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501(C)(3) Veterans Non-Profit

STATEMENT FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

ON

PENDING LEGISLATION

DECEMBER 17, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on some of the pending legislation impacting the Department of Veterans Affairs (VA) that is before the subcommittee. No group of veterans understand the full scope of benefits and care provided by the VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). Thus, we appreciate the opportunity to offer our observations on the bills being discussed during today's hearing.

VA's SCI/D system of care is the crown jewel of the VA's health care system. It is unequaled in the care it provides to paralyzed veterans. There are no comparable systems of such care in either the private sector or the world. PVA's number one priority is to protect this system of care. Access to the care it provides is the difference between life and death for our members and we view its existence as tied to that of our own welfare.

PVA supported the passage of the VA MISSION Act of 2018 (P.L. 115-182), which reformed VA's ability to provide timely access to care and modernize its health care infrastructure. Of particular importance to PVA were the bill's provisions that increased VA's internal capacity to provide care by improving the recruitment, hiring, and retention of highly qualified clinicians; expanded eligibility for VA's Program of Comprehensive Assistance for Family Caregivers; and established a process to address the department's aging health care infrastructure.

While the MISSION Act also allowed greater numbers of veterans to receive care in the community, it was never intended to replace or undermine VA's health care system. While community care may be a desirable and viable option for some veterans, it cannot fully meet the needs of those with catastrophic disabilities or conditions. We believe that a strong VA health care system is one in which the VA is the main provider and coordinator of veterans' care, with support from community care as required to address veterans' needs.

H.R. 10,267, the Complete the Mission Act of 2024

Although we do not believe codifying access standards would improve veterans' access to care, lower wait times, improve quality, or produce better health outcomes, particularly for veterans with catastrophic disabilities, we take no position on formalizing the access standards for care received in the community (Sec. 101). We support requirements, however, for the VA to notify veterans of their eligibility for care under the Veterans Community Care Program (Sec. 102) and consider veterans' preferences in regard to how, when, and where they prefer to receive their health care, and whether the request requires the assistance of a caregiver (Sec. 103). Additionally, the Veterans Health Administration (VHA) does not have a good process to inform veterans that their requests for community care have been denied; thus, we support such notification requirements (Sec. 104). We strongly believe, however, that the VHA should provide denials in writing not just for community care but all other decisions that affect veterans' access to care.

As health care delivery evolves, we believe veterans should be afforded access to telehealth options. We support requirements for VA to better inform veterans about telehealth appointment availability (Sec. 105). We also do not object to extending the deadline for health care entities and providers to submit claims (Sec. 107).

We continue, however, to have significant reservations with proposals to apply value-based reimbursement models to VA care, regardless of where it is delivered. In value-based care, health care providers are reimbursed based on the quality of care they provide, rather than the number of services they perform. Complex health issues like SCI/D do not fit neatly into such models and could have unintended consequences for veterans with these conditions. We are unable to support such requirements (Sec. 106) until there is straightforward evidence that the care veterans with SCI/D might receive, and/or their access to it, would not be impaired through the use of such models.

We support requirements for the VA to establish an interactive, online self-service module allowing veterans to request and track their appointments and their referrals for VA community care (Sec. 201). This, coupled with publicizing average wait times for care at VA medical centers (Sec. 202) would give veterans greater control over their own medical decisions.

We support improving access to community care based on VA's access standards where required to meet veterans' health care needs. However, standardizing policies and procedures for VA's mental health Residential Rehabilitation Treatment Programs (RRTP) should be carefully thought out, and include an assessment of its availability within VA's health care system and community health care facilities. (Sec. 204). Furthermore, we must note that such care is non-existent within VA and the community for veterans with SCI/D who require assistance for other health conditions, such as bowel and bladder care. It is a well-established fact that depression is strongly associated with poor health

outcomes and exposure to higher pain levels often trigger depression among members of the SCI/D community. Having a history of mental illness or substance abuse, current mental illness other than depression, and current abuse of alcohol or illegal substances are also risk factors for depression among the SCI/D community. Substance use disorders are prevalent and associated with poor outcomes in individuals with SCI/D, with 14 percent of individuals with SCI/D reporting significant alcohol-related problems and 19.3 percent reporting heavy drinking. With its expertise in SCI/D care, the VA is uniquely positioned to provide this level of care for these veterans and should be directed to do so. Based on outreach from our members, most veterans with SCI/D want to receive their care at a VA facility. So, if Congress is sincere about completing the MISSION Act, the 119th Congress must take meaningful steps to strengthen VA's internal capacity, in particular, the department's specialized services like SCI/D and blind rehabilitation. Also, there must be meaningful discussions about what can be done to address VA's infrastructure backlog, which was a primary goal of the MISSION Act.

H.R. 214, the Veterans' True Choice Act of 2023

The Veterans' True Choice Act will allow certain veterans to choose if they want health care from TRICARE or the VA. Once a decision is made, those veterans who choose to enroll in the TRICARE program will no longer be eligible to receive VA health care while they are enrolled in TRICARE. Although it is an intriguing proposition, it is unclear how moving veterans from one strained health care system to another equally strained one would actually improve access to care for them. Thus, greater transparency about the proposal, including the level of access to care that would be provided, is needed. Also, what happens to the veteran if TRICARE fails to meet the veteran's needs? Would there be some type of "open season," like most health care programs, to allow the veteran to return to VA? More discussion and consideration of these and other issues should take place before any further decisions are made on this or similar proposals.

H.R. 3176, the Veterans Health Care Freedom Act

This bill directs the VA to establish a three-year pilot program in four Veterans Integrated Service Networks (VISNs) that would eliminate the VA MISSION Act's rules for access to non-VA care. Eventually, the program would become permanent for all VISNs. Uncoordinated care like this would most certainly lead to rapidly rising costs and draining off resources needed for VA direct care. Therefore, we have grave concerns about the impact this legislation would have on catastrophically disabled veterans.

H.R. 5287, the Veterans Access to Direct Primary Care Act

This measure seeks to establish a pilot program that would provide veterans with health savings accounts which they could use to receive primary care services in the local community. In the same manner as the previous bill, PVA has grave concerns about the impact this legislation would have on the ability of VA to provide quality, robust direct care to catastrophically disabled veterans.

H.R. 6333, the Veterans Emergency Care Reimbursement Act of 2023

On April 16, 2016, the United States Court of Appeals for Veterans Claims (CAVC) struck down a VA regulation that prevented any reimbursement to veterans for emergency care covered by third-party health insurance. The court declared that the regulation was inconsistent with Congress's unambiguous mandate to reimburse a veteran for the reasonable value of emergency treatment the veteran received in a non-VA facility. It has been over eight years since the CAVC ordered the VA to

reimburse veterans for the portion of their emergency medical costs that was not covered by a third-party insurer and for which they are otherwise personally liable. To date, the VA has not fully complied with the court ruling. PVA supports H.R. 6333, which modifies the limitation on reimbursement for emergency treatment for veterans covered by private insurance to ensure they are not forced to incur expenses that veterans without secondary health insurance do not.

H.R. 8347, the Improving Menopause Care for Veterans Act of 2024

According to the Women Veterans in the Veterans Health Administration Sourcebook, in fiscal year (FY) 2020, 45 percent of women enrolled in VHA were 45-64 years old, and an additional 15 percent were 65 or older. Between FY 2010 and FY 2020, there was significant growth among women aged 55-64, from 17 percent to 24 percent, and aged 65-74 grew from 5 percent to 11 percent. Common symptoms of menopause tend to amplify other existing conditions like depression or PTSD, emphasizing the need for VHA to be better prepared to care for and treat the complex health needs of women veterans.

PVA supports H.R. 8347, the Improving Menopause Care for Veterans Act of 2024, which directs the Comptroller General to conduct a study on menopause care furnished by the VA. The establishment of guidelines, protocols, appropriate training for medical providers, and robust understanding of the diagnosis and treatment for women veterans experiencing menopause will be essential in delivering effective health care to aging women veterans.

H.R. 8481, the Emergency Community Care Notification Time Adjustment Act of 2024

PVA supports this legislation, which seeks to clarify the reimbursement process for emergency treatment furnished in non-VA facilities. Currently, 38 C.F.R. 17.4020(c)(2), says the VA can only authorize emergency treatment if the covered veteran, someone acting on their behalf, or the eligible entity or provider notifies the department within 72-hours of such care or services being furnished and the VA approves the furnishing of such care or services. This bill clarifies the application of the 72-hour period, changing it from 72-hours from the start of treatment to 72-hours from the time of discharge, allowing veterans to focus on their recovery first.

H.R. 9924, the What Works for Preventing Veteran Suicide Act

PVA supports this legislation, which seeks to establish clear and measurable objectives and implement best practices for suicide prevention through pilots and grant programs that allow for more effective data collection. There are many factors that can contribute to suicide, and as highlighted in VA's 2023 Suicide Report, it requires everyone working together to support the implementation of a full public health approach, as outlined in the White House's Strategy Reducing Military and Veteran Suicide[1] and VA's National Strategy for Preventing Veteran Suicide.[2] VA must constantly identify new ways to decrease the number of veteran suicides and requirements laid out in this legislation would help ensure they do that.

[1] Military-and-Veteran-Suicide-Prevention-Strategy.pdf

[2] National Strategy for Preventing Veteran Suicide

H.R. 10,012, to include eyeglass lens fittings in the category of medical services authorized to be furnished to veterans under the Veterans Community Care Program

PVA supports this legislation, which would allow veterans to receive eyeglass lens fittings by a community care provider under the Veterans Community Care Program. Providing veterans with the opportunity to obtain eyeglass lens fittings by a community provider would free-up valuable resources in the VA, allowing the department to redirect them to other critical patient care needs. VA could also expand eye clinic services at its Community-Based Outpatient Clinics in the same manner that they do for audiology services now.

H.R. 10,381, the Supporting Medical Students and VA Workforce Act

PVA supports this bill, which would authorize the VA to pay for the medical education of an officer of the commissioned corps of the Public Health Service in return for a period of obligated service by such officer at a VA health care facility. Recently, the VA Office of Inspector General (OIG) found that the VHA is facing severe occupational staffing shortages.[3] Specifically, 86 percent of VA health care facilities reported severe occupational staffing shortages for medical officers, and 82 percent of facilities reported severe shortages for nurses. In fact, vacancies in these critical skill areas have been identified as severe shortages in every VA OIG annual report since 2014. Psychology was the most frequently reported clinical severe occupational staffing shortage in FY 2024 with 61 percent of facilities (85 of 139) reporting it as a shortage. It has been in the top five reported clinical severe occupational staffing shortages every year since FY 2019 and was among the top five most frequently reported shortages in FY 2018.

One of PVA's top priorities is to ensure proper staffing in VA's health care system. Without proper staffing, veterans may be forced to accept care in the community, even when it is not their choice to do so. PVA believes this legislation will help fill some of VA's most critical staffing needs and offers a viable solution for attracting health care providers to the VA.

PVA would once again like to thank the subcommittee for the opportunity to submit our views on some of the bills being considered today. We look forward to working with you on this legislation and would be happy to take any questions for the record.

[3] OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024 | Department of Veterans Affairs OIG

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 2025

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $502,000.

Fiscal Year 2023

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $479,000.

Fiscal Year 2022

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $ 437,745.

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.