excellent customer service, improving or eliminating processes, and shaping more productive and Veteran-centric internal operations.

That's MyVA – our top priority to bring VA into the 21st century.



**CHART 1 – VA Physician Productivity**

**OUTCOMES**

Our strategy is paying dividends for Veterans.

We've increased VA Care in the Community authorizations – including Choice – by 44 percent since we started accelerating access to care a year ago – that's 900,000 more authorizations than the previous year.

Between the end of June last year and May, we completed 56.2 million appointments – a 4 percent increase over last year, and there were 1.5 million encounters during extended hours, a 10 percent increase.

Even with that increase, we completed 97 percent of appointments within 30 days, 93 percent within 14 days, 88 percent within seven days, and 22 percent same day.

For specialty care, wait times are down to an average of five days.

For primary care—down to an average of four days.

And an average of three days for mental healthcare.

So we're making verifiable progress for Veterans, and with your support, VA can be the best customer-service agency in Federal government.

But even as we increase access and transform, important challenges remain—and there will be more in the future as Veteran demographics evolve.

It's now clear that the access crisis in 2014 was predominantly a matter of significant mismatch of supply versus demand, exacerbated by greater numbers of Veterans receiving services.

That sort of imbalance predicts failure in any business, public or private, especially when we promise benefits to Veterans without the flexibility to fulfill the obligations.

So a fundamental problem is VA working to a budget—not to the package of benefits and services Veterans have earned and been promised by Congress.

Budgets are static—our requirements are fluid. And changes in Veterans’ needs and preferences for care far out-pace the federal budget-cycle.

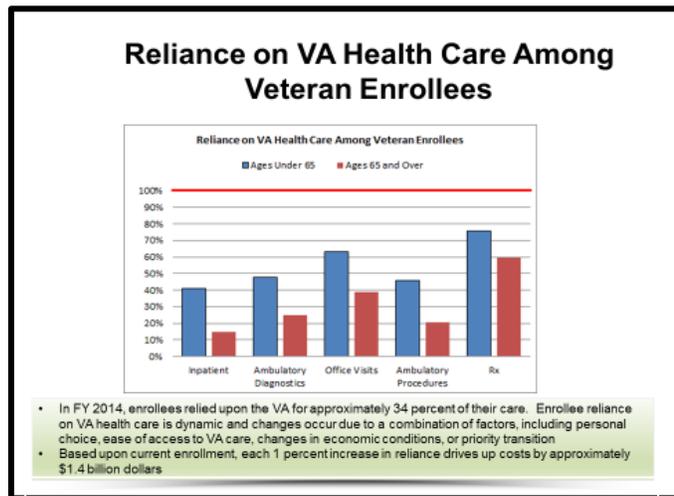
For instance, last year—on average—we added 51,000 Veterans to our healthcare rolls each month. This year the monthly average of new enrollees has been 131,000 – a 147 percent increase.

And we welcome them all.

But we can’t miss that, today, enrolled Veterans only rely on VA for 34 percent of their care—just one percentage point growth in reliance increases costs by approximately \$1.4 billion dollars.

So we’re working hard to best serve more Veterans, but without flexibility we can’t provide they need and you’ve directed.

We have reached a decision point—Congress can either shape a different benefit profile for Veterans or give VA the flexibility and money for legislated entitlements.



**CHART 2 – VA Health Care Reliance**

## **FLEXIBILITY**

My worst nightmare is a Veteran going without care because I have money in the wrong pocket.

I earlier compared the inflexibility we face to having one checking account for gasoline and another for groceries.

The inflexibility we’re talking about today is even more puzzling: I can’t spend food money for food.

Altogether, over 70 line items of our budget are inflexible. Freed up, they would help us give Veterans the VA you envision and they deserve.

- We need flexibility to move money from line item to line item.
- We need flexibility to move money from VA Community Care to Choice and from Choice to VA Community Care.
- We need flexibility to transfer both directions, depending on demand.

We owe it to Veterans and ourselves to be more agile 15 years into the 21st century.

It was February when I asked for flexibility to move resources.

It was May when we again asked for flexibility—to use some Choice Program funding to provide care in the community.

I’m asking—again—for the simple flexibility to serve Veterans with the money you’ve already appropriated so we can resource the capacity we’ve grown.

More flexibility will go far toward meeting Veteran care and increasing access across the country.

## Denver Funding

Money for the Denver Replacement Medical Center will be depleted by early October and work on the project will cease, unless we receive congressional authorization for the full cost of the project and flexibility in FY16 to transfer \$625 million of our existing resources to the Major Construction account.

We have presented several plans to Congress, the latest on 5 June, and we'll have an update shortly.

We anticipate the Corps of Engineers will award a contract to complete the facility in October and assume construction management of the project, if we receive full authorization and the flexibility we seek.

## Consolidation of Care

To improve community care for Veterans, we need to streamline antiquated business processes for purchasing care.

For years, a variety of authorities and programs have provided community care to Veterans.

Today, we have seven different programs:

- Traditional VA Care,
- Choice,
- Patient-Centered Community Care (PC3),
- Two separate plans for emergency care in the community,
- ARCH,
- Indian Health Service / Tribal Health Program.

And these don't include other programs for Veterans' beneficiaries.

It's all very difficult to understand. Veterans don't get it. Providers don't get it. And our employees don't get it.

We look forward to continuing to work with you on an integrated network of VA and community care and a single, integrated reimbursement system to get the providers we need on board.

## Provider Agreements

On 1 May, we sent you our proposal, the "Purchased Health Care Streamlining and Modernization Act"—a bill to make critical improvements in provider agreements and give us flexibility to provide timely local care to Veterans.

Our proposal—modeled on the purchased care authority in the Choice Act—includes protections for procurement integrity, provider qualifications, and reasonable cost.

VA Care in the Community Cross-Reference							
	Veteran Choice Act (Choice Program)	Patient-Centered Community Care (PC3)	Traditional VA Care in the Community (Formerly Non-VA Medical Care)	Emergency Care in the Community for Certain Veterans with Service-Connected Conditions	Emergency Care in the Community for Non-VA Non-Service-Connected Veterans	Project Access Received Care to Home (ARCH)	Indian Health Service / Tribal Health Program
<b>Eligibility Requirements</b>	Veteran enrolled in VA system* or before August 1, 2014 for a newly diagnosed Combat Veteran) and: VA geographically infeasible (> 40 miles) VA unable to schedule appointment within 30 days from clinically indicated date (CID)	Veteran enrolled in VA system* and: Receiving care from a VA facility, and Necessary continued care is not available due to geographic inaccessibility or resource limitations.	Veteran enrolled in VA system* and: Receiving care from a VA facility, and Necessary continued care is not available due to geographic inaccessibility or resource limitations, and Veteran meets statutory/regulatory eligibility criteria (38 U.S.C. 170519-21, 37.55)	Veteran enrolled in VA system* and: VA is not facility available Symptoms of veteran condition satisfy emergency based on "Patient Lagerment" definition of emergency, and Treatment is for an SC condition or an MCC condition appearing on SC condition.	Veteran enrolled in VA system* and: VA is not facility available Symptoms of veteran condition satisfy emergency based on "Patient Lagerment" definition of emergency, and received VA care in previous 24 months No coverage under a health plan contract No third party liability (in vehicle) Not eligible under 38 U.S.C. 1729	Veteran enrolled in VA system* and: Receiving care from a VA facility, and Necessary continued care is not available due to geographic inaccessibility or resource limitations.	Veteran enrolled in VA system*
<b>Access to care mechanism</b>	Contract Veteran contacts applicable contractor and is scheduled in community	Contract VA sends referral to contractor and is scheduled in community	Individual authorization VA issues individual authorization of community provider with approved care	Self-referral VA retrospectively reviews claim for care in accordance with statutory and regulatory criteria	Self-referral VA retrospectively reviews claim for care in accordance with statutory and regulatory criteria	Contract VA sends referral to contractor and is scheduled in community	Self-referral
<b>Care provided</b>	All care available in a VA facility (inpatient/outpatient)	All care available in a VA facility (inpatient/outpatient) Includes dental, contract, and C&P examinations	All care available in a VA facility (inpatient/outpatient)	Emergency care and limited continued non-emergency care if VA cannot accept transfer of veteran	Emergency care and limited continued non-emergency care if VA cannot accept transfer of veteran	All care available in a VA facility (inpatient/outpatient)	Direct Care services available at a given IHS/TPH facility
<b>Excluded Care</b>	Emergency care	Emergency care	Emergency care	Emergency care	Emergency care	Emergency care	Emergency care

**CHART 3 – VA Care in the Community**

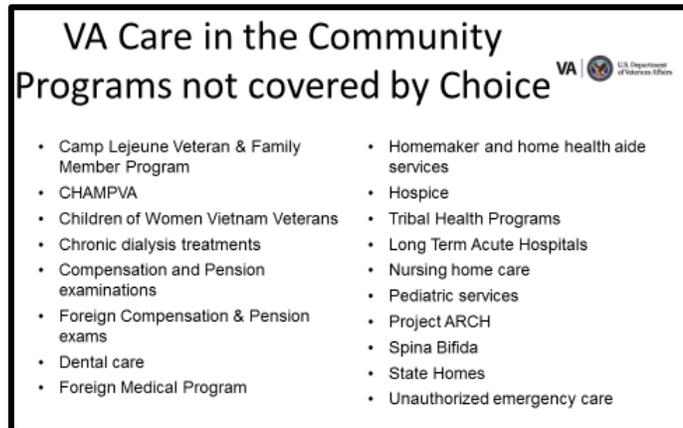
## The Choice Act

Flexibility with respect to Choice is central to resolving the budget shortfall and ensuring Veterans continue receiving timely care as we strive to meet the 30-day access goal.

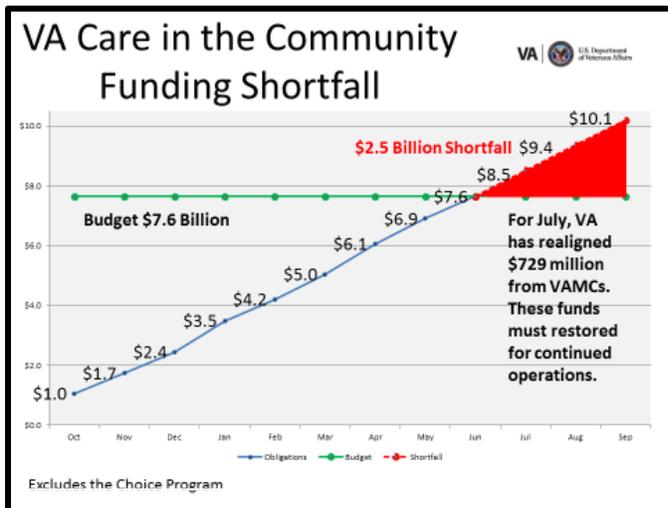
On top of the \$7.6 billion of VA Community Care we already provide, Congress added new entitlements for Veterans in the Choice Act. But there are many programs Choice doesn't cover.

Because Choice authorizations and community care authorizations are in different buckets, we have a funding shortfall—in spite of the fact that both types of care are community care.

At the current rate, we expect Care in the Community in FY2015 will cost an additional \$2.5 billion.



**CHART 4 – What's not covered by Choice**



**CHART 5 – Funding shortfall**

The new Hepatitis C drugs for Veterans will cost an additional \$500 million.

All we seek is flexibility—through limited authority—to use money for community care to the extent those exceed our FY15 budget.

## 2016 Budget

To meet these growing requirements next year, VA needs the adequate funding the President's 2016 budget request provides.

But the House-proposed \$1.4 billion reduction means \$688 million less for Veterans Medical Care—meaning as many as 70,000 Veterans may not receive care.

Further, it means no funding for four

Major Construction projects and six cemetery projects, and 17,000 Veterans and family members may not receive VA burial honors.

## Beyond 2016

The increase in requirements we're seeing anticipates greater challenges ahead.

Services and benefits peak years after conflicts end, and healthcare requirements and the demand for benefits increase as Veterans age and exit the workforce.

So full funding of the 2016 budget request is a critical first step in meeting these challenges, but we have to look much further ahead for the sake of Afghanistan and Iraq Veterans.

In 1975, just 40 years ago, only 2.2 million American Veterans were 65 years old or older—7.5 percent of our Veteran population. By 2017, we expect 9.8 million will be 65 or older—46 percent of Veterans.

What does that mean?

Consider: VA provides the best hearing aid

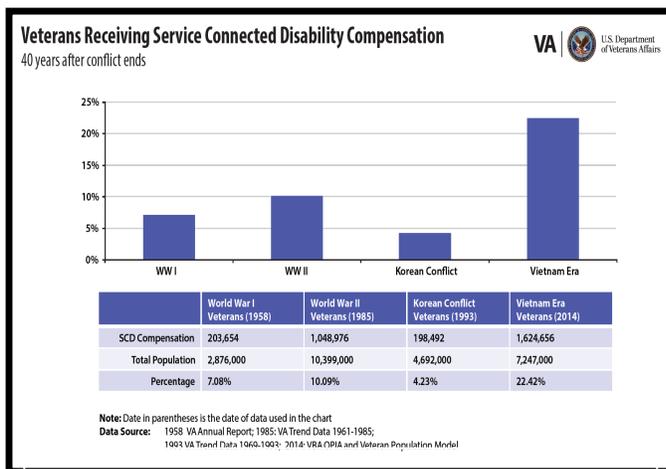
technology anywhere. Medicare doesn't cover hearing aids—and most insurance plans have limited coverage, at best.

So choosing VA for hearing aids saves Veterans around \$4,200.

As VA continues to improve access, more Veterans will come to VA—because they want to, and because it makes financial sense.

So it's a foregone conclusion that the cost of fulfilling our commitments will grow for the foreseeable future.

It bears repeating: the 2014 access crisis was, in part, a Vietnam debt, not a debt of Afghanistan and Iraq where Servicemembers still serve.



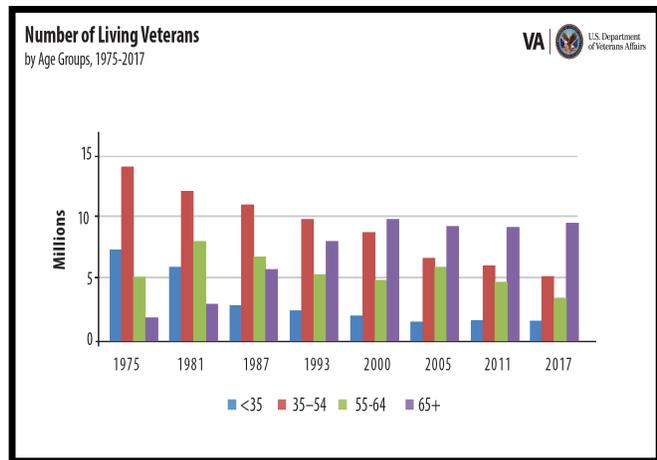
**CHART 7 – Vietnam debts coming due**

They rightly expect us to fulfill our obligations with the same degree of dignity and fidelity with which they put their lives on the line for the Nation.

If we choose shutdown, we fail all of them.

Given the commitment we made at breakfast last week—to keep working together—I know we'll honor all our obligations to Veterans and their families of every generation.

Thank you. We look forward to your questions.



**CHART 6 – An aging Veteran population**

We can't be shortsighted.

We have to respond today with a long-term view that underlines a commitment to VA transformation.

~

Veterans who have preserved our freedom are watching us.

As the military drawdown continues, Servicemembers are watching us.

And young men and women who might choose to serve are watching.

They rightly expect us to fulfill our