STATEMENT FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

PENDING LEGISLATION

March 15, 2016

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on legislation pending before the Committee. The magnitude of the impact that veterans health care reform will have on present and future generations of veterans cannot be overstated, and we are proud to be part of this important discussion.

S. 2633, the Improving Veterans Access to Care in the Community Act, and S. 2646, the Veterans Choice Improvement Act of 2015

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 the Department of Veterans Affairs (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 and the Senators for sponsoring the legislation being considered during today's hearing. Both bills provide thoughtful approaches to incorporating community care and other health care resources in a consolidated and effective manner.

As we consider legislation designed to reform VA health care, it is important to recognize that VA's specialized services, particularly spinal cord injury care, cannot be adequately duplicated in the private sector. 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 the VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers.

Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. As the VA 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 VA the most.

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 specific aspects of both S. 2633 and S. 2646, as well as the discussion draft legislation that would reform the Senior Executive Service (SES).

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. The network structure proposed in S. 2633 is best suited to setting VA up for success in achieving this goal.

By encouraging VA to develop a tiered network of eligible providers, the focus remains on providing not only increased access and choice, but the quality of care veterans earned and deserve. High-quality health care for veterans requires more than expanding options. Establishing a tiered network where VA is able to capture and synthesize information related to specific providers enables veterans to make informed decisions related to their care. This ultimately leads to better results. Consistent with this idea, a specific provision in S. 2646 alleviates situations where the "best option," as indicated in VA's tiered network, might not be the best fit for the veteran due to his or her particular circumstances. The proposed language prevents VA from requiring a veteran to receive care or services from an entity in a higher tier than any other entity or provider network. We recommend this provision be incorporated in the final legislation this Committee passes.

A tiered system also permits VA to identify culturally competent community providers who understand the unique needs of the veterans they serve. VA academic affiliates and the corresponding workforce training programs have long provided clinicians their first extensive exposure to the unique needs of the veteran patient community. As integrated networks are developed, it is important to recognize the value of having primary care providers in the

community who have passed through the VA academic affiliate programs. It also gives VA a baseline for identifying community health care providers who have at least some level of cultural competency. Despite these long-standing partnerships, academic affiliates are conspicuously absent from the explicit list of eligible providers in S. 2646.

Critical to such a restructuring is the ability to bring community care providers into the fold. S. 2633 and S. 2646 each address VA's request for authority to enter into non-federal acquisition regulation (FAR) provider agreements. The current requirement that providers enter into agreements with VA governed by the FAR System have 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 critical piece to filling the gaps in health care services in certain areas. PVA is concerned, however, that the implied directive in S. 2646 is for VA to exhaust FAR based acquisitions before turning to "Veterans Care Agreements." To facilitate the efficient development of high-performing networks, we support the unambiguous language in S. 2633 which permits VA to utilize such agreements as it sees fit.

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. While both pieces of legislation contain the current 30-day wait time and 40-mile distance eligibility standards for care in the community, we highlight a subtle, but significant, shift in S. 2633's proposal to use the veteran's residence as the center of origin as opposed to the nearest VA facility. S. 2646 offers another enhancement by ensuring that any follow-up care, including specialty and ancillary services deemed necessary as part of the original treatment, is conducted by the same provider and considered one episode of care. This ensures that veterans are not shuttled back and forth between different providers, including VA, for ancillary services based on piece-meal eligibility determinations conducted on the basis of separate episodes of care.

Effective care coordination is essential to producing high-value health care outcomes for veterans served by the proposed high-performing networks. Both bills propose measures aimed at streamlining the authorization process, payments to providers and the exchange of medical records. Modernizing these processes through automation and improved technology features will relieve stress on the current system and the veterans who fall victim to the financial distress inadvertently caused by lapses in the authorization and/or payment processes.

Rather than employing the current Non-VA Care Coordination Program as proposed in S. 2646, VA should be permitted to modernize its care coordination efforts. VA's Choice Consolidation Plan spells out levels of care coordination administered based on the intensity of coordination

needed. VA will directly manage care coordination for patients receiving care within its facilities and those eligible for care in the community based on wait times.

For those veterans who are distance eligible for care in the community, a third-party administrator will be responsible for "Basic" care coordination. As a distance eligible patient's needs escalate, VA care coordination is available for "Care/Disease Management" and a more intensive level of oversight, "Case Management." In light of VA's current proposals, we support the provision in S. 2633 which permits VA to establish procedures it considers appropriate to facilitating care coordination. The method proposed by VA offers the functionality and flexibility needed to ensure that patients with complex cases receive adequate attention and resources. It also allows VA to provide a level of care coordination that corresponds to each individual patient's complexity and needs, regardless of whether the veteran receives care in VA facilities or in the community.

PVA applauds the sponsors and co-sponsors of S. 2633 for incorporating our proposals to expand access to emergency and urgent care. We have long opposed co-payments for veterans who are otherwise exempt, and we are glad to see this reflected in legislation.

We do, however, continue our opposition to any requirement that a veteran have received VA care within the preceding 24 months in order to qualify for emergency and urgent care benefits. The strict 24-month requirement is problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to appointment wait times, despite their timely, good-faith efforts to procure one. This barrier has caused undue hardship on veterans and has resulted in some receiving unnecessarily large medical bills through no fault of their own. Additionally, this provision discriminates against healthier veterans who otherwise do not need as much health care as other veterans and may go more than two years without being seen.

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

PVA supports the provisions in both bills which would require advance appropriations for the Veterans Health Administration, Care in the Community program to begin in fiscal year 2017. Not reflected in either piece of legislation is a plan for addressing VA's inability to take the long view toward strategic resource allocation and planning. Under the framework presented by PVA and our IB partners, we call for the implementation of a Quadrennial Veterans Review, similar to the Quadrennial Defense Review.

Additionally, while much of the focus in this legislation is keyed to addressing smooth integration of community care, we would reiterate that the access issues plaguing VA have been exacerbated by staffing shortages within the VA health care system which impacts VA's ability to provide direct care. 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 are based on deflated utilization numbers that fail to properly account for the true demand on its system.

For example, a shortage of nurses within the Spinal Cord Injury and Disease (SCI/D) system of care has precluded SCI/D centers from fully utilizing available bed space and has forced SCI/D centers to reduce the amount of veterans they admit. This has caused a decrease in the daily average census at some SCI/D centers and implies that there is a lack of demand on the system, when in reality veterans who want to access SCI/D care are turned away because those centers lack the staff to man available beds.

Discussion Draft on title 38, United States Code Revisions for Senior Executive Service

IV. Reforming VA's culture with workforce innovations and real accountability.

PVA believes workforce innovation and accountability are critical to evolving the VA health care system into a truly dynamic system best suited to meet the demands of veterans. We applaud Secretary McDonald for acknowledging that employee experience is vital to its transformation efforts as a part of the MyVA initiative. The MyVA taskforce has developed a number of programs and initiatives to engage and empower VA employees. However, federal hiring still reflects a mismatch between the skills desired and the compensation provided for many of the professionals VA recruits. If Congress is focused on bolstering VA's ability to fire poor-performing employees, Congress must also give VA the leverage to hire employees quickly and offer compensation commensurate with their skill level.

With this in mind, we believe thoughtful consideration should be given to the draft proposal before the Committee, as put forward by the Secretary, which begins to address the question of workforce innovation and accountability, at least at the Senior Executive Service (SES) level. We do remain skeptical as to whether or not this draft legislation will produce meaningful accountability across the VA system, but we are convinced that the current system does not work. Additionally, while not contemplated by any of the bills on today's hearing agenda, workforce innovation and accountability are critical at all levels within the management structure of the VA. As VA is generally at a competitive disadvantage to hire and retain the best professionals in the health care field, the Committee should consider what additional incentives and tools the VA needs in order to enhance its ability to attract the best employees at every level, from the SES down to the bedside nurse.

Lastly, as we have stated in previous testimony, we have consistently heard from veterans that their patient advocates are ineffective or seek to protect the medical facility's leadership instead of addressing their concerns. PVA believes that patient advocates cannot effectively meet their obligations to veterans if their chain of command includes VA medical facility staff that is responsible for the actions and policies they are required to address. If accountability is going to be a key tenet of reform, then PVA, along with our IB partners, recommend strengthening the Veterans Experience Office by combining its capabilities with the patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring the health care protections afforded under title 38, United States Code (U.S.C.), a veteran's right to seek redress through clinical appeals, claims under section 1151 of title 38, U.S.C., the Federal Tort Claims Act, and the right to free representation by accredited veteran service organizations

are fully applied and complied with by all providers who participate in Veterans-Centered Integrated Health Care Networks, both in the public and private sector.

S. 2473, the Express Appeals Act of 2016

PVA is pleased with the introduction of the Express Appeals Act in the Senate. This bill mirrors legislation recently passed in the House on February 9, 2016 (H.R. 800) as part of an omnibus bill (H.R. 677). We are glad to see that many of the recommendations we submitted in previous testimony were incorporated into the language prior to House approval, and those same recommendations are reflected in the Senate version presented here.

This legislation is a good beginning and a framework for critical changes to the appeals process that may help veterans receive benefits they have earned more rapidly. While we understand there may be concerns about the fairness of allowing only new appeals, we strongly believe that limiting the participants to those entering the pilot at the initial Notice of Disagreement (NOD) stage will produce a much more accurate picture of the effectiveness of the process being tested.

We also want to emphasize the importance of maintaining substantial veteran service organization (VSO) representative involvement throughout this process. Notifying VSO representatives who are working under a Power of Attorney of any actions or updates on their client's appeal is critical to ensuring veterans who opt in to this program do not miss out on the expertise VSO representatives bring to bear on their behalf.

One of the strongest ways to impact the appeals process is to mandate that VA provide thorough notice of the basis for decisions on disability ratings. One cannot make an educated decision on whether to appeal a claims decision without knowing why it was denied. We support the provision in subsection (e)(2), which contemplates a review conducted in conjunction with VSOs as to the efforts of the Secretary to improve this aspect of the claims process.

Finally, we maintain our position that a shift of employees from the Appeals Management Center (AMC) to the Board for purposes of developing claims should be done with strict oversight from this Committee. While it can be expected that reducing resources or manpower will have an impact on AMC's processing rate, we fear this may become an excuse by the Veterans Benefits Administration for why they are unable to complete traditional appeals.