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by
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Chairman Isaacson, Ranking Member Blumenthal and Members of the Committee. It is a pleasure for me to be here before you today to address the work of the Commission on Care. That pleasure is heightened by the fact that, for five years I sat on the other side of the table as Chief Counsel and Staff Director of the Committee then Chaired by Senator Alan K. Simpson (R, WY). I have also been on this side of the table twice when the Committee considered my nomination to be Deputy Administrator of the Veterans Administration and, in 2005, to be Assistant Secretary of the Department of Veterans Affairs for Congressional Relations.

Mr. Chairman, I particularly want to thank you for placing my name in consideration for appointment by the Majority Leader to serve as a member of the Commission on Care.

In my personal experience, the vast majority of VA staff at all levels have been professional and highly committed to the veterans they serve. Like many of us, I was concerned to learn of the issues that came to light regarding, among other things, the manipulation of wait times for appointments at the Phoenix VA Medical Center. I am happy to have been a part of the effort to better understand what had gone awry and to find solutions to those problems for today and into the future.

Service on that Commission has been an interesting experience. I have known some of the Commissioners for many years. Commissioner Dave Gorman, formerly Executive Director of the Disabled American Veterans, and I go back to my time on the Committee Staff in 1981. Commissioner Michael Blecker and I served as members of the Commission on Service Members and Veterans Transition Assistance in the 1990's. Commissioners Darin Selnick and Lucretia McLenny and I served in the Department during my stint there from 2005 to 2008.

The Commissioners brought their varied backgrounds to this venture with one characteristic in common: All of us were committed to assuring that this country's commitment to its veterans was well met. We may have differed in just how best to do that, but the good faith of the Commissioners was palpable. Under the leadership of our very competent Chair, Nancy Schlicting, each Commissioner had an opportunity to express his or her priorities and defend those, should they be challenged.

The final report, ably assembled by a very competent staff under the leadership of Executive Director Susan Webman, and John Goodrich, Executive Officer, contains 18 recommendations. I personally believe that some of these are good ideas. Others

strike me as unrealistic. Some are included because one or more of the Commissioners felt very strongly about them. The White House made it clear to our Chair and Vice-Chair, Dr. Delos Cosgrove, that they would like a consensus report. I signed off on the report in deference to that expectation even though I had some reservations. I had had a full and fair opportunity to express my concerns in open session. Among the many things I learned from Senator Simpson was that in negotiation on matters such as these, following all of the give and take, you have to be able to take what you can, hold your head high, and declare victory one more time.

And that is what I would like to do here.

The Department of Veterans Affairs is an immense organization — a behemoth, so to speak. Making changes in such an organization has been described as comparable to making a change in direction of a naval carrier battle group. There are innumerable moving pieces, all of which have to move together in a choreographed fashion. Everything can't happen at once — although in our impatience, we would like that to be the case.

Over nearly a year that the Commission met, aided by the very comprehensive Independent Assessment, we discussed a broad array of problems within the VA. Many of those were long standing. We discussed those with senior VA leadership, who themselves recognized that there were issues that were beyond their ability to address. I like to think that by shining the light of discussion on some of those, we may have provided the impetus to the professional staff of the VA to raise such issues — and the solutions that they may have been unable to raise previously.

Background:

In 2014 there were problems at the Phoenix VAMC with regards to scheduling veterans for medical appointments. There have been significant demographic changes in the veteran population with a major migration from the snow belt and the rust belt to the sun belt. It was suggested that several veterans died while waiting for a medical appointment. VA IG found that the VAMC was gaming the scheduling process and keeping duplicate records attempting to show that appointments were scheduled within time guidelines. The IG did not find that the wait times for appointments were causative of the deaths that did occur.

So, in 2014, Congress passed the Veterans Access, Choice and Accountability Act (The Choice Act) which provided, among other things, that if you couldn't get a VA appointment within 30 days, or if the VA was more than 40 miles from your home, you had the choice to get care in the community at VA expense. The Act also provided for a detailed study of many aspects of VA health care and its management and created a Commission on Care to review the study and make recommendations as to what the VA health care system should look like in 20 years. The 15 member commission was bipartisan, with appointments from the leadership of the House and Senate and the President. The Commission's report was issued just after July 4th of this year

My background:

Much of my professional career has been in positions related to serving this country's veterans. I spent five years as Staff Director of this Committee (1981-83 and 1995-96,) I also spent three years as Deputy Administrator of the Veterans Administration (1986-89,) and for nearly three years was Assistant Secretary of Veterans Affairs for Congressional Relations under Secretary Jim Nicholson (2005-08.)

I also served as a member of the Congressional Commission on Service Members and Veterans Transition Assistance, then chaired by former VA Secretary Tony Principi.

After law school at Notre Dame (BA, 1963; JD, 1966) I served for nearly five years in the U.S. Army (1966-71) as an infantry officer, two and a half of those in Vietnam. While there, I commanded a company with the 173rd Airborne Brigade and served as an advisor with the Vietnamese Airborne Division. My decorations include the Silver Star and Purple Heart and 12 others for valor and service. I am a Ranger, Senior Parachutist and have the Combat Infantryman's Badge.

I have remained connected to many of the issues affecting veterans through the publications of the VA and of the VSO's. I am a life member of the VFW, DAV and AMVETS.

Other aspects of my professional life include nearly five years with Milbank, Tweed, Hadley and McCloy, a major Wall Street law firm (1972-77,) and my selection as a White House Fellow in 1977 — and my service in that role as an assistant to Admiral Stansfield Turner, then the Director of the Central Intelligence Agency. Following that I also served in the Department of the Army and of the Navy at the Deputy Assistant Secretary level (1978-81,) and as General Counsel of the United States Information Agency (1983-86.)

Some statistics regarding veterans and the VA:

In 2008, there were 26 million veterans, today there are about 21 million. In 2008 the budget of the VA was $68 billion, today about $175 billion. In 2008, VA had 240,000 employees, today about 368,000. The number of veterans is in precipitous decline — we lose about 5 million a decade. Of the total number of veterans, about a third use the VA for some or all of their health care. Many just for prescriptions.

Significant findings/recommendations in the report:

VHA Care System (recommendation #1): The Commission recommended that the VA partner with providers in the community so that health care could be available to veterans in the most efficient, cost effective way possible. If there is capacity in the community to offer major cardiac surgery, it doesn't make sense to send a veteran to a VA facility across the country for the same thing. While this seems to make sense,

some in the veteran community think that this would be the death knell for the VA health care system which is important to many veterans.

Board of Directors (recommendation #9): I think it is unlikely that Congress will relinquish the authority that it has over the VA and give that to an independent board of directors. Indeed, I would think that the President would not want to relinquish his Executive prerogatives to appoint or discharge individuals directly. Would that be a good idea? Perhaps, if the Veterans Health Administration was a business, but just as it was not adopted after being proposed in the 1999 Commission report, I would expect that it would be rejected now.

BRAC (recommendation #6): A Base Realignment and Closing Commission type of process would be a good idea to enable the VA to eliminate facilities that are under utilized so that resources could be concentrated where the veteran patients are. I understand that there are about 50 VA hospitals with less than a 30% occupancy rate. But, even though there may be very few eligible veterans in a particular hospital's catchment area, there are some. And there are hundreds individuals working at those hospitals. Two senators and one or more members of Congress will fight to the death to protect those jobs.

Underutilized facilities (recommendation #6): A problem VA has is that on many VA campuses, there are scattered buildings that are not used. Congress has made it virtually impossible to get rid of those, and even if you could, they are in the middle of a campus and would not lend themselves to easy disposal. Many have been designated as historically significant. VA has generally done the sensible thing and just used those for storage which is much less costly than trying to give the buildings to GSA or another government agency.

Family Members (recommendation #18): One recommendation of the Commission is that the VA should allow family members of veterans — or others in the community — to access underutilized VA hospital facilities. They would do this and pay for the services received thereby creating a source of revenue to the facility to complement appropriations.

This is a position particularly espoused by Commissioner Phillip Longman, the author of a 1995 book on VA health care entitled "The Best Care Anywhere." He was recently interviewed for the *Washington Monthly* magazine and took that opportunity to state his support for aspects of the Commission report which he believed would bring us closer to a single payer health care system — true "socialized medicine." Commissioner Longman was recommended for the Commission to the Minority Leader by Senator Bernie Sanders.

Allowing family members to use the VHA system isn't realistic. Look at the patient population of VHA — almost all are male. Many are elderly. We wring our hands about the problem of providing appropriate care to women veterans — and about 9% of veterans are women. I have been faulted for the use of a sample size of one — my wife

— in addressing this issue. She is not about to go to the VA for her health care. And don't even talk about pediatrics.

And if we did have family members use the VA system, that would cannibalize the patient population of the community hospitals in the area. I have at times in the past seen the numbers of local hospitals that close each year because they can't operate efficiently. This would exacerbate that problem.

Personnel (recommendation #15.): The Commission recommends changing the personnel system so that VA could, among other things, offer salaries competitive with the private sector. A review of the IRS 990 Forms of not-for-profit hospitals gives a sense of what those salaries are. In New York, for example, some hospital CEOs make in the range of $10 million annually. The President of the United States makes $400,000.

Health Equity (recommendation #5.): The Commission places an emphasis on "Health Equity," a concept that I had never heard of prior to my service on the Commission. It focuses on the fact that minority veterans (indeed, any minorities) have less favorable health care outcomes than white veterans. This is much more of a social welfare issue than one of direct health care. The fact is, there is a maldistribution of health care resources in the country. Not many doctors want to go to rural areas, Indian reservations, poor inner city neighborhoods, etc. What are the responsibilities of VHA to try to rectify that situation? These seem to me to be societal problems, not a VA problem.

Information Technology (recommendation #7): The VA generally lacks the skill sets to deal effectively with IT needs. It has to contract with consultants to tell it what it needs and then to draft the specifications to meet those needs and then provide the services to make the hardware and software respond to those needs. In the Commission report we are saying that VA should get a commercial off the shelf product that does an amazing range of things, to include electronic health records, scheduling, business applications to effect the payment of non-VA providers and coordinating data among the different VA administrations. The fact is, VHA has spent years trying to develop a scheduling system — and isn't there yet. I think it is really asking for something well beyond the capability of the VA to accomplish to suggest that it get the comprehensive — and very expensive — IT system we would like them to have.

Veteran Voices: One of our Commissioners bemoans the fact that we haven't done a comprehensive survey of what veterans want. In fact, we have had extensive comment from the VSO community —the group that Congress looks to to articulate the concerns of veterans. The reality is, they claim to speak for veterans and are perceived to do so.

What I wish we had done:

There are a number of very basic questions that I wish the Commission had addressed. Some of these are things that no one wants to touch. Such as:

Why do we have a VA health care system at all?

This is something that a number of people ask me. We need to do something for those who are injured in training or in combat, but the fact is, most of those being treated in the VA system are suffering the same illnesses most of us can be expected to experience with the passage of time. There is nothing uniquely "veteran" about those injuries or diseases. And in most communities, there is ample surplus space to treat them in a community hospital. Some say that there are some veteran specific medical conditions — such as spinal chord injury, blind rehabilitation, PTSD and traumatic brain injury. In fact, annually automobile and diving accidents create more SCI patients than the VA treats. Very few VA SCI patients were injured in combat. They were in accidents like so many others.

And most of the veterans using the VA system are medicare eligible. If they use a community hospital, it can just bill medicare. VA could consider paying for the medicare supplement insurance, which would limit the veteran's out-of-pocket expense.

If we are committed to having a VA health care system, who should be eligible to use it?

Some people assume that, once an individual puts on a uniform, they are entitled to free health care for the rest of their lives — no need to worry about health insurance ever again.

I don't think this is what we want. A system was established a few years ago which said that for those with service connected disabilities, treatment of those disabilities was the first priority of the system. Priorities also included veterans who were just poor.

Is there a better way to articulate eligibility so that the veteran — and, as importantly, the American taxpayer — can better understand what the VA health care system is trying to do, who it is obligated to provide care for?

Where are the VA hospitals? Where are the veterans?

I think that if we look closely, we'll find a real disconnect here. Why is it that the issue of wait time delay first arose in Phoenix? Because a lot of veterans who used to live in the snow belt retired and moved there because of the weather. Thus the greater demand on the VA health care system there. Meanwhile in Canandaigua, NY, the VA maintains a hospital with a 1,700 bed capacity — within an hour driving distance of three other VA hospitals — with (when last I heard the numbers) about 70 patients and a hospital work force of more than 700. There was talk of closing Canandaigua at one time, but it was determined that it couldn't be done because it was the largest employer in the region.

VA Hospital Construction.

Every Member of Congress would like a new VA hospital built in his or her Congressional district. The multi-billion dollar construction project will provide construction jobs for five years, and once completed, the hospital will have an annual operating budget of about $250 million. And the hospital will be perceived as a benefit to a number of constituents — a demonstration of the ability to "bring home the bacon."

VA management of most recent new construction projects has been disastrous. With the predicted decline in the veteran population, I would suggest that no new construction be undertaken in the foreseeable future.

Processes.

In reviewing the materials relating to patient scheduling, I was struck by the fact that the gatekeeper for most VA care is a primary care physician. The medical education establishment is just not turning out a lot of primary care physicians. So that is a bottle neck that is only going to get worse.

There was an op-ed in the *Wall Street Journal* recently by a retired VA primary care doctor. He observed that many veterans do, in fact, get their primary health care elsewhere, but they want to utilize the VA for their prescriptions because of the very low co-pay. Yet to do that, they have to schedule an appointment with the VA primary care doctor, who then takes the prescriptions from the outside doctor and, assuming they are on the VA formulary, processes them to be filled by the VA pharmacy. He suggests that much of the scheduling problem could be eliminated if the prescriptions from the outside doctor could be processed directly.

General changes coming to health care: Over the past several years, there have been significant changes to the way health care is delivered in the U.S. There is much more reliance on out-patient care rather than in-patient. The Affordable Care Act (Obama Care) and what follows that will mean many more changes to come in the future. In addition, if the decline in the number of veterans continues as it has, by 20 years hence, there will only be about 12 million veterans alive — with a physical plant that was designed to accommodate more than twice that number.

Was the Commission a success? Several of my colleagues believed that we could only count it a success if the Administration and the Congress adopted the entire document as we presented it. I personally am willing to declare victory with the moves that VA Secretary McDonald, Deputy Secretary Gibson and Undersecretary for Health, Dr. David Shulkin, and their staff are now making.

Thank you.