

Annual Legislative Presentation
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National President
Paralyzed Veterans of America
Before a Joint Hearing of the
House and Senate Committees on Veterans' Affairs

March 9, 2017

Chairman Isakson, Chairman Roe, and members of the Committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2017 policy priorities. For more than 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.

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.

Additionally, we thought it would be appropriate to reflect on some of the important achievements in 2016. However, even in the case of some of those legislative accomplishments, significant work remains to ensure proper implementation of those new requirements.

BACKGROUND—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 unique needs. Being told that their life expectancies 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 edition of *The Independent Budget* policy agenda. We also recently released our budget recommendations to inform the debate on funding for the VA for FY 2018 and FY 2019.

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—Preserving and strengthening the VA's specialized systems of care—such as spinal cord injury and disease care, blinded care, amputee care, polytrauma care, and mental health care—remains the highest priority for PVA. As we have stated many times, the VA is the best health care provider for veterans. The VA's specialized services, particularly spinal cord injury care, follows higher clinical standards such as the Commission on Accreditation for Rehabilitation Facilities, which is not required in the private sector. We appreciate the fact that the newly confirmed Secretary of VA, Dr. David Shulkin, has strongly affirmed that privatizing health care for veterans is something that will not happen on his watch. We also appreciate that the leaders of these two Committees on both sides of the aisle have reiterated their rejection of privatizing VA health care. And yet, that pressure still exists, even from people advising President Trump on these matters.

Many advocates of 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 recognize that VA is faced with a daunting challenge given the ever-growing demand for health care services. We understand that leveraging community care is a necessary part of delivery of timely access to services, but community care must be the exception, not the rule. We cannot turn our backs on the number of veterans who reap the benefits of being treated as a "whole" person in the connective care culture at the VA, such as a woman veteran who needs specialized care for her spinal cord injury in coordination with psychological care for the Post Traumatic Stress Disorder she incurred on her third deployment to Afghanistan. She will also likely need gynecological care, anatomically specialized prosthetics, and possibly obstetrics at some point. For her, care in the

community would be a matter of piecing together a giant puzzle with each piece being only one aspect of her care. That care may come together eventually but, like a puzzle, the cracks will still be obvious even when the full picture is complete. She, and other PVA members with unique, specialized needs, are the reason PVA must carefully monitor the expansion of community care as we champion the preservation of those multidisciplinary, coordinated VA services that keep paralyzed veterans viable. We understand that leveraging community care is a necessary part of delivery of timely access to services, but community care must be the exception, not the rule.

With this in mind, we strongly advocate for Congress to provide sufficient funding for VA to hire additional clinicians, particularly physicians, nurses, psychologists, social workers, and rehabilitation therapists to meet demand for services in the SCI/D system of care. In 2015, SCI/D nurses worked more than 105,000 combined hours of overtime due to understaffing. Lack of staffing is an unnecessary and dangerous trend that has led to staff burnout, low morale and in some circumstances, jeopardized the health care of patients. Left to their own devices, too many facility directors have staffed spinal cord injury centers like non-specialty/general rehabilitation or geriatric units. VA's 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. Considering SCI/D Veterans are a vulnerable patient population, the reluctance to meet legally mandated staffing levels is tantamount to willful dereliction of duty.

TITLE 38 PROTECTIONS FOR COMMUNITY CARE—There is also another serious concern that has been overlooked in the expansion of community care access. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability is incurred or health care problem arises. Under Title 38 U.S.C. § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility. However, when PVA asked VA if this protection extends to veterans served in the community, we were told that those veterans do not have 1151 protections. If medical malpractice occurs during outsourced care, the veteran must pursue standard legal remedies unlike similarly situated veterans who are privy to VA's non-adversarial process. Adding insult to literal injury, these veterans, if they prevail on a claim, are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again.

This is simply unacceptable. Congress must ensure that these protections follow the veteran into the community. Congress must ensure veterans who receive care in the community retain current protections unique to VA health care under title 38 U.S.C., particularly including medical malpractice remedies governed by 38 U.S.C § 1151, clinical appeal rights, no-cost accredited representation, and Congressional oversight and public accountability.

IMPLEMENTATION OF THE ANNUAL CAPACITY REPORTING MANDATE FOR SPECIALIZED SYSTEMS OF CARE—As we have emphasized repeatedly, 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. We were very pleased to see that Congress reinstated this important reporting requirement late last year. However, we have serious concerns about VA's plan to re-implement this requirement.

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 acute treatment and 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 can assess its ability to meet the capacity mandate.

We also must emphasize the importance of Congressional oversight to ensure that the VA is meeting capacity requirements within the recognized specialized systems of care, in accordance with P.L. 104-262. Despite our repeated warnings about these capacity problems, the House and Senate VA Committees have conducted very little meaningful oversight specifically examining VA's ability to deliver specialized health care services.

ACCOUNTABILITY AND DEALING WITH THE ADMINISTRATIVE BUREAUCRACY OF VA—

It is no secret that VA's administrative bureaucracy has ballooned in recent years. Arguably, resources devoted to expanding administrative staff have significantly jeopardized the clinical operations of VA. We believe serious consideration needs to be given to rightsizing the administrative functions of VA to free critical resources and dedicate them to building clinical capacity.

Additionally, VA has struggled with the notion of accountability. Too often, VA staff who should be terminated are "removed," but not in the way the ordinary citizen in the workforce would envision that action. VA has allowed too many VA employees who have compromised the public's trust to collect a full paycheck while under reassignment in one of those positions that are neatly tucked away from public view, or to simply retire with full benefits. The public has grown tired of this happening. So have America's veterans. We implore Congress to provide the new VA secretary whatever authority he needs to prevent this from continuing.

We were pleased to see Secretary Shulkin, during his confirmation hearing before the Senate Committee on Veterans Affairs, explain:

"The VA needs change...It needs to advance its culture of accountability and eliminate those from the system that have lost their commitment to doing what is right for our veterans ... I don't have a lot of patience. And I am going to be serious about making these changes and regaining that trust. And if I don't do it, I should be held accountable, and you should replace me."

We could not agree more. He knows what needs to be done; so does Congress; and the public has long known it. Now it is time for real action.

EXPAND ELIGIBILITY FOR VA CAREGIVER SUPPORT SERVICES—The current VA Comprehensive Family Caregiver Program is only available to veterans seriously injured due to their military service on or after September 11, 2001. 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.

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 service-connected injuries or illnesses should be excluded from the caregiver program.

The caregiver program includes respite care, a monthly stipend, paid travel expenses to attend veterans' medical appointments, and healthcare through CHAMPVA. Without these support services the quality of care provided by the caregiver is compromised and the veteran is more likely to be placed in a long-term care facility that would be much more costly to the government. 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 veterans and their families suffer.

Additionally, Congress should not only eliminate the unjust date of injury requirement, it should also include "service connected illness" as a criterion for eligibility for the program. The fact that this inequitable program was established in this manner reflects the misplaced priorities of Congress.

Congress continues to find excuses to deny access. It has never been more urgent for those excuses to stop. As the largest cohort of veterans (Vietnam-era) ages, 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 the veterans at home with family, they will have the opportunity to live more normal lives, while also delaying the costs of institutional care. It is time for Congress to do the right thing for all veteran caregivers.

PROVIDE PROCREATIVE SERVICES FOR CATASTROPHICALLY DISABLED VETERANS—In September 2016, Congress passed and President Obama signed into law, a temporary authorization for the Department of Veterans Affairs (VA) to provide in-vitro fertilization (IVF) to veterans with severe service-connected conditions that prevent the conception of a child. On January 19, 2017, IVF services became available through VA. However, these services are set to expire on September 30, 2018, at which time the ban on IVF goes back into effect, after which severely wounded and disabled veterans will once again, have to shoulder the total cost for any attempts to have children.

No group of veterans is more affected by the ban on IVF than PVA's members—veterans with spinal cord injury or disease. PVA has long sought an end to the VA ban on providing IVF. Procreative services 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. Congress must pass legislation to repeal the ban on IVF and make such services a permanent part of the medical benefits package at VA. It is Congress that has a moral obligation to restore to veterans what has been lost in service, to the fullest extent possible. It is Congress that sends young men and women into harm's way and it is Congress that must provide the health care that meets the needs that result from that service.

From 2001 to 2013, over 2,000 service members suffered a genitourinary injury, resulting in the loss of, or compromised ability, to have a child. While the Department of Defense does provide procreative services to service members and retired service members, VA has been prohibited from doing so. Since age is a factor in successful fertilization and completion of a pregnancy, delaying the provision of IVF services can have a deleterious effect on veterans' family building success.

While we were very excited to see procreative services made available for catastrophically disabled veterans, our work is not done. Congress must pass legislation to repeal the ban on IVF and make the service a permanent part of the medical benefits package at VA.

GREATER FOCUS NEEDED TO IMPROVE PROSTHETICS SERVICES— VA Prosthetics replaces missing parts of the body and supports bodily functions to enable veterans to regain independence and mobility. The advances in prosthetics technology and complexities of function have greatly enhanced disabled veterans' ability to assimilate back into the community. However, the cost of technology, materials development, scientific research, engineering skills, and knowledge required to produce and manufacture prosthetics has significantly increased. The sophistication to then fit the prosthetic to the disabled veterans' bodies requires individuals specifically trained to do so. No group of veterans appreciates the importance of prosthetics more than veterans with spinal cord injuries or diseases that have resulted in lost mobility.

The VA's mission is to care for the disabled veteran in a uniform and standardized manner but this is not possible. Prosthetics services vary widely from VA medical center to medical center. The primary reasons are the national Prosthetic policy is changed at local VA Medical Centers to hold down costs, a lack of training, lack of knowledge and poor communications. In addition, the VA Handbooks and Directives are woefully inadequate to the task of meeting the challenges of the advances made in prosthetics for the last 15 years. The majority is over a decade old. The VSOs have been told there are rewrites in progress, but we have not been asked to participate in the critical development phase of these directives. The result will ultimately be flawed because those VSOs most knowledgeable about prosthetics are not included in development of the final product. Lack of direct stakeholder engagement has long been a problem for VA, resulting in the need for major revisions and clarifications after the fact, once those policies are applied out of the abstract and actually impact the lives of veterans.

Automobile Adaptive Equipment (AAE) is a prime example of all that is wrong with VA prosthetics. The Handbook governing AAE was written 16 years ago. The VA is currently trying to rewrite it with a new directive, but there have been multiple delays. There was only one forum where input was sought from VSOs, and there has been no follow up from VA.

Meanwhile, the Clothing Allowance was rewritten with some input from VSOs. Unfortunately, it was finalized and distributed to the field without a review by VSOs. The document contains flaws that cause significant problems with implementation every year. The VA mistakenly believes they can work in the dark to produce policies that affect disabled veterans nationwide.

Prosthetics equipment will continue to increase in complexity and costs. The VA must meet the demand by ensuring an adequate budget, a continuous training program for prosthetic and clinical staff, and increased staff. The VA will make a serious mistake if it attempts to mitigate costs by reducing the personnel who administer the program. The VA must include its partners in more than name alone.

Another major problem the VA will have is the attempt to provide prosthetics through the community health care systems. The administrative burden for VA Prosthetics staff to properly manage, maintain the quality of prosthetics, and control the costs will lead to more delays, inappropriate and non-standard care, and will increase the complaints about the VA's delivery of these critical services. It is incumbent upon Congress to conduct more thorough oversight of the VA's prosthetics program to ensure that the VA is doing all it can to restore lost mobility and independence for veterans who rely upon prosthetics equipment and services.

THE VETERANS MOBILITY SAFETY ACT—Directly related to our concerns about prosthetics is the ongoing work surrounding implementation of P.L. 114-256, the “Veterans Mobility Safety Act.” PVA led the charge during the last Congress in passing P.L. 114-256. The adaptive automobile equipment program is an important issue for our members, as they are the highest users of this particular benefit. Veterans with catastrophic disabilities have a critical need for mobility to help maintain a high quality of life and allow them to continue to be active members of their communities despite their disabilities.

Prior to this law's enactment, VA had no requirement to ensure that adaptive equipment was being installed on vehicles in a safe and adequate manner. Although VA was required to ensure the equipment itself met safety standards, anyone willing to do the installation labor was eligible for reimbursement. The law now obligates VA to update the automotive adaptive equipment program handbook to reflect new safety standards governing equipment installation.

Attempting to satisfy the law's requirement to consult with VSO's and a host of industry and safety organizations, VA recently began the process of developing the new set of safety standards by issuing a Notice of Request for Information in the Federal Register. The shortfall of using the rulemaking process as a means of consultation in this instance is that it leaves all parties speaking at the same time. VA simply collects the comments all at once, and it is left on its own to judge the merits and second and third order effects that would result if those recommendations were implemented. This is hardly the productive dialogue that was expected in this legislation. VSOs were included in the consultation mandate to provide the perspective of the ultimate beneficiaries and vet the motives behind recommendations and proposals related to this policy. Our input helps ensure recommendations do not inadvertently benefit business interests at the expense of the disabled veterans this program is meant to serve. This Committee should call on VA to comply with the spirit of the law and carry out the required consultation through a working group once it has had an opportunity to digest the information provided through the recent notice.

IMPROVE BENEFITS FOR CATASTROPHICALLY DISABLED VETERANS—PVA believes it is time to improve benefits for the most severely disabled veterans, particularly with regards to the rates of Special Monthly Compensation.

There is a well-established shortfall in the rates of Special Monthly Compensation (SMC) paid to the most severely disabled veterans that the VA serves. SMC represents payments for “quality of life” issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to achieve sexual satisfaction or the need to rely on others for the

activities of daily life like bathing or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, PVA does not believe that a veteran can be totally compensated for the impact on quality of life; however, SMC does at least offset some of the loss of quality of life. Many severely injured veterans do not have the means to function independently and need intensive care on a daily basis. Many veterans spend more on daily home-based care than they are receiving in SMC benefits.

One of the most important SMC benefits is Aid and Attendance (A&A). PVA recommends that Aid and Attendance benefits be appropriately increased. Attendant care is very expensive and often the Aid and Attendance benefits provided to eligible veterans do not cover this cost. Many PVA members who pay for full-time attendant care incur costs that far exceed the amount they receive as SMC-Aid and Attendant beneficiaries at the R2 compensation level (the highest rate available). Ultimately, they are forced to progressively sacrifice their standard of living in order to meet the rising cost of the specialized services of a trained caregiver, expensive maintenance and certain repairs on adapted vehicles, such as accelerated wear and tear on brakes and batteries that are not covered by prosthetics, special dietary items and supplements, additional costs associated with “premium seating” during air travel, and higher-than-normal home heating/AC costs in order to accommodate a typical paralyzed veteran’s inability to self-regulate body temperature. As these veterans are forced to dedicate more and more of their monthly compensation to supplement the shortfalls in the Aid and Attendance benefit, it slowly erodes their overall quality of life.

REFORMING THE BENEFITS CLAIMS AND APPEALS PROCESS—In March 2016, PVA joined the Board of Veterans Appeals, VBA, and other major veterans service organizations to form a working group with the goal of reforming the appeals process. With the number of pending appeals recently passing 465,000 in December 2016, VA projects that the inventory will climb to over two million over the course of the next decade if the system remains unchanged. Ten years from now, veterans will expect to wait six years for a decision. PVA believes reform is necessary, but procedural reform and greater efficiency must not dilute substantive rights and benefits that veterans have earned and deserve.

Layer upon layer of substantive and procedural rights have been added over time to this unique system of administrative law governing veterans’ disability claims. But these developments also produced unintended inefficiencies and an inability to identify faults in the process. A long-term fix requires a comprehensive overhaul of the entire claims process, not just appeals. The legislation developed by this working group takes this approach. It consolidates and streamlines redundant processes, provides veterans with more information to help make strategic decisions, and increases protection of the claim’s effective date. Ultimately, the increased efficiency and information will produce faster decisions with a greater degree of accuracy, reducing mistakes that lead to avoidable delays.

It is incumbent upon the Administration to request, and for Congress to supply, the resources to implement the new framework and simultaneously tackle the ballooning inventory of appeals.

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. These aging SCI/D veterans are currently in need of VA LTC services at the 23 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 seven (7) 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 23 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 comprehensive annual examinations and preventative screenings at VA spinal cord injury and disease centers. These services help 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 23 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 some other 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.

FUNDING FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FY 2018 and FY 2019—

The IBVSOs have serious concerns about the FY 2018 advance appropriations requested by the previous Administration and subsequently approved by Congress. Last year, the former Secretary of Veterans Affairs openly admitted that the FY 2018 advance appropriations request was significantly short. He also indicated that the new Administration and Congress would have to correct this shortfall. We are concerned that this new Administration has not yet indicated its desire to correct this problem before it has catastrophic consequences for the VA. If the new Administration's budget request fails to properly address this issue, it is imperative that Congress takes necessary action to properly resource the VA health care system.

We also believe it is necessary to consider the projected expenditures under the Choice program authority that the previous Administration planned in FY 2017 and how that impacts the baseline that will dictate the funding needs for FY 2018. The previous Administration assumed as much as \$5.7 billion in spending through the Choice program in FY 2017, on top of the Medical Services discretionary funding and the newly created Medical Community Care account. That amount has now been revised to approximately \$2.9 billion. This means that the VA projected to spend more than \$59.0 billion in Medical Services and more than \$71.0 billion in overall Medical Care funding in FY 2017. These considerations inform the decisions of The Independent Budget to establish our baseline for our funding recommendations for both FY 2018 and the advance appropriations for FY 2019.

For FY 2018, the *IB* recommends approximately \$77.0 billion in total medical care funding. Congress previously approved only \$70.0 billion for this account for FY 2018 (which includes an assumption of approximately \$3.6 billion in medical care collections). The *IB's* recommendation also considers the approximately \$1 billion VA is expected to have remaining in the Veterans

Choice Fund and expected demand for care, including community care, that will not diminish or go away if the Choice Program expires.

Additionally, *The Independent Budget* recommends approximately \$82.8 billion for total Medical Care for FY 2019. This recommendation reflects the necessary adjustment to the baseline for all Medical Care program funding in the preceding fiscal years.

Chairmen Isakson and Roe, 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 stress 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) 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.

AL KOVACH, JR.



NATIONAL PRESIDENT

Al Kovach, Jr., of Coronado, CA, was re-elected for a third term as national president of Paralyzed Veterans of America (Paralyzed Veterans) in May 2016.

A member of the elite U.S. Navy SEALs, Kovach was paralyzed in a parachuting training accident in 1991. Kovach has served at the highest levels of leadership within Paralyzed Veterans 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.

In his role as national president, Kovach has delivered testimony before the U.S. House and Senate Veterans Affairs Committees, is published monthly in Paraplegia News, and has been interviewed on veterans' issues by local (CA) and national media outlets.

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.