



**STATEMENT OF GABRIEL STULTZ
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FOR THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
"EXAMINING THE VETERANS CHOICE PROGRAM AND
THE FUTURE OF CARE IN THE COMMUNITY"**

JUNE 7, 2017

Chairman Isakson, Ranking Member Tester, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to offer our views on consolidating and improving the Department of Veterans Affairs' (VA) delivery of community care. The impact that veterans health care reform will have on present and future generations of veterans cannot be overstated, and we are pleased to be part of this important discussion.

PVA's historical experience and extensive interaction with veterans around the country leads us to confidently conclude that veterans prefer to receive their care from VA. We recognize, however, that while VA remains the best and preferred option for most enrolled veterans, it cannot provide all types of services, in all locations, at all times. Care in the community must remain a viable option. But it also cannot be considered the failsafe for every situation. Few would give credence to the idea that the private health care system has excess capacity ready to absorb VA's excess patient load. More importantly, specialized services, such as spinal cord injury care, do not always have comparable services in the community. When access issues affect these systems of care, the veteran's "choice" is often simply to wait.

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 its energy on expanding the Choice Program without demonstrating how it plans to make its own services more competitive with the private sector—a key component of the proposed high-performing network. We stand behind any effort to improve health care for all veterans, which is why we support in principle what VA is trying to accomplish. But the plans we are seeing evolve fall woefully short of improving health care for the most vulnerable populations, such as those with spinal cord dysfunction and polytrauma. Sidelining these concerns while everyone focuses acutely on the next iteration of Choice is insulting and demoralizing to our members.

A few recent proposals warrant our attention at the outset. We do not, nor will we, support billing a veteran's third party health insurance for service-connected care received in a VA facility. This amounts to a wholesale abandonment of this country's responsibility to its wounded veterans. Using this tactic as a revenue generator would simply alleviate pressure on Congress to find the resources necessary to meet this sacred obligation. Congressional staff notified the Veteran Service Organization (VSO) community and attributed this proposal to VA officials.

This idea has since been retracted, but replaced with an equally disturbing funding offset—the elimination of Individual Unemployability (IU) benefits for veterans eligible to collect social security benefits. It is beyond comprehension that the Administration would propose such a benefit reduction in order to pay for a program that sometimes provides health care for non-service-connected veterans. Does this committee really believe that veterans with disability ratings between sixty and ninety percent should be the source of funding for the Choice Program? Eliminating IU benefits for veterans over the age of 62 provokes numerous questions for us. Will veterans who have statutorily protected evaluations (the 20-year rule) also be subject to reduction? Will those dependents using Chapter 35 education benefits based on their sponsor's IU rating be forced to drop out of school? Will those veterans on IU who are covered by Service-Disabled Life Insurance (a.k.a. RH insurance) at no premium be forced to now pay premiums in order to keep coverage? What about state benefits, such as property tax exemptions or state education benefits that are based on 100% VA disability ratings? How will this proposal affect efforts to combat veteran suicide and homelessness? We hope this idea will be rejected in the strongest terms.

These off-the-cuff ideas only serve to reinforce our belief that VA's community care team should continue to engage with VSO's as it plans for the future. For over two years, trust has grown through strong engagement at the policy level. We encourage the Secretary to make further engagement a priority.

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 spinal cord injury or disorder (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.

Many advocates for greater access to care in the community also minimize, or ignore altogether, the 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. We cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. The SCI/D system of care and other specialized services in VA do not operate in a vacuum. If these services decline, then specialized care is also diminished. Veterans with catastrophic disabilities rely almost exclusively upon VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers. Making VA's own facilities lean and competitive must not be taken for granted; it must be a significant part of the conversation about expanding access to care in the community.

PVA, along with our *Independent Budget* (IB) partners, Disabled American Veterans (DAV) and Veterans of Foreign Wars (VFW), developed and previously presented to this Committee a framework for VA health care reform. It includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high-quality, veteran-centered health care system. Our framework stands on four pillars: 1) restructuring the veterans health care system; 2) redesigning the systems and procedures that facilitate access to health care; 3) realigning the provision and allocation of VA's resources to reflect the mission; and 4) reforming VA's culture with workforce innovations and real accountability. With this perspective, we offer our views on consolidating and strengthening the delivery of care in the community.

I. Restructuring the system in a way that establishes integrated health care networks designed to leverage the capabilities and strengths of existing local resources in order to provide more efficient, higher quality and better coordinated care.

PVA strongly supports the concept of developing a high-performing network that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. This approach is gaining consensus among stakeholders, including the most recent and current VA Secretaries, the IB, most major VSO's, the Commission on Care, and congressional leadership. As stakeholders coalesce around this concept, though, the dynamics that govern the boundaries of this network need to be thoroughly explored.

PVA believes, like many stakeholders and members of Congress have stated, 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. 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 test run analyses using three individual VHA facilities and their surrounding health care markets. A solicitation for information was also issued to help VA develop its acquisition strategy to procure this analysis nationwide on a continual basis. We look forward to seeing this process develop.

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 same flexibility should be applied to VA's ability to manage its capital infrastructure. The recent report issued by the United States Government Accountability Office (GAO) entitled "VA Real Property" highlights the variety of challenges VA faces in trying to keep up with the ever-evolving broader health care system.¹ Whether it is adjusting capacity to reflect migration patterns of aging veterans or dealing with underutilized facilities that cannot be demolished due to a historical designation, VA must be afforded the appropriate tools to respond to changes in its operating environment. It is unfortunate that the Secretary's comments related to "closing 1,100 facilities" were met with widespread panic instead of a realization of how hard it is for VA to dispose of underutilized infrastructure and reinvest the proceeds where the money is needed.

Care coordination is another piece that has a direct correlation with quality health care outcomes. This is one of VA's strengths, and it must continue to own the responsibility for care coordination for veterans. VA's proposed Plan to Consolidate Community Care Programs revolved around the patient's circumstances, specifically the intensity of coordination needed and whether the non-VA care was being provided based on a wait time or geographical distance.² In light of VA's push toward removing the 30-day/40-mile standards for determining eligibility for community care, this feature should be revisited to accommodate the next iteration of governing criteria. We will continue to support a policy that includes VA's direct involvement in care coordination for complex cases being handled by community care providers.

PVA has another serious concern that has consistently 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 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

¹ U.S. Government Accountability Office. (April 2017). VA Real Property – VA Should Improve Its Efforts to Align Facilities with Veterans' Needs. (Publication No. GAO-17-349). Retrieved from <https://www.gao.gov/assets/690/683938.pdf> on May 6, 2017.

² Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, pp. 21-24, http://www.va.gov/opa/publications/va_community_care_report_11_03_2015.pdf.

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 a veteran receiving care in the community. 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. Congress must ensure that veterans are treated equally and that these protections follow the veteran into the community.

II. Redesigning the systems and procedures that facilitate access to care in a way that provides informed and meaningful choices.

PVA supports the Secretary's leadership in moving the Department away from the current 30-day/40-mile eligibility standards in favor of a case-by-case clinical determination. 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.

This approach requires us to confront the difficult question of how a decision is reached in the absence of arbitrary, but clear, delineations for eligibility. As the Commission on Care's report demonstrated, variations in how liberally access is granted to community care providers can have a drastic impact on cost.³ In the most expansive scenario, where VA maintains a loosely-managed network of providers and veterans have an unmitigated choice to receive care in the community, the Commission's economists found that the cost would be more than \$1.0 trillion over a decade.⁴ It is impossible to rationalize this outcome as sustainable or consistent with good governance.

An objective starting point is to allow veterans to go outside VA when a particular medical service is not provided in that facility. When VA does provide the needed service, though, the decision should be made by the doctor in consultation with the veteran. Providers should be able to sit down with a veteran and consider things such as access and availability of services and the urgency of that veteran's situation. The veteran should also have the opportunity to voice concerns over how a certain care plan will adversely or inadvertently impact him or her. Access to transportation, geographic distance and travel time can often present unreasonable obstacles to care for veterans. For example, a thirty-mile trip to a VA facility might seem reasonable on

³ Commission on Care, *Final Report*, June 30, 2016, Appendix A, p. 171-190.

⁴ *Id.*

paper, but a doctor administering a treatment plan that requires the veteran to commute three times per week may have good grounds to object to that determination.

Providers should have the ability to help educate veterans and make decisions in the context of the patient's specific circumstances. They should be able to take action when it is clear that VA offers a needed service, but a particular veteran's situation requires a higher level of expertise than what that doctor or facility can offer. Arbitrary standards should not prevent a doctor from sending a veteran out to the community when the need is urgent and VA is not prepared to administer the care in a timely fashion.

Some veterans might have reservations about their provider, i.e. VA, having the final say in whether they are eligible to utilize the Choice Program, but it is a marked improvement over the current process where bean-counting bureaucrats make decisions behind closed doors for veterans who appear to be just another number in the queue. A more pointed concern is the past institutional bias exhibited by VA employees for administering care directly in VA at all costs. VA has long had authority to contract for care, but in prior years employees demonstrated a reluctance to utilize this tool to the point that it eventually prevented timely access to care for many veterans. This behavior, though, was largely attributed to mid-level bureaucrats making decisions driven by how the funding was administered. The current funding arrangement under the Choice Program produced a welcome side-effect of removing the incentive to avoid contracting care out to the community. Over the last two years, VA's institutional behavior has been modified to a degree, and it has become more comfortable with contracting for care when the need exists.

Once the clinical parameters are determined, eligible veterans will have meaningful choices among the options developed within the high-performing network and the ability to schedule appointments that are most convenient for them. When you pair this decision-making process with a well-managed, integrated network and the structural flexibilities discussed above, it becomes possible for VA to be a competitive and sustainable enterprise. Of course, we must point out the obvious fact: none of this is possible unless we are able to get veterans out of the waiting rooms and in with the doctor to have this discussion.

PVA and our fellow IBVSO's also 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.

The Secretary was previously weighing the idea of allowing enrolled veterans to utilize urgent care in the community at the veteran's discretion. Instead of using co-payments to control costs, there would be a limit of two authorized urgent care visits per year. We supported this and encouraged the Secretary to explore the concept further. Unfortunately, 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.

III. Realigning the provision and allocation of VA’s resources to reflect the mission.

We stated in the beginning of this testimony that VA cannot provide every type of service in every locality, nor should it. In the broader health care system, patients in some hospitals face greater risk of death and complications because the surgical team conducts too few procedures. The doctors, and the members of their team, are unable to maintain their skills. The same is true for VA. Some medical centers successfully continue to expand the services they offer. Others follow suit but fail to recognize their limitations or true demand levels, and it directly impacts the quality of care throughout the entire facility. Right-sizing facilities and developing a balanced network of community providers has a direct impact on risks and health care outcomes. VA should have the ability to aggressively deal with these failures. Before condemning an entire medical center or clinic, though, it should break down its analysis to the service line level and determine where it should make adjustments or cuts, as well as where it should be growing.

While much of the focus is keyed to addressing smooth integration of community care, we reiterate that the access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system. PVA is proud to have been an integral part of the efforts that led to reinstating the capacity reporting requirement for VA’s specialized services during the last Congress. Evaluating VA’s capacity to care for veterans requires a comprehensive analysis of veterans’ health care demand and utilization measured against VA’s staffing, funding, and infrastructure. However, VA’s capacity metrics fail to properly account for the true demand on its system. The metrics are based on deflated utilization numbers that have been suppressed through census caps and limited patient admission.

The nurse shortage within the SCI/D system of care has precluded these centers from fully utilizing available bed space and forced centers to reduce the amount of veterans they admit. A decrease in the daily average census at some centers naturally follows, suggesting that there is a lack of demand in the system. In reality, veterans who want to access care are turned away because those centers lack the staff to man available beds.

A reduction in capacity to provide services is the immediate effect of staffing shortages. But second and third order effects follow and create a negative feedback loop that is detrimental to the entire SCI/D system of care. As staffing thins and those remaining behind attempt to cover more responsibility, individual patients receive less attention and staff burn out. It impacts morale and eventually erodes the overall quality of care. As this cycle takes hold, demand for care in these facilities shrinks. When VA calculates demand under these conditions, the new demand metrics have been artificially depressed and tend to justify reduced staff, further perpetuating the downward spiral.

By our estimates, VA needs an additional 1,000 SCI/D nurses. These estimates are not abstract; they are drawn from the regular, in-depth site audits our medical services staff conduct across the VHA system. At the SCI/D leadership meeting held in December 2016, nearly every chief and nurse executive answered in the affirmative when asked if empty beds would be filled if more nursing staff were hired. In May 2017, PVA leadership met with the heads of Nursing and SCI/D services. Both individuals stated that their own projections called for an additional 920 SCI/D nurses. The Secretary himself admitted the need and announced at our annual convention that VA would be hiring an additional 800 SCI/D nurses. Actions, though, speak louder than words.

The pathway to proper staffing begins with the revision and recertification of VHA Directive 2008-085, Spinal Cord Injury Center Staffing and Beds, which required updating in December 2013. Despite our constant advocacy, it remains antiquated. A modernized nurse staffing methodology is available. It was developed and field tested in order to address clinician understaffing at virtually every SCI/D facility. It factors in the increasing medical needs of an aging population and wait times for inpatient annual physical exams and extended care. If VA truly intends to strengthen its “foundational” services, this is where it needs to start. It should be part and parcel of building a new Choice framework, not an afterthought.

We note that VA ventured down this road unsuccessfully in the past. A GAO report in October 2014 revealed that VA utterly failed to address staffing shortages after years of trying to implement a nationally standardized methodology for determining an adequate and qualified nurse workforce.⁵ Specifically the report found a lack of oversight and a failure to ensure preparedness for implementing the staffing methodology, including the necessary technical support and resources. Simply put, PVA is not persuaded that these obstacles cannot be overcome. This committee should not be either.

With the capacity reporting requirement reinstated, Congress now has the means to conduct effective oversight and ensure VA stays ahead of the curve in determining where shortages exist and what gaps must be filled. Congress should start immediately by determining how VA plans to abide by the newly reinstated reporting requirement. This committee might also inquire as to why VHA Directive 1176, VHA Handbook 1176.01 and VHA Handbook 1176.02 all remain expired.⁶

Without strong Congressional oversight and the provision of adequate resources, history will repeat itself. These types of issues are not new, and the Independent Assessment’s report in September 2015 repeated findings similar to those in a report from a bipartisan presidential task force back in 2003: there is a disconnect in alignment of demand, resources and authorities.

⁵ U.S. Government Accountability Office. (October 2014). VA Health Care – Actions Needed to Ensure Adequate and Qualified Nurse Staffing. (Publication No. GAO-15-61). Retrieved from www.gao.gov/assets/670/666538.pdf on March 2, 2017.

⁶ VHA Directive 1176, defining policy for the Spinal Cord Injury and Disorders System of Care, expired in October 2015; VHA Handbook 1176.01, defining procedures for the Spinal Cord Injury and Disorders System of Care, expired in February 2016; VHA Handbook 1176.02, defining procedures for Spinal Cord Injury and Disorders Extended Care Services, expired in June 2012.

Beyond simply providing more and more funds, though, PVA supports certain changes being requested by VA that would impact how those funds are spent.

One change would increase efficiency and accuracy in funding by allowing VA to record non-VA care obligations at the time of payment instead of when the care is authorized. The current practice requiring VA to project obligations at the time of authorization incentivizes over-obligation to avoid violating the Anti-Deficiency Act and ultimately results in forgoing funds previously provided by Congress—money which could otherwise be spent on medical care.

The second change we support is giving VA the flexibility to allocate funds in a way that accommodates shifts in demand for health care services. While consolidation of community care programs might obviate the need to lift restrictions on using Choice Program funds to reimburse community providers operating under Patient-Centered Community Care (PC3), any consolidation effort should permit VA to develop internal capacity if utilization patterns demonstrate increasing demand for care in VA facilities.

With this in mind, we believe that Congress must also reject continued funding of the Choice program through a mandatory account and place it in line with all other community care funded through the discretionary Community Care account established previously. This will eliminate competing sources of funding for delivery of health care services in the community, while maintaining visibility on spending through the Choice program.

IV. Reforming VA's Culture with Transparency and Accountability

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 a position that is neatly tucked away from public view, or to simply retire with full benefits, in some cases only to become VA contractors who make even more money with far less accountability. 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.

PVA believes that substantial reform in health care can be achieved, and the time is ripe to accomplish this task. Our organization represents veterans with some of the most complex issues, and we cannot stress enough that moving forward should not be done at the expense of the most vulnerable among them. We must remain vigilant and appreciate the benefits of bringing together the variety of stakeholders who are participating and bringing different perspectives and viewpoints—it is a healthy development process that ensures veterans remain the focus. Thank you for the opportunity to present our views on these issues.

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Gabe was raised in Homer City, Pennsylvania. He attended the University of Pittsburgh where he earned a Bachelor of Arts degree in Political Science and Economics. After college he joined the U.S. Army and received his commission from the Officer Candidate School at Fort Benning, Georgia. He subsequently completed Ranger School, Reconnaissance and Surveillance Leaders Course (RSLC), Airborne School, and Air Assault School and was later assigned to the 2nd Battalion, 506th Infantry Regiment (4th Brigade Combat Team) of the 101st Airborne Division at Fort Campbell, Kentucky. In 2008, he deployed to Afghanistan in support of Operation Enduring Freedom as an Infantry Platoon Leader operating out of a remote outpost in the mountains of Khost Province. During his year-long tour he earned the Combat Infantryman Badge and the Bronze Star.

After the Army, Gabe attended Wake Forest School of Law. During his time as a student he was actively involved in helping establish the Veterans Advocate Law Organization (VALOR), which has since become a school-sponsored legal clinic at Wake Forest serving veterans in Winston-Salem, North Carolina. Before joining PVA in 2015, he was a prosecutor in Florida. He is licensed to practice law in Florida, North Carolina, the U.S. District Court for the Western District of North Carolina and the Court of Appeals for Veterans Claims.

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