Annual Legislative Presentation

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National President

Paralyzed Veterans of America

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Chairman Miller, Chairman Isakson, and members of the Committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2016 policy priorities. For 70 years, PVA has served as the lead voice on a number of issues that affect severely disabled and catastrophically injured veterans in this country. Our important body of work over the past year includes championing much-needed changes within the Department of Veterans Affairs (VA) and educating legislators as they have developed important policies that impact the lives of those who served.

We preface this year's policy priorities with a concern: PVA and the veterans we represent are concerned our point of view is unheard due to the fact so few members of these Committees, and in fact the entire U.S. Congress, are actually veterans. Today, the number of veterans actually serving in Congress has reached an all-time low, and we question the motives of many who claim to want to do "the right thing" for veterans, but may allow political ideology to dictate what is the right thing. We ask instead that you listen to those of us who actually depend on the VA to live and thrive. The priorities we present today represent a collective voice of veterans, and we urge you to give them careful consideration.

Today, I come before you with our views on the current state of veterans programs and services, particularly those that impact our members—veterans with spinal cord injury or disease (SCI/D). Our concerns and policy recommendations are particularly important in light of the ongoing discussion about reforming the delivery of veterans' health care. As the Committees and the Administration advance reforms to the VA health care system, proper consideration must be given to how those reforms will impact veterans who rely on the VA specialized systems of care.

BACKGROUND—PVA is proud this year to marks 70 years of service to veterans who have experienced catastrophic spinal cord injury or disease. Our organization was founded in 1946 by a small group of returning World War II veterans, all of whom were consigned to various military hospitals throughout the country as a result of their injuries. Realizing that neither the medical profession nor government had ever confronted the needs of such a population, these veterans decided to become their own advocates and to do so through a national organization.

From the outset, PVA's founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing individuals with a spinal cord injury, be they medical, social, or economic. They were determined to create an organization that would be governed by the members themselves and address their own unique needs. Being told that their life expectancy could be measured in weeks or months, these individuals set as their primary goal to bring about change that would maximize the quality of life and opportunity for all veterans and individuals with spinal cord injury—it remains so today.

Over the years, PVA has established ongoing programs in Medical Services to ensure our members receive timely, quality care; research; education; sports; service representation to secure our members' and other veterans benefits; advocacy for the rights of all people with disabilities; accessible architecture; and communications to educate the public about individuals with spinal cord injury. We have also developed long-standing partnerships with other veterans' service organizations. PVA, along with the co-authors of *The Independent Budget*—Disabled American Veterans and the Veterans of Foreign Wars—continue to present comprehensive budget and policy recommendations to influence debate on issues critical to the veterans we represent. We are proud that this marks the 30th year of *The Independent Budget*.

Today, PVA is the only congressionally chartered veterans service organization dedicated solely to the benefit and representation of veterans with spinal cord injury or disease.

PROTECT SPECIALIZED SERVICES—The VA is the best health care provider for veterans. The VA's specialized services, particularly spinal cord injury care, cannot be adequately duplicated in the private sector. However, these services are expensive and threatened by efforts to reduce spending on veterans' health care. Even with VA's advances as a health care provider, some political leaders continue to advocate turning the VA health care system into a payer, instead of a provider of care. In fact, PVA is deeply disturbed that the Congressionally-mandated Commission on Care seems to be trending toward recommendations that would see this idea realized. This would be an unacceptable outcome for veterans as it would move them out of the "veteran-centric" care within VA, lead to a diminution of existing services, and increase health care costs in the federal budget.

Many advocates for greater access to care in the community also minimize, or ignore altogether, the devastating impact that pushing more veterans into the community would have on the larger VA health care system, and by extension the specialized health services that rely upon the larger system. Broad expansion of community care could lead to a significant decline in the critical mass of patients needed to keep all services viable. We cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. If these services decline, then specialized care is also diminished. The fact is the SCI system of care, and the other specialized services in VA, do not operate in a vacuum. Veterans with catastrophic disabilities rely almost exclusively upon the VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. As the VA continues the troubling trend toward greater utilization of community care, Congress and the Administration must be cognizant of the impact those decisions will have on veterans who need the VA the most.

PROVIDE ADEQUATE NURSE STAFFING AND BED CAPACITY AT ALL 25 SCI/D CENTERS—In 1970, Life magazine published an exposé on the deplorable conditions to which paralyzed veterans were subjected at the Bronx VA Medical Center. Since that time, PVA has been commissioned by senior leadership in VA to ensure quality health care across the entire Spinal Cord Injury System of Care and make formal recommendations for change to the VA Secretary when necessary.

One of the greatest issues that plagues the spinal cord injury system is chronic understaffing. While we realize understaffing is a problem throughout the VA health care system, veterans with spinal cord injuries and diseases are particularly vulnerable when placed under care that is thinly distributed and unable to provide adequate clinical oversight of paralyzed individuals with higher average acuities than other patient populations. Left to their own devices, too many facility directors have staffed spinal cord injury centers like medical or geriatric units. Their staffing decisions do not properly account for the unique skills required of the nursing staff in an SCI/D unit. This leads to floating nurses who are not properly trained to handle SCI patients or overworking the existing SCI/D nursing staff, which in turn leads to burn out, injury, and loss of work time or staff departure. This ultimately leaves too many veterans without the responsive bedside care they need. In fact, this very scenario played out in a YouTube video that a spinal cord injury patient posted and released to the media from the Memphis VA medical center in August 2015.

Secretary McDonald has been actively working with PVA to resolve this long-standing issue. We hope that the revised nurse staffing methodology currently being developed, with the input of PVA's own Medical Services staff, will set the benchmark for appropriate staffing based on accurate acuity analysis of veterans currently being served in the SCI system of care. Additionally, it is time for VA to acknowledge the true scope of demand for services, which is best shown by the variance in the number of paralyzed veterans on the SCI/D registry and the number of annual examinations completed at all 25 SCI centers. This requires proactive efforts to educate severely disabled veterans who may be unaware of or fail to appreciate the benefits of preventive care and early intervention through annual checkups, which would mitigate the high cost of treating SCI/D-related conditions in the latter stages and allow VA to scale its bedding and staff capacity to actual need, not the minimum requirement.

To that end, we seek support of Congress to bring back mandated bed capacities in the spinal cord injury system of care. This would ensure that the VA would maintain appropriate capacity to meet demand and align with the nurse staffing methodology being developed to right size the human resource infrastructure of the VA SCI system.

REINSTATE THE ANNUAL CAPACITY REPORTING MANDATE FOR SPECIALIZED SYSTEMS OF CARE—The VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disorder, blindness, amputations, and mental illness—as mandated by P.L. 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996." As a result of P.L. 104-262, the VA developed policy that required the baseline of capacity for VA's Spinal Cord Injury/Disease System of Care to be measured by the number of available beds and the number of full-time equivalent employees assigned to provide care. Under this law, the VA was also required to provide Congress with an

annual "capacity" report to be reviewed by the Office of the Inspector General. Unfortunately, this reporting requirement expired in 2008.

Currently, within the SCI/D system of care, the VA is not meeting capacity requirements for staffing and the number of inpatient beds that must be available for SCI/D veterans. Reductions of both inpatient beds and staff in VA's acute and extended-care settings have been continuously reported throughout the SCI/D system of care. VA has eliminated staffing positions that are necessary for an SCI/D center or clinic to maintain its mandated capacity to provide care, or has operated with vacant health care positions for prolonged periods of time. When this occurs, veterans' access to VA care decreases, remaining staff become overwhelmed with increased responsibilities, and the overall quality of health care is compromised.

VA's capacity to provide health care through its specialized health systems is based on catastrophically disabled veterans having access to quality care in VA rehabilitation programs. To provide such care, as a component of workforce planning, VA tracks the status of vacant and staffed health care positions throughout the Veterans Health Administration, as well as the number of veterans utilizing the specialized systems of care. With this information readily available, VA should compile and use the collected data for annual reports to assess its ability to meet the capacity mandate.

PVA recommends that Congress reinstate the aforementioned reporting requirement for VA specialized services to complete an annual capacity report, without a specific end date to prevent future expiration of the mandate. This requirement will ensure that catastrophically disabled veterans' access to care is not diminished due to the VA's lack of transparency with regard to its mandated capacity requirements, and ensure that the VA is held accountable for having the requisite number of available inpatient beds for veterans, as well as required levels of staff to deliver quality care.

IMPROVE BENEFICIARY TRAVEL FOR CATASTROPHICALLY DISABLED VETERANS— While a great deal of attention recently has been focused on reforming the delivery of veterans health care, much of that discussion has not fully considered the specialized health care needs of veterans with catastrophic disabilities, particularly spinal cord injury or disease. PVA members often travel farther and more frequently than any other cohort of the veterans' population. It is not unusual for PVA members, and other veterans with SCI/D, to travel hundreds of miles to reach one of the 25 spinal cord injury centers located around the country. They do this because the VA SCI/D system of care is far and away the best option they have. The access problems these veterans face are usually not wait times or distance, but the cost of travel. As a result, veterans may avoid traveling to receive care until a minor condition becomes serious or even life-threatening, requiring more costly and intensive care.

Congress should expand beneficiary travel to include non-service connected, catastrophically disabled veterans, who are already granted higher priority, to ensure they are able to receive timely, quality specialty care. While VA will continue to face tighter budgets in the future, the short-term costs of expanding this benefit to this population of veterans far outweigh the potentially greater long term health care costs for these veterans. Too often, catastrophically disabled veterans choose not to travel to VA medical centers for appointments and procedures due to significant costs associated with their travel. They end up at an outpatient clinic or a private health care facility that is ill-equipped to meet their specialized health care needs. The result is often the development of far worse health conditions and a higher cost of care. By

ensuring that catastrophically disabled veterans are able to travel to the best location to receive necessary care, the overall health care costs to the VA can be reduced.

PVA believes that expanding VA's beneficiary travel benefit to this population of severely disabled veterans will lead to an increasing number of catastrophically disabled veterans receiving quality, timely comprehensive care, and result in long-term cost savings for the VA. Eliminating the burden of transportation costs as a barrier to receiving health care, will improve veterans' overall health and well-being, as well as decrease, if not prevent, future costs associated with exacerbated health conditions due to postponed care.

During the 114th Congress, H.R. 288 and S. 171, the "Veterans Medical Access Act" have been introduced to deal with the transportation needs of these low-income veterans. We call on the Committees to pass these important measures that will positively impact veterans who rely upon the VA health care system the most. In the long run, this will save money for veterans and the VA, as medical issues can be dealt with early before they become serious.

INCREASE LONG-TERM CARE RESOURCES—PVA continues to be concerned about the lack of VA long-term-care (LTC) beds and services for veterans with spinal cord injuries or disease. Approximately 50 percent of our members are now over 65 years of age and another 30 percent are between 57 and 66. These aging SCI/D veterans are currently in need of VA LTC services at the 25 VA SCI/D centers (or "hubs"). Unfortunately, we believe the VA is not requesting and Congress is not providing sufficient resources to meet the current demand. As a result of insufficient resources, the VA is moving toward purchasing private care instead of maintaining acute care and long-term care in-house at SCI/D centers.

The VA has designated SCI/D long-term-care facilities because of the unique comprehensive medical needs of SCI/D veterans, which are usually not met in community nursing homes and non-SCI/D–designated facilities. SCI/D centers provide a full range of services and address the unique aspects of delivering rehab, primary, and specialty care. SCI/D veterans require more nursing care than the average hospitalized patient. Additionally, in SCI/D LTC units, the distribution of severely ill veterans is even more pronounced as a sizable portion requires chronic pressure ulcer, ventilator and tracheotomy care due to secondary complication of SCI/D issues.

The demand for additional LTC facilities in SCI/D is ever-present. From 2009 to 2013, the VA increased required available beds in LTC units at SCI/D centers by an annual average of 16 percent. However in 2014, the number of SCI/D LTC beds was not increased. Since 2009, the number of SCI/D veterans in those LTC units has increased by an average of more than 14 percent per year. Often, the existing LTC units do not have space available for new SCI/D veterans and thereby have long waiting lists for admission. An increase in SCI/D LTC required beds would reduce or eliminate waiting lists and ease the SCI/D LTC demand in the acute SCI/D centers.

Currently, the VA operates only five (5) SCI/D LTC facilities, with the newest facility being located at the Long Beach VA Medical Center. In 2014, PVA conducted a survey of its members in certain geographic regions regarding their LTC plans. The percentage of members that stated they planned to live at an SCI/D LTC Center ranged from seven (7) percent to 20 percent. The San Diego/Long Beach region responded the highest for likelihood to use an SCI/D LTC center. However, currently there is only one SCI/D LTC unit with a capacity of 12 inpatient beds. Unfortunately, this woefully inadequate number of beds available barely

addresses the high demand in that region. In fact, residing in an SCI/D center was the third most common response behind residing with family and not being sure of one's LTC plans.

In anticipation of the need for additional LTC services among the SCI/D veteran population, PVA conducted a survey in 2013 and 2014 to examine the non-VA LTC landscape. More than 400 VA-contracted skilled nursing homes and State Veterans Homes within a 50-mile radius of the 25 SCI/D centers were contacted. Three hundred and forty-three (343) skilled nursing homes, including 19 State Veterans Homes completed the survey. The results were astounding. Only 49 (approximately 14 percent) VA-contracted nursing homes accepted ventilator patients. Only nine of the 49 facilities were on the East Coast; 25 were in the central US; and 16 were located on the West Coast. Additionally, State Veterans Homes cannot ease the ventilator caseload as none of the State Veterans Homes surveyed could accept ventilator patients. Private skilled nursing facilities are generally not trained and staffed to care for SCI/D veterans. They also lack the equipment needed to treat the most severe cases. Thus, a plan to increase purchasing of LTC at VA-contracted nursing homes would be detrimental to SCI/D veterans.

While VA has identified the need to provide additional SCI/D LTC facilities and has included these additional centers in ongoing facility renovations, such plans have been pending for years. To ensure that SCI/D veterans in need of LTC services have timely access to VA centers that can provide quality care, both the VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing SCI/D LTC facilities. PVA, in accordance with the recommendations of *The Independent Budget* Policy Agenda for the 114th Congress, recommends that VA SCI/D leadership design an SCI/D LTC strategic plan that addresses the need for increased LTC beds in VA SCI/D centers.

ENSURE EFFECTIVE OUTREACH BY VA TO VETERANS WITH SPINAL CORD INJURY/DISEASE—PVA members, as well as all veterans with spinal cord injury served by the VA (approximately 43,000), are encouraged to complete annual examinations at spinal cord injury centers. This preventive health measure helps prolong veterans' lives and maintain good health, while also allowing the VA to study longitudinal information on the course of spinal cord injury and disease over individuals' lifetimes.

Unfortunately, we still encounter too many cases where veterans do not know they are entitled to an annual examination or have not been encouraged by a VA clinician to complete one. As a result, those veterans eventually end up at one of the 25 VA SCI Centers; however, instead of preventative care, it is to treat a severe bedsore, a renal, circulatory, or respiratory condition that has progressed to a point requiring critical intervention, or another acute health condition typically associated with spinal cord injury or disease.

PVA believes an adequately staffed system of care with statutorily mandated staffed beds, coupled with a proactive outreach and education program, will improve what is already regarded as the best spinal cord injury and disease system of care in the world while also guaranteeing the best health care option for catastrophically disabled veterans. Ultimately, while the VA Choice program may serve other segments of the veteran population well (an assertion that is clearly debatable), our members have overwhelmingly made their choice. That choice is the VA spinal cord injury system of care. Congress and the Administration owe it to those veterans to ensure that choice is indeed a viable one.

MAINTAIN CHOICE OF PROSTHETICS AND TIMELY ACCESS TO REPAIR SERVICES—For all PVA members, access to high quality prosthetics in a timely manner is nearly as important as

basic health care. Prosthetics equipment, ranging from power wheelchairs to orthotic devices to personal equipment, are life-changing devices that veterans rely upon to replace lost function and regain independence and normalcy. Unfortunately, prosthetics policy and issues have become so esoteric that they do not hold the interest and attention of our members of Congress. And so, VA is left to implement ever-changing policies that simply eliminate choices for prosthetic equipment and make it harder to receive necessary equipment in a timely manner, while the Committee conducts very little substantive oversight to address these issues. The House VA Committee in particular has focused on prosthetics purchasing so as to suggest that buying these devices off-contract is an unacceptable proposition when in fact it is a necessity to support the specific needs of catastrophically disabled veterans.

While PVA wholeheartedly supports any effort to ensure the government gets best value for its purchases in terms of price and quality, a number of VA facilities have implemented prosthetics policies that are inconsistent with VA central office interpretation of policy. This variability forces some veterans to live with limited choices for equipment that they need to live independently. For example, some prosthetics departments in the VA limit the brand, type, and style of wheelchair that our members can receive, while other facilities afford catastrophically disabled veterans the benefit of making choices that are the most conducive to their identities, independence, individual circumstances and lifestyles, as outlined in VHA policy.

To put it bluntly, veterans are not mere commodities that can be connected to the cheapest parts the government can procure at the expense of their self-identities. PVA believes VA must be held accountable for maintaining consistent application of VHA prosthetics policies across the health care system, to include to timely access to prosthetics repair services at VA expense. The Committees should direct their focus on how veterans are not being uniformly served across the entire prosthetics system of the VA, rather than worry about whether the VA is purchasing equipment and parts through a FAR-based contract.

EXPAND ELIGIBILITY FOR VA CAREGIVER SUPPORT SERVICES—The current VA Comprehensive Family Caregiver Program is only available to a veteran seriously injured due to their military service on or after September 11, 2001. Unfortunately, the majority of PVA members are excluded from the Family Caregiver Program because of the arbitrary selection of the September 11 date, or because the law excludes veterans with serious diseases such as Amyotrophic Lateral Sclerosis (ALS) and Multiple Sclerosis (MS), both of which have a catastrophic impact on activities of daily living, and eventually leave veterans dependent on caregivers. No group of veterans better understands the importance of caregivers than PVA members.

Congress should eliminate the unjust date of injury requirement and include “service connected illness” as a criterion for the program. The fact that this clearly inequitable program is still established in this manner reflects the misplaced priorities of Congress. Expansion of this critical program will provide a significant number of catastrophically disabled veterans and their caregivers’ access to critically needed support services.

Caregivers are the most important component of rehabilitation and eventual recovery for veterans with catastrophic injuries. Their wellbeing directly impacts the quality of care veterans receive. No reasonable justification, other than cost considerations, can be provided as to why pre-9/11 veterans with a service-connected injury or illness should be excluded from the caregiver program.

The caregiver program includes respite care, a monthly stipend, paid travel expenses to attend veteran's medical appointments, and healthcare through CHAMPVA. Without these support services the quality of care provided by the caregiver is threatened and the veteran is more likely to be placed in a costly institutional setting. Both the exclusion of "serious illnesses and diseases," and the use of the "date of injury" as eligibility requirements for such an important benefit are unjust. As a result, the veteran and their family suffer.

As the largest cohort of veterans (Vietnam era), the demand for long-term care resources will continue to grow significantly. Catastrophically injured veterans will require the most intensive and expensive institutional care. By providing their caregivers the means to care for them at home with family, they will have the opportunity to live more normal lives while also delaying the costs of institutional care. PVA urges passage of S. 1085, the "Military and Veteran Caregiver Services Improvement Act" and H.R. 2894, the "Care for All Veterans Act," legislation that would expand access to veterans injured before September 11, 2001. This bipartisan legislation would open eligibility for VA's comprehensive caregiver assistance benefits to veterans with severe injury, regardless of the date.

PROVIDE PROCREATIVE SERVICES FOR CATASTROPHICALLY DISABLED VETERANS—The VA does not provide health care benefits for procreative services to veterans with a service-connected condition that prevents the conception and gestation of a child. Reproductive assistance provided as a health care benefit through VA would ensure that these veterans are able to have a full quality of life that would otherwise be denied to them as a result of their service.

For many, one of the most devastating results of spinal cord injury or disease is the loss or compromised ability to have a child. As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries from explosive devices that have made them unable to conceive a child naturally. While the Department of Defense does provide reproductive services to service members and retired service members, VA does not. When veterans have a loss of reproductive ability due to a service-connected injury, they must bear the total cost for any medical services should they attempt to have children. It is often the case that veterans cannot afford these services and are not able to receive the medical treatment necessary for them to conceive. For many paralyzed veterans, procreative services have been secured in the private sector at great financial and personal cost to the veteran and family.

PVA has long sought inclusion of reproductive services in the spectrum of health care benefits provided by the VA, and further recommends amending title 38 U.S. Code, Section 1701(6) to include reproductive assistance as standard VA medical care. Reproductive assistance services must include care and delivery options for fertility counseling and treatment for service-connected veterans and their spouses. Improvements in medical treatments have made it possible to overcome infertility and reproductive disabilities. Veterans who have a loss of reproductive ability as a result of a service-connected injury should have access to these advancements.

Reproductive assistance provided as a health care benefit through VA would ensure that these veterans are able to have the highest quality of life that would otherwise be denied to them as a result of their injury during service. PVA urges the House of Representatives to pass H.R. 2257, legislation that would correct this prohibition once and for all. Similarly, we urge the Senate to pass S. 469, the "Women Veterans and Families Health Services Act."

We were particularly disappointed to see S. 469 pulled from a Senate VA Committee legislative markup last summer due to partisan squabbling over political ideology. If this country is to uphold its moral obligation to make whole those men and women who have been sent into harm's way and returned broken, then it is time for this legislation to be enacted. If a member of Congress wants to debate the moral issues they believe supersede the need to do the right thing for these men and women who have sacrificed so much, we suggest that they meet these men and women face-to-face and explain to them why they cannot support this legislation. Ultimately, it is Congress that sends young men and women into harm's way, and it is Congress that has a moral obligation to restore to veterans what has been lost in service, to the fullest extent possible.

INCREASE FUNDING FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FY 2017— PVA, along with our partners in *The Independent Budget*, believe that the FY 2017 VA Budget Request is a generally good budget. The Administration's budget request is $78.7 billion in total discretionary spending for FY 2017. When considering the additional $5.7 billion that the Administration projects spending from the Choice Act, the total projected expenditure from VA in FY 2017 is approximately $84.2 billion. *The Independent Budget* veterans' service organizations (IBVSOs) recommend $84.4 billion in total funding for the VA.

PVA believes that significant attention must be placed on ensuring adequate resources are provided through the Medical Services account to ensure timely delivery of high quality health care. We are generally pleased with the Administration's revised overall medical care funding level for FY 2017, and overall discretionary funding level, but believe the advance appropriations recommendation for Medical Services in FY 2018, approximately $54.3 billion, is woefully inadequate to meet continually growing demand for health care services. The Administration appears to have punted responsibility for properly addressing the funding question for VA medical care to a new Administration following this fall's election. This is an unacceptable proposition. For FY 2018, the IBVSOs recommend approximately $64 billion in advance appropriations for Medical Services.

Similarly, PVA has serious concerns about the massive expenditure growth in community care spending in FY 2017 totaling $12.2 billion. While we understand the need for leveraging community care to expand access to health care for many veterans, as discussed in *The Independent Budget* framework, we are troubled by the rapid growth in this area of health care spending. Congress and the Administration must ensure they devote critical resources to expand capacity and increase staffing of the existing health care system, particularly for specialized services such as spinal cord injury or disease, not just punt this responsibility into the private sector. Simply outsourcing more care to the community will ultimately undermine the larger health care system, which many veterans with the most catastrophic disabilities rely upon.

Also as we have previously stated, we believe the advance appropriations amount for FY 2017 provided for by Congress in the "FY 2016 Consolidated and Further Continuing Appropriations Act," approved in December 2015, is insufficient to meet the full demand for services being placed on the system. For FY 2017, the *IB* recommends approximately $72.8 billion for total Medical Care. Congress recently approved only $66.6 billion for total Medical Care (based on an assumption that includes approximately $3.3 billion for medical care collections).

VETERANS HEALTH CARE REFORM—Veterans health care reform will remain a sharp focus of debate in 2016. Our priority is to ensure that these reform efforts guarantee care that is high quality, accessible, comprehensive and veterans-centric. PVA strongly believes that veterans

have earned and deserve to receive high quality, comprehensive, accessible and veteran-centric care. In most instances, VA care is the best and preferred option, particularly for veterans with SCI/D and other specialized health care needs. However, we acknowledge that VA cannot provide all services to all veterans in all locations at all times. This became clear from the access crisis that came to the forefront in April 2014 and has continued to burden the VA as more and more veterans seek care from, and through, VA. Adequate resources should be devoted to building a comprehensive health care system within VA supported by a dynamic, integrated health care network that leverages private sector providers and other public health care systems to expand viable options. This is essentially the concept the VA has proposed in its community care consolidation plan and is mirrored by the framework the IB has presented as well.

PVA has worked with VA staff as well as our partners in the VSO community throughout the development of the new Veterans Choice Program, a plan to consolidate all non-Department provider programs. Many of our key recommendations were incorporated into that plan, such as ensuring through care coordination that VA remains accountable for the care veterans receive, regardless of where that care is delivered. As such, PVA generally believes that the VA community care consolidation plan is a very good one. It clearly represents a model of how health care should be delivered. In fact, it mirrors in many ways the veterans' health care reform framework that PVA, along with our partners in *The Independent Budget* have presented.

The Independent Budget framework offers comprehensive policy ideas designed to immediately impact the delivery of care. It also lays out a strategic, long-term vision for a sustainable, high-quality and veteran-focused health care system that we believe veterans have earned and deserve. Our historical expertise and extensive interaction with veterans around the country leads us to confidently conclude that veterans prefer to receive their care from VA. They like the quality of care received, and they believe VA is best suited to provide veteran-specific health care. This is particularly true of veterans with spinal cord injury or disease, as there is not comparable specialized care in the private sector. To ensure that reforms focus on veterans' experience, service delivery, management and accountability, our framework should inform and drive future legislative and regulatory proposals.

As Congress considers the VA's new Veterans' Choice Program, PVA believes some critical concepts should also be considered. Specifically, PVA supports a shift in access eligibility from arbitrary standards (such as the current 30-day wait time and 40-mile travel distance standards in the Choice program) to one of clinical need and patient/doctor decision-making. We propose removing the arbitrary wait time and distance analysis which is non-existent in the private sector.

PVA supports employing a Quadrennial Veterans Review, similar to the Quadrennial Defense Review. The ability to take the long view of prospective personnel and infrastructure resources will offer continuity of planning across administrations and better prospects for meeting future demand with sufficient resources. Similarly, we believe a fundamental change in the workforce culture through a holistic approach focused on more than firing employees is essential. Strengthening VA's ability to recruit, train and retain quality professionals, particularly in the SCI system of care, dedicated to placing veterans' interests first is critical to restoring faith in VA.

Ultimately, Congress and veterans service organization stakeholders must ensure that the highest quality health care is delivered in a timely manner, both inside of the VA health care system and outside in the private sector.

FUND VA INFRASTRUCTURE—VA currently has 153 hospitals, more than 800 community-based outpatient clinics (CBOCs), and 161 extended-care facilities and domiciliaries. Additionally, the VA operates 25 spinal cord injury centers that serve the needs of PVA members. Unfortunately many of these facilities are aging and struggling to meet the needs of today's veterans. In 2004, VA's capacity was at 80 percent. Today it sits at nearly 120 percent, despite more care being sent into the community, while the condition of the facilities continues to decline. Moreover, the VA Secretary has testified in the past that it has more than 1,000 buildings that are more than 90 years old and many that are more than 100 years old.

Over the past few years VA's budget request and Congress's VA construction appropriations have fallen far short of actual need. While the Major Construction appropriation provided by Congress last year was a positive step forward, it is certainly not enough to overcome years of chronic underfunding and another woefully inadequate construction request for FY 2017. Of grave concern to PVA is the Administration's terribly inadequate funding request for Major and Minor Construction in the recently released budget request. For FY 2017, the VA recommends only $528 million for Major Construction and $372 million for Minor Construction. The IBVSOs recommend $1.5 billion for Major Construction and $749 million for Minor Construction. VA leadership's reasoning for these inadequate requests is particularly galling—they would prefer to wait and see what recommendations the Congressionally-mandated Commission on Care makes with regard to infrastructure before committing significant new resources to projects. This despite the fact that the VA currently has more than 30 major construction projects that are either partially funded or funded through completion, but in which construction is incomplete.

Likewise, as previously mentioned, there is an immediate and dire need for long-term care for spinal cord injured veterans. VA projects at Brockton, Bronx, Dallas, and San Diego have already been designed and would provide approximately 200 SCI/D long-term care beds, yet they have inexplicably been delayed or put on hold. It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion.

It is important to remember that VA facilities are where our veterans receive care, and they are just as important as the physicians and staff who deliver that care. A VA budget that does not adequately fund facility maintenance and construction will continue to negatively impact the quality and timeliness of veterans' health care.

Chairmen Miller and Isakson, and members of the Committees, I would like to thank you once again for the opportunity to present the issues that impact PVA's membership directly. As the VA continues to evolve in a manner that can improve access to veterans seeking care, it will be imperative to remember that any changes to the VA health care system will affect our members, and other veterans with specialized health care needs, who use the VA almost exclusively for services. We cannot impress enough the need to preserve and strengthen the VA health care system while more resources, including the community, are leveraged to expand access to care.

We look forward to continuing our work with you to ensure that veterans get timely access to high quality health care and all of the benefits that they have earned and deserve. I would be happy to answer any questions that you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2015

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $425,000.

Fiscal Year 2014

No federal grants or contracts received.

Fiscal Year 2013

National Council on Disability — Contract for Services — $35,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations, which in some cases are U.S. subsidiaries of non-U.S. companies.

AL KOVACH, JR.

NATIONAL PRESIDENT

Al Kovach, Jr., of Coronado, CA, was re-elected national president of Paralyzed Veterans of America (Paralyzed Veterans) during its 69th Annual Convention, held in May 2015.

A member of the elite U.S. Navy SEALs, Kovach broke his neck in a parachuting accident in 1991. Kovach has served at the highest levels of leadership within the organization since 2007. He began service to the organization in 1991, at the chapter level as government relations director for the Cal-Diego Chapter in San Diego, and has since served on its board of directors.

Kovach has been a two-time winner of the LA Marathon, a participant of the 1996 Paralympic Games, and completed a 3,700-mile transcontinental triathlon. He was selected as San Diego Hall of Champions' Disabled Athlete of the Year in 1999. He was honored by KPBS in San Diego as a "Local Hero" in October 2013, during "Disability Awareness Month."

In 2015, Kovach received the "Breaking Away Award of Excellence" from KUSI News and Torrey Pines Bank, in recognition of his commitment for improving the quality of life for veterans and all people living with spinal cord injury or disease.

A native of Philadelphia, Kovach attended Indiana University (1983-1987), and was a member of their legendary swim team before joining the Navy in 1988. He and his wife, Magaly, reside in Coronado, CA.