



**STATEMENT FOR THE RECORD  
OF  
PARALYZED VETERANS OF AMERICA  
FOR THE  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
CONCERNING  
"SHAPING THE FUTURE: CONSOLIDATING AND  
IMPROVING VA COMMUNITY CARE"**

**MARCH 7, 2017**

Chairman Roe, Ranking Member Walz, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to offer our views on consolidating and improving the Department of Veterans Affairs' (VA) delivery of community care. The magnitude of the impact that veterans health care will have on present and future generations of veterans cannot be overstated, and we are proud 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 for most enrolled veterans VA remains the best and preferred option, VA cannot provide all services in all locations at all times. Care in the community must remain a viable option. As VA seeks to take the next major step in improving access to quality care for veterans, we appreciate the Committee's significant efforts in this matter.

As an initial matter, PVA supports the Chairman's bill, H.R. 369, which would eliminate the August 7, 2017 sunset date for the current Choice program and allow VA to continue to provide care with the remaining funding. VA currently estimates that remaining funds can carry the program an additional three months. This would provide both more time to formulate a plan for

the next phase of community care and a mechanism to bridge the gap during the transition. Trying to pin down exactly when funds will run out, however, is like shooting at a fast-moving target. It is imperative that Congress not lose its sense of urgency as we push toward consolidation and reform. Failing to protect against overly-optimistic funding projections could lead to a painful transition if the Choice program came to an abrupt halt prior to the next iteration being implemented.

Specialized services, such as spinal cord injury care, 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 VA the most.

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 disease (SCI/D) system, which, in turn, allows us to measure and scrutinize the quality of care provided. When individual facilities are lagging behind, the evidence is not just anecdotal. 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. What are the equivalents in the private sector? 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 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 cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. If these services decline, then specialized care is also diminished. The bottom line is that the SCI system of care, and the other specialized services in VA, do not operate in a vacuum. 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.

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 high-performing networks 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 Veteran Service Organizations (VSO), the Commission on Care, and congressional leadership. As stakeholders coalesce around this concept, though, divisions are still apparent as to the dynamics that govern the boundaries of this network.

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 an acceptable outcome for a healthy VA health care system capable of sustaining critical, veteran-centric, specialized services. It is flat-out cost-prohibitive and, in many cases, leads to fractured care as veterans attempt to navigate the private health care system without assistance in care coordination. We believe that the design and development of VA's network must be locally driven with national guidance and reflect the demographics and availability of resources within that area. While faith in VA to develop dynamic provider networks on its own may be weak, the proactive efforts of Third Party Administrators (TPAs) to work with VA and evaluate gaps in service have proven to be a valuable asset thus far in filling gaps.

VA would be able to make greater strides in this area 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 a vital piece to filling the gaps in health care services in certain areas, especially rural areas.

Care coordination is an essential part of delivering quality health care. VA must continue to own the responsibility for care coordination for veterans. VA's proposal for care coordination in its Plan to Consolidate Community Care Programs revolved the patient's circumstances, specifically the intensity of coordination needed and whether or not the non-VA care was being provided based on a wait time or geographical distance.<sup>1</sup> In light of the Secretary's recent comments indicating a desire to remove the 30-day/40-mile standards for determining eligibility for community care, this aspect may soon need to be revisited.

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 38 U.S.C. Section 1151, veterans can file claims for disability as a result of medical malpractice that occurs

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<sup>1</sup> 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](http://www.va.gov/opa/publications/va_community_care_report_11_03_2015.pdf).

in a VA facility or as a result of care provided by a VA provider. Responding to PVA's inquiries, VA confirmed that this protection does not follow the veteran receiving care in the community. 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, particularly including medical malpractice remedies governed by 38 U.S.C. Section 1151, clinical appeal rights, no-cost accredited representation, and Congressional oversight and public accountability.

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

PVA firmly believes that eligibility and access to care should 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 should be able to choose among the options developed within the high-performing network and schedule appointments that are most convenient for them. Access decisions dictated by arbitrary wait times and geographic distances have no comparable industry practices in the private sector. We are encouraged by the Secretary's recent comments indicating a desire to move away from the current 30-day/40-mile standard in favor of a clinical determination. VA should be able to ensure that when and where the veteran receives care is based on clinical need and availability of services. It shifts the organizational mindset and focus of VA to clinical outcomes instead of catering to arbitrary metrics governing access to care in the community.

PVA and our fellow IBVSOs 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. 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 otherwise 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. VA should instead incentivize use of primary care providers by increasing the ease with which veterans access care in its integrated network.

## **III. Realigning the provision and allocation of VA's resources to reflect the mission.**

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 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 have been based on deflated utilization numbers that fail to properly account for the true demand on its system.

The nurse shortage within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and forced SCI/D centers to reduce the amount of veterans they admit. A decrease in the daily average census at some SCI/D centers naturally followed, suggesting that there is a lack of demand in the system. In reality, veterans who want to access SCI/D 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.

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 need filled. Congress should start immediately by determining how VA plans to abide by the newly reinstated reporting requirement. A Government Accountability Office (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.<sup>2</sup> 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. 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. 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.

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<sup>2</sup> 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](http://www.gao.gov/assets/670/666538.pdf) on March 2, 2017.

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.

#### **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 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.

PVA believes that substantial reform in health care can be achieved, and the time is ripe to accomplish this task. Our organization represents clients 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 veterans. 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.

## **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.