

STATEMENT OF CARL BLAKE
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PARALYZED VETERANS OF AMERICA
FOR THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
CONCERNING
ELIGIBILITY FOR HEALTH CARE SERVICES
AS DEFINED BY THE VA CONSOLIDATED
COMMUNITY CARE PLAN

FEBRUARY 2, 2016

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today. We appreciate the fact that the Subcommittee is addressing the very serious question of eligibility for health care services for veterans through the Department of Veterans Affairs (VA) community care plan. Let me say up front, that PVA generally thinks that the VA 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*—Disabled American Veterans and Veterans of Foreign Wars—have presented to the full Committee, as well as to Senate VA Committee, the Commission on Care and the VA itself.

As eligibility dictates access to veterans health care, so too does the capacity of the systems providing that care. Over the years, the VA health care system has relied on a number of methods and standards to measure access and timeliness of health care delivery. Prior to the scandal that enveloped the VA health care system in the spring of 2014, the Department's wait-time goal was 14 days from a veterans preferred date for existing patients or 14 days from the date an appointment request was created for new patients. After the health care access crisis exposed that the 14-day goal was unattainable, VA reevaluated its standard and moved to 30 days from a veteran's preferred date. Less than a year later, VA changed its wait-time standard again to facilitate the implementation of the Veterans Choice Program. In an attempt to align its standards with industry best practices, VA elected to base its wait-time goal on clinical need first and rely on a veteran's preference when a clinically indicated date was not identified. There is no evidence to suggest that arbitrary wait-time standards are indicative of quality, rather they are bureaucratic tools to self-assess output performance. They are not a measure of quality care and to suggest otherwise is unfounded.

Over the years, VA has also relied upon a number of geographic-based access standards to determine eligibility. Through the Strategic Capital Investment Planning (SCIP) process, dating back to its fiscal year 2008 budget request, VA has used a 60-minute drive-time distance for veterans who live in urban areas and 90 minutes for veterans who live in rural areas as a standard for specialty care. In 2013, VA's long range SCIP process began to include a corporate target of 70 percent of veterans having access to VA primary care within a 30-minute drive time in urban areas and 60 minutes in rural areas. Additional geographic-based standards have accompanied statutory programs, to include 40 miles from a primary care provider (as well as 30 days) for the Veterans Choice Program, or 60-minute drive time from primary care, 120 minutes from acute care, and 240 minutes from tertiary care under Project ARCH. VA has also established geographic-based network standards for contracted programs. Under Project HERO, VA required Humana to provide access to required services within 50 miles of a veteran's home. Under PC3, HealthNet and TriWest are required to provide health care options within a 60 minute drive for veterans who live in urban areas, 120 minutes for veterans who live in rural areas, and 240 minutes for veterans who live in highly rural areas, when seeking general care. For veterans who need a higher level of care, the PC3 network must provide them with options

within 120 minutes for urban areas, 240 minutes for rural areas, and an acceptable community standard for highly rural veterans. Geographic-based access standards are another means of narrowing the scope of how VA measures its performance and simplifies the budgeting projections. Geographic-based access standards are not derived from industry best practices for the provision of health care.

The independent assessment on access standards conducted by the Institute of Medicine (IOM) determined that industry benchmarks for health care access vary widely throughout the private sector. IOM was unable to find national standards for access and wait-times similar to the Veterans Choice Program's 40-mile and 30-day standards. Instead of focusing on set mileage or days-based calculations, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients. PVA, along with our partners in *The Independent Budget*, strongly agrees with the IOM's recommendation that "decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families."¹ We believe that this concept will also best serve the needs of our members and all veterans.

The Independent Budget has reported for years that VA's access standards are not aligned with veterans' perceptions. Moreover, the IB firmly believes that federally regulated, arbitrary access standards, such as living 40 miles from a VA clinic or waiting up to 30 days for an appointment, should not inhibit a veteran's access to care. That is why we propose to move away from federally regulated access standards. Under the IB's framework, access to care would be a clinically based decision made between a veteran and his or her doctor or health care professional. Once the clinical parameters are determined, veterans would be able to choose among the options developed within the network and schedule appointments that are most convenient to them. Veterans not satisfied with clinical determinations or scheduling options would be able to seek a second clinical review of their health care needs.

¹ IOM (Institute of Medicine). 2015. *Transforming Health Care Scheduling and Access: Getting to Now*. Washington, DC: The National Academies Press

The irony of all these access standards is PVA members often travel farther than any of the other special populations of veterans served by VA, or even veterans in general seeking care from VA. It is not unusual for PVA members, and other veterans with spinal cord injury or disease (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 system of care is far and away the best option they have to meet their specialized health care needs. The access problems these veterans face are usually not wait times or distance, but the cost of travel. As a result, veterans may wait to be seen until their condition deteriorates, requiring more costly and intensive care. Congress should expand travel benefits to non-service connected, disabled veterans, to ensure they are able to receive quality specialty care. This Subcommittee is reviewing the question of eligibility without even considering this important fact. PVA believes that the 30-day and 40-mile eligibility standards that determine access under the new Veterans Choice Program (VCP) do not consider what is best for veterans with catastrophic disabilities, to include SCI/D. Moreover, arbitrary access standards will not increase eligibility or guarantee timely, quality care.

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 supports the idea to move beyond arbitrary federal standards regulating veterans' access to care in the community. However, we are not convinced that the VA's plan goes quite far enough. We believe it is time to move towards a health care delivery system that keeps clinical decisions

about when and where to receive care between a veteran and his or her doctor—without bureaucrats, regulations or legislation getting in the way.

PVA, and our IB partners, also supports the plan to expand emergency treatment and urgent care in the community. However, we strongly oppose the proposal for an across the board \$100 co-payment for emergency care and \$50 for urgent care. This proposal seemingly makes no exception for veterans with service-connected disabilities or who are currently exempted from co-payments. These veterans should not be required to bear a cost-share as it may disincentive the veteran or their caregiver from accessing emergency treatment or urgent care. For many disabled veterans who are unable to work and living off their earned benefits, a trip to an urgent care clinic for \$50 might be just enough of a burden that they delay being seen. We know this delay means an increased chance that something as seemingly benign as a small wound becomes a costly infection.

As an alternative, VA should consider establishing a national nurse advice line to help reduce overreliance on emergency room care. The Defense Health Agency (DHA) has reported that the TRICARE Nurse Advice Line has helped triage the care TRICARE beneficiaries receive. Those who are uncertain if they are experiencing a medical emergency, and would otherwise visit an emergency room, call the nurse advice line and are given clinical recommendations for the type of care they should receive. Such an advice line must have available SCI trained providers, who are able to identify potential complications specific to an SCI veteran. As a result, the number of beneficiaries who turn to an emergency room for their care is much lower than those who intended to use emergency room care before they called the nurse advice line. By consolidating the nurse advice lines and medical advice lines many VA medical facilities already operate, VA would be able to emulate DHA's success in reducing overreliance of emergency room care without having to increase cost-shares for veterans.

Additionally, PVA, as well as the IB, has raised serious concerns with the requirement that eligible veterans must be “active health care participants in VA” in order to access these benefits. The strict 24-month requirement is extremely problematic for newly

enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to limited capacity, despite their timely, good faith efforts to make appointments following their separation from military service. This barrier has caused undue hardship on veterans who are undergoing the difficult transition from military service back to civilian life, and has resulted in veterans receiving unnecessarily large medical bills through no fault of their own. VA is aware of this problem and has requested the authority to make this exemption; however, the consolidation plan does not specifically address this needed change. Furthermore, this restriction could negatively impact healthier veterans who do not need as much health care as others and may go more than two years without accessing VA care. This requirement could encourage veterans to seek unnecessary services from VA in order to remain eligible for VA's emergency and urgent care services.

Ultimately, a comprehensive health care network should not be designed to limit eligibility and exclude veterans seeking care. PVA has long argued that limiting eligibility to VA health care services undermines the intention of the Affordable Care Act (ACA). PVA played a key role in ensuring that VA health care was deemed acceptable coverage under the ACA. And yet, millions of veterans are still denied enrollment into the VA due to the prohibition on new Priority Group 8 enrollments. VA should immediately lift the ban on Priority Group 8 enrollments to make veterans who need health care eligible for these critical services. If VA will not make that decision, then Congress should pass legislation to do so.

Mr. Chairman, I would like to thank you once again for the opportunity to testify. We encourage this Subcommittee, and all of Congress, to closely examine the VA's community care consolidation plan and provide the necessary resources and support to see this plan through to implementation. While there are issues that must still be worked out with this plan, this is a real step towards ensuring greater access to critical health care services for veterans. We would be happy to answer any questions that you might 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 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.

Fiscal Year 2014

No federal grants or contracts received.

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.

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Carl Blake is the Associate Executive Director for Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.