STATEMENT FOR THE RECORD OF

PARALYZED VETERANS OF AMERICA

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

PROPOSED LEGISLATION

OCTOBER 24, 2017

Chairman Roe, Ranking Member Walz, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to provide comments on these critically important bills being considered before the Committee today. Since the establishment of the Veterans Choice program in 2014, VA has struggled with ever-changing requirements enacted by Congress to the program and significant new demand for these services. The uncertain nature of the Choice program over that time period caused unnecessary complications in the implementation of the program. However, the Department of Veterans Affairs (VA), with assistance from its community partners and the third party administrators, has made great strides to improve the program. The draft bills being considered today lead to the next logical step of solidifying this program once and for all. That being said, concerns still remain.

Draft Bill to Make the Veterans Choice Program Permanent
Draft "Veteran Coordinated Access & Rewarding Experiences (CARE) Act''

Given the similar nature of the two primary draft bills being considered regarding future of the Choice program, we will address the provisions of both bills together in our statement. We would like to say up front that we do not explicitly oppose either draft bill. However, we do believe that the bill presented by this Committee provides a much better path forward for the implementation of the Choice program. It is also important to understand that some of the provisions in both bills mirror one another.

Before the Committee takes steps to reform the delivery of veterans' health care in the community, it is important to affirm that specialized services are part of the core mission and responsibility of VA. As the Department continues the 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 level of complex care that, more often than not, only VA can deliver. This includes VA's decision to continue concentrating all of its energy on expanding the Choice Program balanced against the need to demonstrate how it plans to make its own services more competitive with the private sector—a key component of the proposed high-performing network.

In recent months, VA has indicated that, along with improving the delivery of care in the community to veterans, it plans to concentrate on expanding and improving what it considers "foundational services." However, we have yet to see any indication of how this concept is defined. Moreover, we are troubled that VA is inclined to have local facilities determine what should be defined as foundational based on local markets. The Secretary has indicated that it considers spinal cord injury and disease (SCI/D) care and blinded care foundational services. However, he must make that policy unequivocally clear to all networks and all facilities. Additionally, we do not believe foundational services end with just those areas; there are many areas of service within VA that inform the principle of veteran-centric care. We appreciate the fact that the Secretary has committed to expanding SCI/D nurse staffing by approximately 1,000 new positions. Guidance has been directed towards the field to set aside approximately five percent of funds from special use funds to be used to augment foundational services. Unfortunately, we are not certain that the steps to set aside those funds are actually pointed towards strengthening those foundational services. These concerns about foundational services cannot be dismissed simply in the interest of focusing attention on more community care.

As we have stated repeatedly, any legislation designed to reform VA health care must incorporate or match the attributes that make VA's specialized services strong. For example, VA utilizes outcome-based standards of care across the SCI/D system, which, in turn, allows us to measure and scrutinize the quality of care provided. The system is governed by comprehensive policies laid out in Veterans Health Administration (VHA) Directive 1176 and the corresponding handbook governing procedures. These authorities require VA to track the SCI/D population in a variety of ways, specifically capturing data on outcomes. When individual facilities are lagging behind, the evidence is not just anecdotal. VA's facilities are also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission. When the entire system is questioned, Congress can commission an independent assessment, similar to the

one carried out as part of the original Choice legislation. VA officials can also be called to testify about the conditions of care in VHA facilities.

Congress should examine more closely how VA will monitor the quality of care veterans are receiving in the community. This question goes beyond a plan for care coordination. If VA is unprepared to retain ownership of responsibility for care delivered in the private sector, Congress will be helpless in conducting adequate oversight. Moreover, it places a spotlight on one of the fundamental principles of both bill that presumably dictates access to community care—VA facilities not meeting an undefined quality standard. Clear comparisons need to be made between the VA and the local community when decisions about choice are made to ensure that unbiased decisions are made.

With this in mind, PVA strongly supports the concept of developing a high-performing integrated health care network that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. The Committee's draft proposal clearly considers this concept at the center of its bill. The VA has emphasized all along that it would like to evolve into a dynamic, high-performing network model. And yet, the proposed CARE Act does not address the need for a high-performing network at all. VA apparently believes it has the authority to establish such a network without Congressional approval. We disagree. Absent a clear plan with the design of a fully-integrated health care network, we defer to the concepts proposed in the Committee draft bill as the best path forward.

PVA believes, like many stakeholders and members of Congress, that the definition of an integrated VA network is one that utilizes private providers to supplement, not supplant, the VA health care system. Unfettered choice of provider granted to all veterans is not a realistic or financially viable basis for a healthy VA health care system capable of sustaining critical, veteran-centric, specialized services. In fact, at the end of the Committee round table held earlier this month, Chairman Roe emphasized that the notion of unfettered choice is a false choice. He explained that the only people who get unfettered choice in their health care in America are those who pay completely out of pocket. Otherwise, all other people seeking health care do so through variously defined types of managed care. This is a critical point as some continue to advocate for unfettered choice within VA. It is cost-prohibitive and, in many cases, leads to fractured care as veterans attempt to navigate the private health care system without managed care coordination.

We believe that the design and development of VA's network must be locally driven using national guidance, and it must reflect the demographics and availability of resources within that area. VA has taken the first steps toward this goal by conducting its pilot market assessments using three individual VHA facilities and their surrounding health care markets. Unfortunately, none of the stakeholders, particularly in the VSO community, have seen the findings and methodology developed from these test markets. If that methodology does not include a component that considers the actual wants and needs of veterans in the given community (market), then we believe it is a flawed process.

Our philosophy is that the development of VA's network of providers should be locally driven, contemplating demographics, demand and availability of resources within that particular area. It

is more, though, than just filling access gaps. Quality, both within VA and in the community, is inextricable from this analysis. It should be a critical factor in determining whether VA should continue to offer a service or if it should capitalize on segments of the community that are already delivering that service with excellent results. Similarly, just because VA is offering poor quality in a particular service line does not automatically mean there is a second choice available in the community. VA is obligated to raise the quality in its own house in those circumstances. Moreover, the Committee bill requires that the VA publish its wait times on a monthly basis seemingly as a measure of quality and as a means to determine potential access to community care. We recommend that wait time data for all facilities with each health care market, to include VA and private providers, should be provided to afford veterans a clearer perspective. A well-balanced network that supplements service gaps in VA's system sets a natural boundary for the network. It is efficient and preserves VA core competencies and specialized services such as spinal cord injury and disorder care.

PVA supports the Secretary's plan to move the Department away from the current 30-day/40-mile eligibility standards in favor of a case-by-case clinical determination. The Committee's draft bill targets the same desired end goal. Access decisions dictated by arbitrary wait times and geographic distances have no comparable industry practices in the private sector. This change would shift the organizational mindset and focus of VA to clinical outcomes instead of catering to arbitrary metrics governing access to care in the community. We have consistently advocated for this proposition before Congress and the administration, stating that eligibility and access to care in the community should be a clinically-based decision made between a veteran and his or her doctor. Establishing appropriate eligibility standards will be an integral part of a sustainable network.

We do remain concerned that the Committee draft bill sets up a scenario all but asking the VA to fail by requiring an annual capacity assessment of each VISN and VA medical center. The administrative burden of doing this on an annual basis will almost certainly lead to bad information and incomplete data. These assessments should be spread out to be done less frequently. Considering that it took months for VA to complete three pilot market assessments, we cannot see how VA will effectively accomplish this task. Fortunately, in discussions with the Committee, there is clearly an openness to modifying this requirement to better align with the capabilities of the VA to complete these important assessments on a recurring basis. It would also align expectation with what is currently being debated in the context of the "Asset and Infrastructure Review Act."

VA will be able to make greater strides, especially in rural areas, if given the ability to bring more community providers into the fold with flexible provider agreements. The current requirement that providers enter into agreements with VA governed by the federal acquisition regulation (FAR) system has suffocated VA's attempts to expand access to care in a timely manner. Smaller health care provider organizations otherwise disposed to serve the veteran population are especially resistant to engaging in the laborious FAR process. And yet they remain vital to filling the gaps in health care services in certain areas.

The CARE proposal focuses a great deal of attention on the need for provider agreements establishing the authority for Veterans Care Agreements. We are pleased to see that the proposed

Committee bill also provides for the authority to enter into Veterans Care Agreements. PVA, along with our partners in *The Independent Budget*—DAV and VFW—have strongly supported the need to give VA this authority over the last two years. These agreements are critical to filling gaps that may be left by an integrated network.

One area of this debate that has received very little attention is that of Native American veterans and the Indian Health Service (IHS). The VA CARE Act does not explicitly address the existing agreements with IHS and tribal governments. Due to the unique relationship that exists between VA and IHS and tribal governments, we urge the Committee to revise the draft language in its bill so it does *not* consider IHS and tribal health programs (THPs) as part of the core provider network. This request was made explicitly clear by tribal governments during consultations with VA in 2015 and 2016. IHS and THPs must be allowed to continue to set up agreements directly with VA as part of the government-to-government relationships. According to the VA's 2016 Tribal Consultation Report tribes have uniformly opposed any proposal to consolidate IHS and THPs into a standard community care program.

VA responded to the tribes' concerns stating that they will "ensure VA's consolidated community care program allows for the continuation and growth of the unique relationship that tribal health programs have with VA." It is our understanding that VA intends to hold these agreements harmless from the impact of the CARE Act. However, VA has not provided any details on how IHS and THPs will be treated in their proposal should the national IHS-VA Reimbursement Agreement expire on June 30, 2019, as it is currently scheduled to do. It appears THPs and IHS would be relegated to community provider status which would disrupt the care currently being provided to 9,000 unique Native American veterans among the 99 tribes who had finalized agreements at the end of 2016. PVA urges Congress and VA to ensure the legislation put forward dutifully fulfills the federal trust responsibility to provide access to health care eligible native veterans.

PVA, along with our partners in the VSO community, continue to advocate for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care. This is consistent with current health care trends, and greater utilization could provide a relief valve to VA emergency services, the Choice Program, and the system as a whole. VA previously proposed in its Plan to Consolidate Community Care Programs a more common sense determination of what constitutes reimbursable emergency and urgent care, thereby expanding access, but it came with the imposition of cost-sharing for otherwise exempt veterans. We strongly oppose co-payments for veterans who are currently exempt. Using co-payments as a means to discourage inappropriate use of emergency care by service-connected veterans is not an acceptable method of incentivizing behavior. Unfortunately, the VA's proposed CARE Act retains the possibility of all eligible veterans having a co-payment requirement to access "walk-in care," albeit with the Secretary having discretion to limit the co-payment requirements based on Priority Group. What the CARE Act fails to do is exempt all veterans who currently are not required to pay any co-payments from paying when they access "walk-in care." Any final legislation should affirm this exemption unequivocally.

While there was the promise of an urgent care benefit from the VA's originally proposed community care plan, the proposal has evolved to provide access to community walk-in care

clinics within the community care network. It remains unclear whether this is a departure from urgent care in favor of retail minute clinics, and whether it has also curtailed the number of eligible providers to those who are within the community care network. Given the disparity in quality and scope of care provided between urgent care and retail minute clinics, we would encourage this committee to seek further clarification from VA. We would also encourage the Committee to add an urgent care component to its own draft proposal or to whatever final version of this legislation is passed.

PVA continues to have serious concerns about the funding mechanism for community care going forward. *The Independent Budget*, as well as many of our partners in the VSO community, have advocated for moving all funding authorities for the Choice program (and other community care programs) into the discretionary accounts of the VA managed under the Medical and Community Care account. The Committee draft bill clearly makes this necessary change. Unfortunately, the CARE Act is unclear at best on how it addresses this question. Our interpretation of the VA's proposal is it retains the mandatory funding stream for community care. This is a wholly unacceptable proposition. Every member of this Committee and all stakeholders in this debate know that this program should not be funded through a mandatory funding mechanism. And yet, the VA insists on carrying this bad practice forward, presumably at the urging of the Office of Management and Budget (OMB), which should have no say in this matter. The Committee should without question enact the provisions included in its draft bill that would ensure proper alignment of funding authorities in the discretionary budget of the VA.

Additionally, as long as the VA continues to propose a mandatory funding proposal, we will have to deal with the unacceptable mandatory pay-for issue that the Administration continues to bring forward. A reasonable debate can be had on the merits of rounding down the cost-of-living adjustment (COLA) or on the amount that should be provided for flight school training under the provisions of the Post-9/11 GI Bill. What is not acceptable in this debate is the notion that veterans benefit reductions (benefits for service connected disabled veterans in the case of the COLA in particular) should be used to pay for access to health care, to include for non-service connected disabled veterans, in the community. The American public will not accept Congress reducing any type of veterans benefit simply because the Administration and Congress are unwilling to properly fund the expansion of health care services in the community.

Finally, PVA believes that the Committee and VA need to seriously consider the consequences for veterans when they are injured during the course of their treatment in the community. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability or health problem is incurred. Under 38 U.S.C. § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility or as a result of care delivered by a VA provider. When PVA questioned VA as to whether these protections are conferred to veterans being treated in the community, VA officials confirmed in writing that this protection, as a matter of law, does not attach to the veteran in such circumstances. If medical malpractice occurs during outsourced care, the veteran must pursue standard legal remedies instead of VA's non-adversarial process. Adding insult to literal injury, veterans who prevail in a private action are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. These include treating the resulting injuries as service-connected conditions, such as a botched spinal surgery

resulting in paralysis where the veteran did not provide adequately-informed consent. It also includes access to adaptive housing and adaptive automobile equipment benefits should the veteran require these features. Furthermore, the limits on these monetary damages vary from state to state leading to disparate results for similarly-situated veterans. The disparity in outcomes and the different processes by which they are achieved are unacceptable. This Committee and Congress must ensure that veterans are treated equally and that these protections follow the veteran into the community.

Ultimately, we believe the House draft proposal is a much better proposal for the future of the VA's community care program. It more adequately addresses long-standing concerns the VSO community has expressed about how to provide access to community care and how to ensure proper coordination of care. The mechanics of how it expects the VA to operate an integrated community care network are clearer. It places the proper focus on how community care should be funded going forward, recognizing that this will still be a difficult problem to overcome. The draft CARE Act leaves too many unanswered questions. The VA claims that it has a plan currently being reviewed by the White House and OMB to implement a future community care program. However, it has chosen not to share that plan with any key stakeholders. Without a clear plan for how VA intends to execute the delivery of community care for veterans, and given the clearly unrestricted authorities the draft CARE Act provides that could allow VA to go in any number of directions for delivery of those services, including a very significant expansion into the community, we believe the Committee should move to advance its own proposal incorporating key aspects of the VA draft into the final bill.

H.R. 1133, the "Veterans Transplant Coverage Act of 2017"

PVA supports H.R. 1133, the "Veterans Transplant Coverage Act." This legislation gives VA the authority to provide organ transplants to veterans from a live donor regardless of veteran status of the donor or the facility they are in. Under the current Choice program, veterans in need of organ transplants are denied due to the program's eligibility requirement. If a living donor is not a veteran, the transplant coverage is denied if the surgery is not performed at a VA facility. However, due to the very access problems that prompted the Choice program—long distance travel, inaccessible transportation, etc.—these veterans are unable to receive the care they so desperately need. Whether or not a veteran receives a necessary organ transplant should not depend on who or where the donor is.

H.R. 2123, the "Veterans E-Health and Telemedicine Support (VETS) Act of 2017"

PVA supports H.R. 2123, the "Veterans E-Health and Telemedicine Support (VETS) Act of 2017." This bill would improve access to telemedicine services from the Department of Veterans Affairs. Under current law, VA may only provide at home telehealth to a veteran if the physician and veteran are in the same state. This requirement can be a particularly troubling barrier for veterans who have specific medical or mental health needs, have moved, or live in rural communities without providers. This bill would alleviate some of these pressures by waiving the instate requirement, allowing VA health professionals to operate across state lines.

H.R. 2601, the "Veterans Increased Choice for Transplanted Organs and Recovery (VICTOR) Act of 2017"

PVA supports the intent of H.R. 2601, the "Veterans Increased Choice for Transplanted Organs and Recover Act of 2017." This bill would amend the existing Choice Program to allow veterans who live more than 100 miles from one of VA's fourteen transplant centers to seek care at federally certified, non-VA facilities. This legislation would seemingly improve access for veterans in need of organ transplants. However, it does not address the barriers to care for those veterans who live less than 100 miles of a transplant center. As we have seen over the lifetime of the Choice Program, arbitrary distance and time measurements can complicate an already confusing community care system. Much as the discussion about the future of community care in the VA has trended towards decision-making based on clinical need, we would like to see access to transplant services in non-VA facilities be based on clinical need and quality of care rather than an arbitrary mileage standard.

H.R. 3642, the "Military Sexual Assault Victims Empowerment (SAVE) Act"

PVA supports the intent of H.R. 3642, the "Military Sexual Assault Victims Empowerment (SAVE) Act." This legislation would establish a three year pilot program to furnish non-department medical care to eligible military sexual assault survivors in five locations. PVA believes Congress must enable VA to provide timely, high-quality care for veterans struggling with military sexual trauma (MST). However, it is unclear how this legislation as written will achieve that end.

The bill states the Secretary may not restrict which community provider a veteran chooses to receive care from. We would argue that such a suggestion is misleading to veterans as the participating provider must accept the payment rates of any contract the provider is already in or the rates pursuant to section 1703 of title 38, United States Code. A veteran's choice of private provider will be unimpeded provided their chosen provider accepts the established rates. It is with this in mind that we point out VA already has the authority to contract for care in the community for the treatment of MST. It is unclear what the proposed pilot would make available that is not already.

We are not convinced that the current state of VA care and contract authorities necessitates this pilot. While VA does still struggles to increase its capacity, and provide timely access to care, they are not in isolation. The same barriers to care, wait times and provider shortages, often exist in the private sector. Further, this bill makes no mention of how or if the care will be coordinated with VA. MST survivors often have multiple comorbidities and need access to services such as primary care, substance abuse treatment, housing, disability benefits and travel assistance. MST coordinators are available at every VA medical center to help veterans to access these services.

Currently all VA mental health and primary care providers must complete mandatory trainings on MST and trauma-related disorders as specified by VHA Directive 2012-004. These issues may not be commonly found in the community. There is no assurance that private providers have any such specialized training in evidence-based treatments for MST.

Draft Bill Regarding State Homes and Other Purposes

PVA generally supports the draft bill addressing state homes and other purposes. Section 1 of this proposal seeks to modify the authority of VA to enter into agreements with state homes by striking contract authority under 1720(c)(1) and relying solely on "agreements." These agreements could be entered into without the requirement that the Secretary use competitive procedures to select the party. Further it would stipulate that the partnering state home would not be subject to any law to which providers of services and suppliers are not subject to under Medicare and Medicaid programs. PVA supports the efforts to make available to veterans the long term services and supports they need and that VA be able to do so in a timely manner.

Section 3 seeks to encourage individuals to fill graduate medical education residency positions that were established by the Choice Act. The Secretary would be charged to carry out a program of educational assistance to recruit applicants. While PVA supports such intent the legislation as written is not clear what the education assistance would look like; whether it be loan forgiveness, competitive compensation, or other incentives. Similarly, there is little illumination as to how the length of the period of obligated service is to be determined.

PVA believes VA must be adequately resourced to attract the best and brightest medical professionals. There is a current and worsening provider shortage in the United States and VA must take steps to see that the veterans community be the least affected by this trend. By providing competitive incentives in exchange for a period of service, VA would become a reasonable choice for residency. Competitive incentives and loan assistance for residents can cultivate a culture of commitment by those unburdened by debt and revive areas too long stressed by continuous shortages.

Lastly, Section 4 appears to be duplicative of the intent of H.R. 2123, the "VETS Act of 2017." PVA supports the expansion of the use of telemedicine regardless of the state patient and physician are located in and would encourage the Committee to consider either of these provisions to accomplish the desired end.

Draft Legislation Regarding the Veterans Crisis Line

PVA generally supports the intent of the draft legislation that would require greater reporting and analytics of the Veterans Crisis Line (VCL). The information required by the legislation could prove invaluable in analyzing the function and efficacy of the VCL and the patterns of veterans who reach out to the VCL. However, we have a serious concern about this effort. We wonder how the Committee believes that this information that would allow individual veterans to be tracked for data collection purposes can be obtained from a veteran, who is in crisis, without potentially upsetting them further? Exactly what does the Committee believe the reaction of a veteran in crisis would be if the VCL representative asked for his or her name and last four numbers of the Social Security number in order to open up the "log" for tracking the data about that individual? That would almost certainly exacerbate the situation.

Furthermore, the bill can be interpreted as though it would blame VA in instances where veterans commit suicide. But it does not address the circumstances of the nearly 70 percent of veterans

who commit suicide who never touch VA in any way. We are more interested in knowing why those veterans do not come to VA; or where are they going for help if not VA; and what is the efficacy of that support in the community. This bill certainly is well-intentioned. The information that it seeks could certainly be valuable, but at what risk. The Committee should be very careful as it pursues the information that this draft bill seeks.

Mr. Chairman and Ranking Member Walz, we would once again like to thank you for the opportunity to share our thoughts on these critical measures. The impact of this legislation could set the course for health care delivery in the VA for many years to come, so it is important that we get this right. We cannot simply rush to a final conclusion just to claim victory. We look forward to working with each of you, the members of this Committee, and the respective staffs to ensure that VA is best positioned to deliver on the promise of the timely, quality health care in the most appropriate setting.

Thank you again. We would be happy to take any questions for the record that you may have.

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

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

Fiscal Year 2017

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — $275,000.

Fiscal Year 2016

Department of Veterans Affairs, Office of **National Veterans Sports Programs & Special Events** — Grant to support rehabilitation sports activities — $200,000.

Fiscal Year 2015

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

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.