Annual Legislative Presentation

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National President

Paralyzed Veterans of America

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Chairman Sanders, Chairman Miller and members of the Committees, I appreciate the opportunity to present the legislative priorities for 2014 of Paralyzed Veterans of America (Paralyzed Veterans). Since its founding, Paralyzed Veterans has developed a worthy record of accomplishment, of which we are extremely proud. Again, this year, I come before you with our views on the current state of veterans' programs and services and recommendations for continued improvement in the services and benefits provided to veterans.

BACKGROUND—Paralyzed Veterans was founded in 1946 by a small group of returning World War II veterans, all of whom had experienced catastrophic spinal cord injury and who were consigned to various military hospitals throughout the country. Realizing that neither the medical profession nor government had ever confronted the needs of such a population, the returning veterans decided to become their own advocates and to do so through a national organization.

From the outset the 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. Paralyzed Veterans' founders were determined to create an organization that would be governed by the members, themselves, and address their own unique needs. Being told that their life expectancy could be measured in weeks or months, these individuals set as their primary goal actions that would maximize the quality of life and opportunity for all veterans and individuals with spinal cord injury—it remains so today.

To achieve its goal over the years, Paralyzed Veterans has established ongoing programs of research, sports, service representation to secure our members' and other veterans' benefits, advocacy in promoting the rights of all citizens with disabilities, architecture promoting accessibility, and communications to educate the public about individuals with spinal cord injury. We have also developed long-standing partnerships with other veterans' service organizations. Paralyzed Veterans, along with AMVETS, Disabled American Veterans, and the Veterans of

Foreign Wars, co-author *The Independent Budget*—a comprehensive budget and policy document that has been published for 28 years.

Today, Paralyzed Veterans is the only congressionally chartered veterans' service organization dedicated solely to the benefit and representation of veterans with spinal cord injury or disease.

SUFFICIENT, TIMELY AND PREDICTABLE FUNDING FOR VA AND ADVANCE APPROPRIATIONS— As Congress and the Administration continue to face immense pressure to reduce federal spending, we cannot emphasize enough the importance of ensuring that sufficient, timely and predictable funding is provided to the Department of Veterans Affairs (VA). While we appreciate the increases offered by the Administration's budget for FY 2015 and the FY 2016 advance appropriations, particularly with regards to health care and benefits services, we have real concerns that the serious lack of commitment to infrastructure funding to support the system will undermine the VA's ability to deliver those services. Similarly, we remain concerned that the funding levels provided by the House and Senate Committees on Appropriations in the recently passed omnibus appropriations bill will be insufficient to address the continuously growing demand for VA health care services.

Moreover, *The Independent Budget* co-authors oppose the steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. The Administration continues to rely upon "management improvements," a popular gimmick that was used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system. Additionally, the VA continues to overestimate and underperform in its medical care collections. Overestimating collections estimates affords Congress the opportunity to appropriate fewer discretionary dollars for the health care system. However, when the VA fails to achieve those collections estimates, it is left with insufficient funding to meet the projected demand. As long as this scenario continues, the VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this nation.

For FY 2015, *The Independent Budget* recommends approximately $61.1 billion for total medical care, an increase of $3.4 billion over the FY 2014 operating budget. Meanwhile, the Administration recommended a revised advance appropriation estimate for FY 2015 of approximately $56.0 billion in discretionary funding for VA medical care. When combined with the $3.1 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2015 would be approximately $59.1 billion, approximately $2.0 billion less than *The Independent Budget* recommendations.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2015, *The Independent Budget* recommends approximately $49.3 billion for Medical Services. For Medical Support and Compliance, *The Independent Budget* recommends approximately $6.1 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion.

As with last year, *The Independent Budget* also offers baseline advance appropriations projections for funding for the medical care accounts for FY 2016. While we have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we have growing concerns that this responsibility is not being taken seriously. The fact that for three fiscal years in a row the Administration recommended funding

levels that were not changed in any appreciable way upon review, and the fact that Congress simply signed off on those recommendations without thorough analysis, leads us to conclude that VA funding is falling farther and farther behind the growth in demand for services. We believe the continued feedback from veterans around the country about long wait times and lack of access to services affirms this belief.

For FY 2016, *The Independent Budget* recommends approximately $62.5 billion for total medical care. We appreciate the fact that the Administration has recommended a substantial increase for FY 2016—approximately $62.0 billion for total medical care. However, we must reiterate our concerns about the Administration's estimate relying too heavily on medical care collections estimates that it rarely achieves and on operational improvements savings that VA also struggles to realize. For FY 2016, *The Independent Budget* recommends approximately $50.8 billion for Medical Services. For Medical Support and Compliance, *The Independent Budget* recommends approximately $6.0 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion.

Within the VA's FY 2015 and FY 2016 advance appropriations request, our greatest concern is focused on the wholly insufficient funding requested for infrastructure, particularly with regards to Major and Minor Construction and Non-Recurring Maintenance (NRM). The VA continues to slash funding for NRM as evidenced by the rapidly decreasing estimates for Medical Facilities. And yet, the VA admits in its own documents that it spends between $1.3 billion and $1.4 billion per year on NRM. Similarly, we are extremely disappointed that the VA has requested such a laughable funding level for Major and Minor Construction, particularly considering the rapidly advancing age and condition of its infrastructure. It is time for Congress to take the necessary steps to reverse this course before the VA system collapses on itself.

Paralyzed Veterans is also very concerned that the broken appropriations process continues to have a negative impact on the operations of the VA. Once again this year Congress failed to fully complete the appropriations process in the regular order. In fact, many federal operations were shuttered as part of a partial government shutdown in October 2013. This had a significant negative impact on many of the services provided by the VA. While VA health care was shielded from this political disaster, benefits services, research activities, and general operations for the rest of the VA were impacted.

With this in mind, PVA calls on Congress to immediately approve legislation that would extend advance appropriations to all VA discretionary and mandatory appropriations accounts. Advance appropriations have shielded VA health care from most of the harmful effects of the partisan bickering and political gridlock that has paralyzed Washington in recent years. Now Congress must provide the same protections to all remaining discretionary programs, including Medical and Prosthetic Research, General Operating Expenditures, Information Technology, the National Cemetery Administration, Inspector General, Major Construction, Minor Construction, State Home Construction Grants, State Cemetery Grants and other discretionary accounts, and all mandatory funded programs, including disability compensation, pension, education benefits, and dependency and indemnity compensation.

There are currently bills pending in both the House of Representatives (H.R. 813, the "Putting Veterans Funding First Act") and the Senate (S. 932) that can be quickly amended and approved to achieve this goal. Similarly, S. 1982 (formerly S. 1950), the "Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014," provides advance appropriations authority for VA's mandatory funding accounts to ensure that in the event of a future government shutdown, veterans' benefits payments would not be delayed or

put in jeopardy. Enactment of these bills will generally free all VA services from the political gridlock that has crippled the appropriations process in Congress.

PROTECTION OF THE VA HEALTH CARE SYSTEM, WITH A FOCUS ON SPECIALIZED SERVICES—The VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the nation, VA is a model health care provider that has led the way in various areas of medical research, specialized services, and health care technology. In fact, the VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. However, these services are often expensive, and are severely threatened by cost-cutting measures and the drive toward achieving management efficiencies.

Over the years, the VA has earned a reputation as a leader in the medical field for its quality of care and innovation in both the health care and medical research fields. However, even with VA's advances as a health care provider, some political leaders and policy makers continue to advocate expanding health care access for veterans by contracting for services in the community. While we recognize that VA must tap into every resource available to ensure that the needs of veterans are being met, such changes to the Veterans Health Administration (VHA) would move veterans out of the "veteran-specific" care within VA, leading to a diminution of VA health care services, and increased health care costs in the federal budget. Despite recent calls for providing veterans with increased access through vouchers for private care or the expansion of fee basis care, Paralyzed Veterans strongly believes that VA, as a provider of care not a payer, remains the best option available for veterans seeking health care services.

The VA's unique system of care is one of the nation's only health care systems that provide expertise in a broad continuum of care. Currently, VHA serves more than 8 million veterans, and provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related poly-traumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector.

Moreover, specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. These services were initially developed to care for the unique health care needs of veterans. The provision of specialized services is vital to maintaining a viable VA health care system. Specialized services are part of the primary mission of the VA. The erosion of these services would lead to the degradation of the larger VA health care mission. Reductions in beds and staff in both VA's acute and extended care settings have been reported, even though Public Law 104-262, "The Veterans' Health Care Eligibility Reform Act of 1996," mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans. In addition, Congress required that VA provide an annual capacity reporting requirement, to be certified or commented upon, by the Inspector General of the Department. Unfortunately, this basic reporting requirement expired in 2008.

With growing pressure to allow veterans to seek care outside of the VA, the VA faces the possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care programs provided to veterans. If primary care services decline, then specialized care is also diminished.

Meanwhile, as VA services are designed specifically to meet the needs of veterans, VHA has received excellent ratings from patient satisfaction surveys, and garnered much recognition for

its national safety program. The VA's system of patient-centered and coordinated care helps to ensure safe and consistent delivery of services. Additionally, independent research organizations have also found VA to be the lowest cost provider when compared to private health care systems. Paralyzed Veterans will continue to oppose any efforts that place the VA health care system at risk of being unable to properly meet the health care demands of veterans, particularly veterans with spinal cord injury or dysfunction.

OVERSIGHT OF THE VA PROSTHETICS PROGRAM—Under direction from the VA Office of Acquisition and Logistics, the Veterans Health Administration implemented a new process for delivering prosthetics to severely disabled veterans that leaves far too many of those veterans sitting in hospitals or confined to their homes longer than necessary. We call your attention to the attached document **"*Prosthetics Purchase Process*"** that reflects how the VA redesigned the system. The new process essentially dissolved the Simplified Acquisition Process and replaced it with stringent contracting standards that, in too many cases, have significantly delayed the receipt of customized wheelchairs, artificial limbs, and other high-dollar prosthetics devices costing over $3000, the micropurchase threshold established by statute. Incidentally, this "new" standard was the very same one that made Simplified Acquisition Procedures and the title 38 United States Code, Section 8123 statute necessary after veterans of past eras who were paralyzed or missing limbs decided that unreasonably long delays would no longer be tolerated. But it appears VA has resigned itself to pursuing a policy of insanity—doing the same thing over and over again and expecting a different result.

The reality is the implementation of this change, dubbed the "warrant transition," has not unfolded as planned where the most vulnerable veterans in the system are concerned. Paralyzed Veterans supports the notion that VA must operate more efficiently and take measures to better serve all veterans. However, lengthening the process for delivering prosthetics to veterans with the greatest need—the five percent who rely entirely on customized prosthetics—is unconscionable. That five percent happens to be 100 percent of our membership. Moreover, as a practical matter, it ultimately costs VA more in terms of unnecessarily long hospitals stays and the costly consequences of inadequately equipped veterans who risk trying to get by without equipment that assures their safety. In addition to failing to consult with external stakeholders before launching the warrant transition, new rules and policies that will impact veterans for generations to come are still being developed behind closed doors without the input of those who have the most to lose if the new policies fall short. This needs to change immediately. We are willing to partner with VA to make the prosthetics process successful but not as an afterthought.

Paralyzed Veterans believes that VA's new system for delivering prosthetics to veterans with conditions like spinal cord injury, Multiple Sclerosis (MS), and terminal afflictions like Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) requires more Congressional oversight than it is currently receiving. When veterans die, suffer preventable injuries, or are forced to bear the excruciating wait for independence while waiting for their prescribed prosthetics items or devices due to red tape, the country's reputation suffers. George Washington said it best when he declared that "a nation is judged by how well it treats its veterans." We declare today that this Congress and VA will be judged by the independence—or lack thereof—enjoyed by veterans who rely on VA prosthetics to live.

EXPAND ELIGIBILITY FOR VA CAREGIVER SUPPORT SERVICES— Severely disabled veterans with a service-connected injury or illness do not have full access to caregiver support programs and services from the Department of Veterans Affairs (VA). As a result of Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," the VA only

provides comprehensive benefits as part of the Caregiver Support Program to caregivers of veterans with a service-connected injury that was incurred after September 11, 2001. Specifically, these benefits include health care coverage through the VA's Civilian Health and Medical Program of Veterans Affairs, a monthly stipend based on the care provided, and payment for travel and lodging when participating in medical appointments with a veteran.

The majority of PVA members are excluded from these VA caregiver benefits because of the arbitrary selection of the September 11, 2001 date; or because the law also excludes veterans with serious illnesses or diseases such as ALS and MS, both of which have a catastrophic impact on activities of daily living, and eventually leave veterans dependent upon caregivers. The provisions of benefits and services to service-connected, catastrophically disabled veterans should be not based on their date of injury. No reasonable justification (other than cost considerations) can be provided as to why pre-9/11 veterans with a service-connected injury or illness should be excluded from the caregiver program.

To ensure that all service-connected, catastrophically disabled veterans receive adequate caregiver support services from the VA, PVA recommends that Congress enact legislation to expand eligibility for the VA Caregiver Support Program that eliminates the post-9/11 injury requirement, and includes "serious illnesses and diseases" in the eligibility criteria. PVA strongly supports the "Caregiver Expansion and Improvement Act of 2013," (H.R. 3383 and S. 851), which would eliminate the post 9/11 injury requirement, and the "Support Our Services to Veterans' Caregivers Act, H.R. 3672, which proposes to include "serious illness" as a criteria of the current caregiver program. PVA also supports S. 1982 (formerly S. 1950), the "Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014," which among other provisions, proposes to expand eligibility for VA caregiver assistance benefits to veterans who became injured or ill prior to September 11, 2001.

As severely disabled veterans begin to age, the responsibilities of their caregivers grow, as well as their need for VA support services. Both the exclusion of "serious illnesses and diseases," and the use of the "date of injury" as an eligibility requirement for such an important benefit is unfair, and likely to have negative impacts on veterans' quality of care and well-being.

REINSTATE THE ANNUAL CAPACITY REPORTING MANDATE FOR SPECIALIZED SYSTEMS OF CARE— The Department of Veterans Affairs (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." This law requires VA to maintain its capacity to provide for the special treatment and rehabilitative needs of catastrophically disabled veterans. As a result of P.L. 104-262, the VA developed policy that required the baseline of capacity for VA's Spinal Cord Injury/Disorder (SCI/D) system of care to be measured by the number of staffed 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. Unfortunately, this reporting requirement expired in 2008.

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 operated with vacant health care positions for prolonged periods of time. When

this occurs veterans' access to VA care decreases, remaining staff becomes 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 disabled veterans having access to quality care in VA 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 would be able to compile and use the collected data for annual reports and assess its ability to meet the capacity mandate.

PVA recommends that Congress reinstate the aforementioned reporting requirement for VA specialized services to complete an annual capacity report, without a specific end date to prevent future expiration of the mandate. This requirement will ensure that catastrophically disabled veterans' access to care is not diminished due to the VA's failure to meet mandated capacity requirements and ensure that the VA is held accountable for having the requisite number of available inpatient beds for veterans, as well as required levels of staff to deliver quality care.

PRO-CREATIVE SERVICES FOR CATASTROPHICALLY DISABLED VETERANS— A continuing high priority for Paralyzed Veterans is the provision of reproductive services for catastrophically disabled service-connected veterans. The Department of Veterans Affairs (VA) does not provide health care benefits for reproductive services to veterans who have sustained a service-connected injury, such as a spinal cord injury or disorder (SCI/D) that prevents conception of a child. Reproductive assistance provided as a health care benefit through VA would ensure that these veterans can afford to seek medical reproductive services, and pursue their desire to have children. One of the most devastating results of spinal cord injury or dysfunction for many individuals is the loss of the ability to have children and raise a family.

As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries from explosive devices that have precluded them from being able to conceive a child naturally. Although the Department of Defense provides reproductive services to service members and retired service members, when a veteran has a loss of reproductive ability due to a service-connected injury, they must pay for any medical reproductive assistance services should they attempt to have children. It is often the case that veterans cannot afford these services and are not able to receive the medical treatment necessary for them to conceive. For some paralyzed veterans procreative services have been secured in the private sector at great financial and personal cost to the veteran and family.

Paralyzed Veterans has long sought inclusion of reproductive services in the spectrum of health care benefits provided by the VA, and further recommends amending title 38 U.S. Code, Section 1701(6) to include reproductive assistance as standard VA medical services provided to veterans. Reproductive assistance services must include care and delivery options for fertility counseling and treatment for service-connected veterans and their spouses. Therefore, Paralyzed Veterans urges Congress to pass the "Women Veterans and Other Health Care Improvements Act of 2013," introduced in both the Senate and House (S. 131 and H.R. 958). Both of these bills will help veterans overcome infertility and reproductive disability due to a service-connected injury. Paralyzed Veterans also supports S. 1982 (formerly S. 1950), the "Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014," that includes provisions to authorize VA to provide veterans with reproductive assistance services. Improvements in medical treatments have for some time made it possible to

overcome infertility and reproductive disabilities, and veterans who have a loss of reproductive ability as a result of a service-connected injury should have access to these advancements.

BENEFITS FOR SEVERELY DISABLED VETERANS— Paralyzed Veterans believes that it is time for the Committees to make a concerted effort to improve benefits for the most severely disabled veterans particularly with regards to the rates of Special Monthly Compensation paid to severely disabled veterans. We also believe the Committees should consider the larger benefit that providing travel reimbursement to catastrophically disabled non-service connected veterans will have on the long term care costs that can be saved from this population of veterans.

As you know, 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, we do 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.

Paralyzed Veterans believes that an increase in SMC benefits is essential for veterans with severe disabilities. 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. With this in mind, Paralyzed Veterans would like to recommend that Aid and Attendance (A&A) benefits be appropriately increased. Attendant care is very expensive and often the A&A benefits provided to eligible veterans do not cover this cost. In fact, many Paralyzed Veterans members who pay for full-time attendant care incur costs that far exceed the amount they receive as SMC-A&A beneficiaries at the R2 compensation level (the highest rate available). We encourage the Committees to consider legislation that specifically address increases to the R1 and R2 rates for SMC and A&A benefits soon.

Also, we believe the Committee should consider expanding travel reimbursement benefits to catastrophically disabled non-service connected veterans. While we recognize that the VA will face tighter budgets in the future, and that this benefit could add a significant cost to the VA, we believe the short term costs of expanding this benefit to this population of veterans would be far outweighed by the potentially greater long term health care costs for these veterans. Too often, catastrophically disabled veterans choose not to travel to VA medical centers for appointments and procedures due to significant costs associated with their travel. They then may end up at an outpatient clinic or a private health care facility that is ill-equipped to meet their specialized health care needs. The result is often the development of far worse health conditions and a higher cost of care. By ensuring that catastrophically disabled veterans are able to travel to the best location to receive necessary care, their overall health care costs to the VA can be reduced.

LONG-TERM CARE—Paralyzed Veterans of America (PVA) continues to be concerned about the lack of VA long-term care (LTC) beds and services for veterans with spinal cord injuries or disorders (SCI/D). Approximately 50 percent of our members are now over 65 years of age and another 30 percent are currently between 55 and 64. These aging SCI/D veterans will soon be in need of VA LTC services at the 24 VA SCI/D centers (or "hubs". Unfortunately, we believe the VA is not requesting and Congress is not providing sufficient resources to meet the demand.

Similarly, as a result of insufficient resources, the VA is moving towards purchasing private care instead of maintaining acute care, and especially long-term care, in-house at SCI/D centers.

The VA has designated SCI/D long-term-care facilities because of the unique 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 sizeable portion requires ventilator and tracheotomy care due to their breathing difficulties.

The demand for additional LTC facilities in SCI/D is ever-present. From 2009 to 2013 the VA has increased required available beds in LTC units at SCI/D Centers by an average of 16 percent. Since 2009, the number of SCI/D veterans in those LTC units has also increased by an average of 18 percent. Currently, the VA operates only six (6) LTC facilities in SCI/D centers. These existing LTC units are not geographically located to meet the needs of a nationally distributed SCI/D veteran population as they are all located in the Central and Eastern states. 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 therefore reduce or eliminate waiting lists and ease the LTC demand in SCI/D centers.

In anticipation of the need for additional LTC services among the SCI/D veteran population, Paralyzed Veterans conducted a survey in 2013 to examine the non-VA LTC landscape. Over 400 VA-contracted skilled nursing homes and State Veterans Homes within a 50-mile radius of the 25 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, 28 were in the Central US, and 12 were located on the West Coast. Additionally, State Veterans Homes cannot ease the ventilator case load as none surveyed could accept ventilator patients. Not only are private skilled nursing facilities not generally trained 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. Thus, Paralyzed Veterans, in accordance with the recommendations of *The Independent Budget* for FY 2015, recommends that VA SCI/D leadership design a SCI/D LTC strategic plan that addresses the need for increased LTC beds in VA SCI/D Centers.

VETERANS EMPLOYMENT— Despite the fact that the current unemployment rate for veterans has dropped, those with catastrophic disabilities still suffer unemployment at a rate as high as 85 percent. This reality is linked to a number of factors, starting with low self-expectations on the veteran's part. But employers have contributed as well, by submitting to stigmas and misperceptions about the drawbacks and cost of hiring "less than perfect" veterans. Paralyzed Veterans confronted these challenges head on with the launch of our Paving Access for Veterans Employment (PAVE) Program in 2007. The program's animating purpose was to

erase stigmas and change expectations for veterans who suffered a life-changing circumstance and need help regaining independence and economic self sufficiency.

Our PAVE Program provides direct services to more than 1500 veterans, extended services (benefits, health, and/or career assistance) to over 30,000, and our Master's-level certified counselors have helped nearly 500 hard-to-place clients achieve their vocational goals. PAVE counselors and service officers serve any veteran, spouse, or dependent, at no cost to them. Our services extend to all 50 states and Puerto Rico through six regional offices collocated with VA Spinal Cord Injury Centers and our network of 69 service offices around the country. The U.S. Chamber of Commerce's Hiring Our Heroes Foundation recently recognized the PAVE Program by awarding Paralyzed Veterans the Don Weber Wounded Warrior Employment Award for leadership in veteran hiring. The secret of our success is the research-based "supported employment" model we use. This model allows us to engage veterans at the bedside while they recover, integrate resources, and customize services to individual needs. We then remain Partners For Life with our veterans to ensure they never have to go it alone.

But we cannot do it alone. We appreciate the emphasis that the Committees have placed on veterans' employment in the last few years. And yet, we believe more can be done to pave access to job opportunities for more veterans. We strongly recommend the Committees adopt a resolution calling for a five-year extension of the Work Opportunity Tax Credit (WOTC), including the VOW Act credits for veterans incorporated in WOTC. WOTC is particularly important to disabled veterans because two out of three veterans find jobs in the private sector. Unfortunately, most small and medium size enterprises aren't participating in WOTC because the program expired at the end of last year. If WOTC were made permanent or at the very least extended for a minimum of five years, we believe significant opportunities would be opened to veterans and disabled veterans seeking employment.

We also urge the Committees to be vigilant in following the implementation of the new rules for federal contractors with regard to recruitment and hiring of veterans, especially veterans with disabilities. PVA strongly supports the effort by the Department of Labor to update and strengthen the obligations of federal contractors and subcontractors under the Vietnam Era Veterans Readjustment Assistance Act (VEVRAA) as well as Section 503 of the Rehabilitation Act which pertains specifically to individuals with disabilities. Most PVA members are covered by both sets of regulations and the targets set for contractor workforces represent important opportunities to advance employment of veterans with the most significant disabilities.

ELIMINATE THE CAP ON VA'S INDEPENDENT LIVING PROGRAM— The Independent Living (IL) program is a support program within the VA's Vocational Rehabilitation and Employment (VR&E) program. The IL program contains flexibility with regard to the services, equipment and training provided for severely disabled veterans during their rehabilitation. As a pilot program in 1980, Congress placed a cap on the number of veterans to be enrolled in this program. That cap was arbitrarily set at 500 veterans per year. With the IL program proving to be an integral part of the rehabilitation process, Congress has expanded the cap for total participation several times to the current level of 2,700. The VA must monitor the number of veterans who participate in the IL program in order not to exceed the cap. However, the cap has no connection to the actual number of veterans who would qualify and could benefit from IL. Monitoring the program to limit participation is contradictory to the mission of providing the best options for disabled veterans. More than a decade of combat has resulted in a significant number of injured veterans that could receive some assistance from the IL program. With this in mind, PVA strongly supports efforts to eliminate the cap on the Independent Living program.

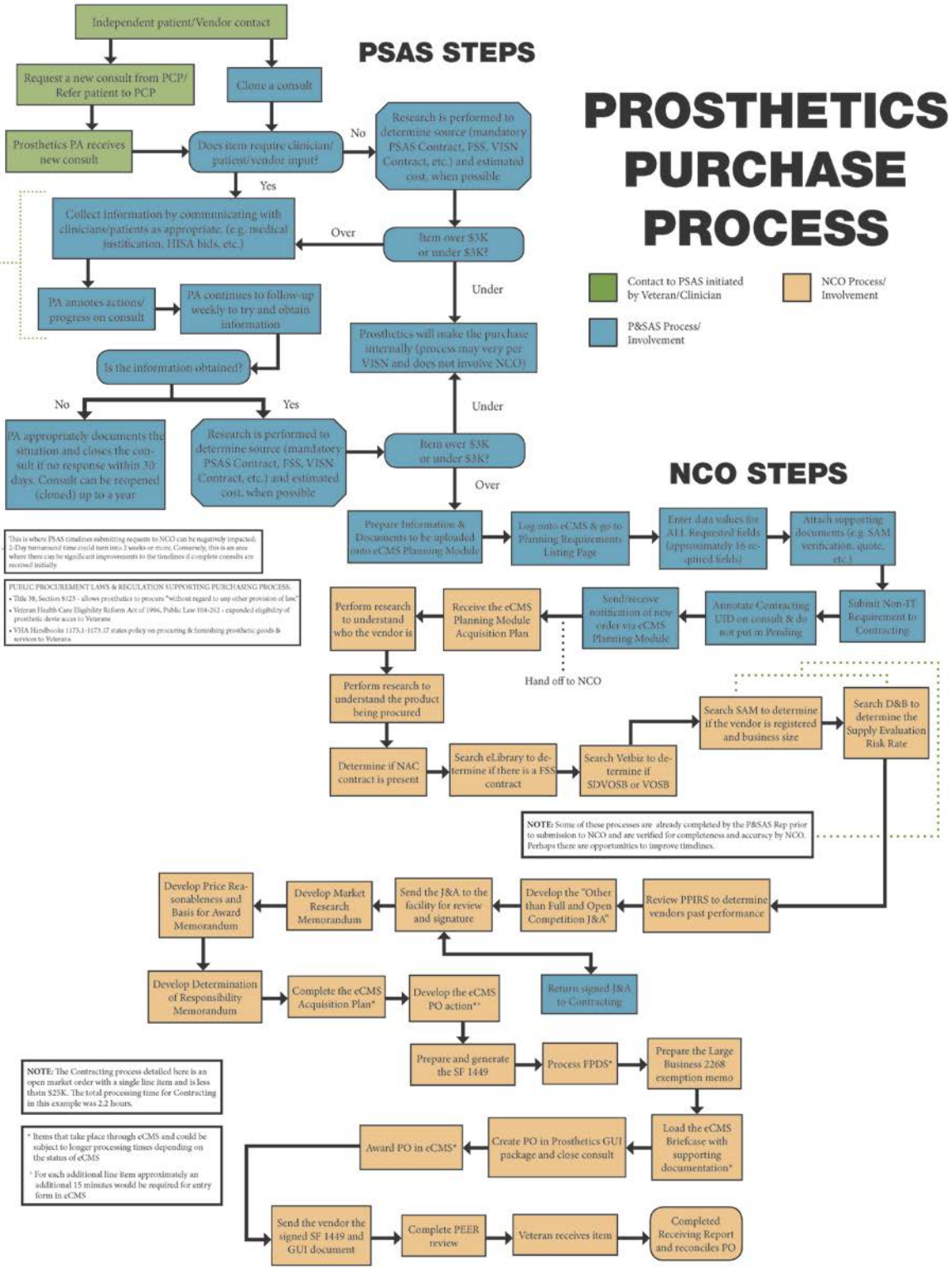
Complicating matters is the requirement to count each IL program created for a veteran towards the cap. One veteran may require multiple IL programs within the same fiscal year, and each of those IL programs count towards the cap. Such a policy has the potential to exclude disabled veterans from receiving services under the IL program even though demand for these services might exceed the limited number. All rehabilitation options, including independent living, must be available for veterans that require such services, regardless of the number of veterans seeking those services.

Meanwhile, H.R. 3330, the "Veterans' Independent Living Enhancement Act" has been introduced in the House. This legislation will eliminate the cap on IL services. Similar legislation has not yet been introduced in the Senate.

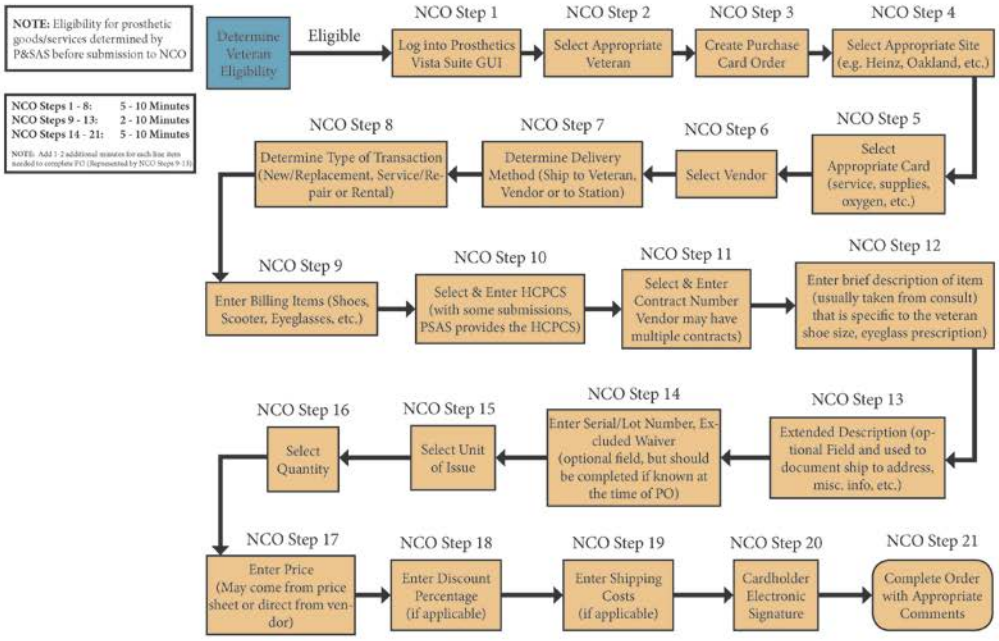
"ONE VA"—Ultimately, I would echo the concerns that I have raised so many times in the past—that this VA is not "One VA." While VA continues to tout this concept, our experiences continue to demonstrate that there are 21 individual VA systems masquerading as Veteran Integrated Service Networks (VISNs) that actually function as little fiefdoms. The VISN model of health care was intended to create strategic alliances among VA medical centers, clinics and other sites; sharing agreements with other government providers; and other such relationships. Instead, the VISNs are run like autonomous entities in a fragmented network, with inconsistent policies and budgetary turf battles that leave many veterans, who VA is obligated to serve, suffering the consequences of delayed or denied access to health care and prosthetics services.

On balance, VA is fortunate to have good people who still adhere to the principle that veterans come before cost considerations and policies. Even in times of national economic difficulty and profound organizational transformation, our Nation's security is still preserved by the men and women who take the oath and believe in the Country's promise to care for him or her should they suffer injury or disease. But until we have 21 VISNs that operate with a common purpose, under common policies, variability between VISNs will create even more gaps in which the most vulnerable veterans will fall. We are tired of hearing about "One VA." It's is time to become "One VA."

Paralyzed Veterans of America appreciates the opportunity to present our legislative priorities and concerns for the second session of the 113th Congress. We look forward to working with the Committees to ensure that sufficient, timely, and predictable resources are provided to the VA so that eligible veterans can receive the health care and benefits that they have earned and deserve. Chairmen Sanders and Miller, I would like to thank you again for the opportunity to testify. I would be happy to answer any questions that you may have.


PROSTHETICS PURCHASE PROCESS
PSAS STEPS
NCO STEPS
Contact to PSAS initiated by Veteran/Clinician
NCO Process/ Involvement
P&SAS Process/ Involvement
Independent patient/Vendor contact
Request a new consult from PCP/ Refer patient to PCP
Clone a consult
Prosthetics PA receives new consult
Does item require clinician/ patient/vendor input?
No
Yes
Research is performed to determine source (mandatory PSAS Contract, FSS, VISN Contract, etc.) and estimated cost, when possible
Collect information by communicating with clinicians/patients as appropriate. (e.g. medical justification, HISA bids, etc.)
Over
Item over $3K or under $3K?
Under
PA annotes actions/ progress on consult
PA continues to follow-up weekly to try and obtain information
Prosthetics will make the purchase internally (process may very per VISN and does not involve NCO)
Is the information obtained?
No
Yes
PA appropriately documents the situation and closes the consult if no response within 30 days. Consult can be reopened (cloned) up to a year
Research is performed to determine source (mandatory PSAS Contract, FSS, VISN Contract, etc.) and estimated cost, when possible
Item over $3K or under $3K?
Under
Over
This is where PSAS timelines submitting requests to NCO can be negatively impacted. 2-Day turnaround time could turn into 2 weeks or more. Conversely, this is an area where there can be significant improvements to the timelines if complete consults are received initially
PUBLIC PROCUREMENT LAWS & REGULATION SUPPORTING PURCHASING PROCESS:
• Title 38, Section 8123 - allows prosthetics to procure "without regard to any other provision of law"
• Veteran Health Care Eligibility Reform Act of 1996, Public Law 104-262 - expanded eligibility of prosthetic devie acess to Veterans
• VHA Handbooks 1173.1-1173.17 states policy on procuring & furnishing prosthetic goods & services to Veterans
Prepare Information & Documents to be uploaded onto eCMS Planning Module
Log onto eCMS & go to Planning Requirements Listing Page
Enter data values for ALL Requested fields (approximately 16 required fields)
Attach supporting documents (e.g. SAM verification, quote, etc.)
Submit Non-IT Requirement to Contracting
Annotate Contracting UID on consult & do not put in Pending
Send/receive notification of new order via eCMS Planning Module
Receive the eCMS Planning Module Acquisition Plan
Perform research to understand who the vendor is
Hand off to NCO
Perform research to understand the product being procured
Determine if NAC contract is present
Search eLibrary to determine if there is a FSS contract
Search Vetbiz to determine if SDVOSB or VOSB
Search SAM to determine if the vendor is registered and business size
Search D&B to determine the Supply Evaluation Risk Rate
NOTE: Some of these processes are already completed by the P&SAS Rep prior to submission to NCO and are verified for completeness and accuracy by NCO. Perhaps there are opportunities to improve timelines.
Review PPIRS to determine vendors past performance
Develop the "Other than Full and Open Competition J&A"
Send the J&A to the facility for review and signature
Develop Market Research Memorandum
Develop Price Reasonableness and Basis for Award Memorandum
Develop Determination of Responsibility Memorandum
Complete the eCMS Acquisition Plan*
Develop the eCMS PO action**
Return signed J&A to Contracting
Prepare and generate the SF 1449
Process FPDS*
Prepare the Large Business 2268 exemption memo
Load the eCMS Briefcase with supporting documentation*
Create PO in Prosthetics GUI package and close consult
Award PO in eCMS*
Send the vendor the signed SF 1449 and GUI document
Complete PEER review
Veteran receives item
Completed Receiving Report and reconciles PO
NOTE: The Contracting process detailed here is an open market order with a single line item and is less thatn $25K. The total processing time for Contracting in this example was 2.2 hours.
* Items that take place through eCMS and could be subject to longer processing times depending on the status of eCMS
* For each additional line item approximately an additional 15 minutes would be required for entry form in eCMS

STEP-BY-STEP PROCESS for CREATING PO in PROSTHETICS GUI PACKAGE & CLOSING CONSULT



ADDITIONAL INFORMATION ABOUT THE GUI PO

PROCESS INVOLVED IN CREATING A PO IN VISTA GUI SUITE

TOTAL TIME NEEDED FOR PROCESS BELOW BASED UPON EXPERIENCE:

Experienced Purchaser: 7 - 15 Minutes
Total Time for Novice Purchaser: 15 - 30 Minutes

NOTE: Add 1 extra minute per line item needed to complete PO

NOTE: The 40-step slide was reviewed and revised. Below is the end-result as noted by the **NCO Step #.**

Additionally, the steps involved to complete the purchase order in the PSAS GUI are dictated by the software so they cannot be eliminated/changed

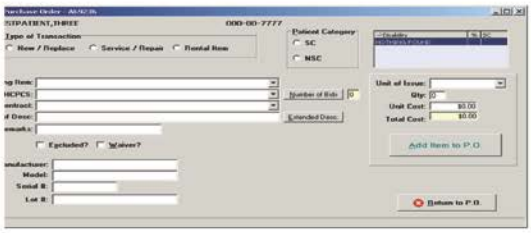
FACTORS TO CONSIDER

Familiarity of user doing purchasing: Estimated line item PO is 15 minutes for experienced personnel, as opposed to perhaps 15 - 30 minutes to someone new.

eCMS planning module takes 10 minutes - does this take into account the work done soliciting for quotes, verifying SAM, etc.?

Dual Monitors - Staff who have these generally have increased productivity in creating POs.

NOTE: NCO Steps 8 - 17 are completed within the same purchase order window.
(See screen capture below.)



Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

National Council on Disability — Contract for Services — $35,000.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, Administered by the Legal Services Corporation — National Veterans Legal Services Program — $262,787.

BILL LAWSON

NATIONAL PRESIDENT

Bill Lawson of Woodward, OK, was reelected for a fourth term as national president of Paralyzed Veterans of America, during its 67th Annual Convention in August 2013. He is a Paralyzed Veterans' life member.

Previously, Lawson served as national senior vice president from October 2009–October 2010, and had served as a national vice president for Paralyzed Veterans since 2006 and had held terms previously from 1995 to 2000. Lawson chaired the Field Advisory Committee from 1996 through 2000 and was reappointed by Paralyzed Veterans' National President Randy L. Pleva Sr. to this position in 2006. As chairman, his primary responsibility was that of "watchdog" of the numerous spinal cord injury facilities across the United States. He also previously served as chairman of a Paralyzed Veterans' ad hoc committee on multiple sclerosis (MS). This committee is charged with reorganizing a system of care for MS veterans using the Department of Veterans Affairs health-care system. Although active in advocacy and legislation issues, Lawson's first priority as president has always been that of improving health care for all veterans, especially those with spinal cord injury or dysfunction.

A native Oklahoman, Lawson was honored with the Advocate of the Year award by the Oklahoma Department of Rehabilitation Services in April 2011, for his work on behalf of all people with disabilities. He has held various key positions in the Paralyzed Veterans' Mid-America Chapter, and has also served as a panelist on the Oklahoma Veterans Council in Oklahoma City, which is composed of numerous veterans service groups within the state. He was also appointed to serve as a representative on a health-care task force developed by Oklahoma lawmakers. Lawson is a founding member of the Disabled American Veterans chapter in northwest Oklahoma, where he served as its commander for three years.

While serving in the U.S. Army, Lawson was stationed at various bases throughout the United States, Germany and Japan. He enlisted in 1968 and was honorably discharged in 1979 after 11 years of service to his country. He and his wife, Linda, currently reside in Woodward, OK.

Lawson took office with the other members of Paralyzed Veterans' Executive Committee on October 1, 2013.