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STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS,
CONCERNING
S. 2634; S. 2433, THE ?RURAL VETERANS CARE ACT OF 2006;?
S. 1537; S. 1731;
S. 2500, THE ?HEALING THE INVISIBLE WOUNDS ACT OF 2006;?
AND DRAFT LEGISLATION

MAY 11, 2006

Chairman Craig, Ranking Member Akaka, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the proposed legislation. We are particularly pleased that this committee is considering legislation that would help veterans with special needs, particularly veterans with Parkinson's disease and Multiple Sclerosis.

S. 2634

PVA opposes the provisions of S. 2634 that would repeal the term of office and the requirement for a commission on appointment for both the Under Secretary for Health and the Under Secretary for Benefits of the Department of Veterans Affairs (VA). Currently, each Under Secretary serves for a specific four-year term. PVA believes that the four-year term requirement serves a very valuable function. Under current law, once the Under Secretary has served the four-year term, that individual, wishing to continue service, must be re-confirmed by the United States Senate. The advice and consent of the Senate Committee on Veterans' Affairs and the Senate as a whole provides additional oversight over the conduct of the Under Secretaries. The reconfirmation also provides an opportunity for others with interests in the operation of the Veterans Health Administration and the Veterans Benefits Administration and their chief administrative officers to have the ability to opt into this process too and re-visit the qualifications and track record of the individuals. Just as initial confirmation at the beginning of the Under Secretary's term serves an outside objective oversight function, so does this four-year end-of-term look-back process let the office holder, and all others, know that the position is beholden to more than just one Secretary and one White House.

For many of the same reasons we oppose the provision in the draft bill to eliminate the role of the appointment commission. Under current law, once there is a vacancy in the Under Secretary position, the Secretary of Veterans Affairs is required to appoint a commission drawn from specific individuals and interest groups, including veterans' service organizations. The commission is called on to screen all candidates for the job, select three of the top candidates, forward those names through the Secretary to the White House where one will be chosen from that group.

We are as convinced today, just as those who created this process in the original legislation were, that the selection of these Under Secretaries, because of their direct roles over the health care and benefits of millions of veterans, must be as objective as possible. The individual must be chosen on the merits without a hint of political considerations. The commission was created as a buffer to isolate the political process from the selection process by allowing the commissioners to screen and actually select the core candidates. We have no qualms about the current Secretary's ability and sincerity in choosing, basically on his own, a candidate for submission to the White House who would certainly meet all the qualifications we could expect in an Under Secretary. But who knows what lies down the road in future Administrations and with future Secretary's of Veterans Affairs. By eliminating this commission there would be no counter balance at all in a future Secretary's choice, or the choice of some future White House seeking appointment purely by partisan objective or potential preconceived disinterest in the mission of the VA. We strongly urge the committee not to support changing their role and this process.

S. 2433, the ?Rural Veterans Care Act?

PVA is fully aware of the challenges the VA faces every day to provide timely access to quality health care for veterans who live in rural areas of the country. However, we are concerned that in addressing the problem of access for these veterans, the long-term viability of the VA health care system may be threatened. PVA members rely on the direct services provided by VA health care facilities recognizing the fact that they do not always live close to the facility. The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans is sent into the private sector for health care, the diversity of services and expertise in different fields is placed in jeopardy.

We have no objections to the establishment of an Assistant Secretary for Rural Veterans. We recognize the need for a senior administrator in the VA that can address the needs of rural veterans as policies are formulated for the larger veterans population. The requirement to consult with other Federal, State, and local agencies is particularly important. Agencies such as the Indian Health Service have dealt with rural health care issues for quite a long time.

PVA has serious concerns about the pilot program authorized by this legislation. This program would give VA additional leverage to broaden contracting out of health care services to veterans in geographically remote or rural areas. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. We believe that this pilot program would set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the federal government to shift its responsibility of caring for the men and women who served.

Current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

We also believe that the VA could address the needs of veterans through broad application of the ?hub-and-spoke? principle. A veteran can get his or her basic care at a community-based outpatient clinic (CBOC). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to a larger VA medical center. This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system.

Ultimately, we believe that in order for the VA to best meet this demand, adequate funding needs to be provided for health care. As we have stated in the past, we recognize that the Administration made a significant step forward this year with its funding request. However, it still does not go far enough. In order to avoid the problems experienced last year, and to address the access issues for all veterans, including those veterans who live in rural areas, Congress must appropriate a minimum of $32.4 billion as recommended by The Independent Budget.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. This legislation attempts to do so by stating that if a veteran lives more than 60 miles from the nearest VA health care facility then they live in a rural area. However, this is very much a subjective idea. Access to VA health care is subject not only to distance, but time and population density as well.

S. 1537

PVA strongly supports S. 1537, a bill that would codify the Parkinson's Disease, Research, and Educational Centers as well as the Multiple Sclerosis (MS) Centers of Excellence. We would like to express our sincere thanks to Senator Akaka for introducing this legislation. This proposal appropriately recognizes the successful strategy of the Veterans Health Administration (VHA) to focus its system-wide service and research expertise on two critical care segments of the veteran population.

Since 1997, PVA has worked closely with VA MS clinicians and administrators, as well as with private MS providers and advocates, to address the ?patchwork? service delivery for veterans with MS. From the beginning, we realized that within that ?patchwork? existed vital elements that, when brought together, could best serve veterans with MS.

The designation of two MS Centers of Excellence located in Baltimore and the Seattle/Portland area provides open access to centers engaged in marshaling VA expertise in diagnosis, service delivery, research and education. Furthermore, these programs are made available across the country through the ?hub and spokes? approach. The mid-term evaluation of these two centers acknowledged the success of VA's strategy.

With regards to the Parkinson's disease centers, PVA recognizes that these centers are a specific approach to focus health care services and research. The very delicate surgical and treatment breakthroughs developed in recent years must be localized so that they might be better assimilated into VA-wide practice. PVA supports this approach for Parkinson's disease just as we support the strategy for MS veterans.

S. 1731

PVA generally concedes to the wishes of our local chapters, as well as other local veterans' service organization members and State Congressional delegations on issues involving naming VA facilities. We, as the National Office of PVA, support, in concept S. 1731.

S. 2500, the ?Healing the Invisible Wounds Act?

PVA supports S. 2500, a bill that would enhance the counseling and readjustment services provided by the VA. PVA realizes the motivations behind Section 2 of this legislation. In light of the efforts by the VA last year to review some 72,000 veterans' claims for service-connection for Post-Traumatic Stress Disorder (PTSD), we believe that this provision is necessary. Veterans who experience serious mental health conditions should not face the prospect of a reduction of benefits simply because the VA does not believe that they are truly disabled.

PVA also supports Section 3 of the legislation that would require the VA to provide readjustment counseling to servicemembers in the National Guard or Reserves who return from a combat theater. It only makes sense that these men and women who are playing a significant role in combat operations around the world have access to counseling. We recognize that when National Guardsmen and Reservists demobilize they generally just want to go home. However, readjustment counseling may ultimately be in their best interest as they may face difficulties down the road.

To that end, we also support the authorization of $180 million for the Vets Centers. The Vet Centers managed by the VA provide vital readjustment services to the men and women who have placed themselves in harm's way and to their families. Vet Centers offer various types of readjustment counseling, including bereavement counseling, as well as related mental health services. The mental health services are especially important as the men and women returning from Iraq and Afghanistan seek to cope with the stress and related difficulties they faced while in combat. Moreover, their value is enhanced by the fact that they are located close to veterans and that they exist within a non-institutional environment.

Amputation and Prosthetic Rehabilitation Centers

PVA supports the creation of Amputation and Prosthetic Rehabilitation Centers outlined by the proposed legislation. The need for these centers is amplified by the number of veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) who have amputations. As we stated with regards to the Parkinson's disease and MS Centers of Excellence, the VA has the essential expertise to focus dedicated services on a wide range of medical conditions. It then transfers learned approaches for specific care to the broader VA health care system. However, the Veterans Health Administration (VHA) often times lacks the financial wherewithal to create a needed focal point or center. This legislation calls for the creation of these focal points and the need for resources to actuate that goal. We must emphasize, however, that additional real dollars will likely be needed to establish these centers.

We would also like the committee to consider going a step further as these centers are created. VHA should be required to partner with manufacturers, dealers, payers, and advocates to develop performance test standards for amputee and prosthetic devices. An example of these types of test standards is the American National Standards Institute (ANSI) and Rehabilitation Engineering

and Assistive Technology Society of North American (RESNA) Wheelchair Performance Standards. These standards are a collaborative effort with specific impacts on wheelchair research and development, consumer disclosure, and payer decisions. PVA believes that these centers could be the spearhead for development of evidence-based performance test standards for amputee and prosthetic devices.

The ?Veterans Long Term Care Security Act?

PVA believes that this proposed legislation is both timely and necessary to preserve and protect the State Veterans' Home program and the thousands of veterans who depend on it. During debate over the FY 2006 VA budget, the administration proposed cutting the per diem rate for State Veterans' Homes by two-thirds and proposed placing a moratorium on construction funding as well. Fortunately, Congress refused to support those recommendations. PVA urges the committee to preserve VA Per Diem rates and construction funding for State Veterans' Homes. Daily per diem funding is vital to the preservation of these programs.

The most recent Government Accountability Office (GAO) report concerning State Veterans' Home (GAO-06-264) release in March points out that 52 percent of VA's nursing home workload is currently being provided by state homes. In contrast, 35 percent is provided in VA-operated nursing homes and about 13 percent is provided in privately-operated nursing homes. Protective legislation is necessary to safeguard the largest segment of VA's three-pronged approach to providing nursing home care.

PVA supports Section 2 of this legislation that would require the VA to provide a report to Congress prior to implementation of a reduction in per diem rates. We believe that in order for the VA to provide a comprehensive report they should follow the GAO recommendations to collect necessary data that will accurately reflect the impact of proposals to reduce per diem rates and construction funding. The report should include information on the number of veterans affected, their age, their VA priority status, their gender, their length-of-stay, and local alternatives to care.

We also support Section 3 of the legislation that would require the VA to pay the full cost of nursing home care to eligible veterans residing in State Veterans' Nursing Homes. It is VA's obligation to pay for nursing home care for eligible veterans regardless of the venue of care. PVA likewise supports Section 4 that requires VA to furnish prescription medicines in State Veterans' Homes.

PVA is uncertain about Section 5 of the legislation that would allow VA to deem certain health care facilities as state homes. We have concerns about allowing the VA to deem any private nursing home as an eligible state home. How would VA and the individual states oversee issues regarding appropriate staffing, quality of care, safety, and cleanliness? PVA is concerned that ?deeming status? could dramatically increase the number of State Veterans' Homes without requiring proper checks and balances. The VA and individual states must have the capacity to monitor quality in any ?deemed status? facility.

PVA is also concerned that ?deemed status? could allow the VA to reduce the number of VA-operated nursing homes. VA nursing homes provide a higher quality of nursing home care than

is available in private sector. We would not support ?deemed status? if it results in a loss of VA-operated nursing homes. At the same time, we recognize the fact that additional ?deemed status? on State Veterans' Homes, that does not sacrifice VA facilities, and that can be successfully monitored, may help solve the problems associated with a rapidly aging veteran population and the increasing demand for nursing home care.

Mr. Chairman, PVA would like to thank you once again for providing us the opportunity to comment on these important issues. We look forward to working with the committee to ensure that meaningful legislation that best benefits veterans is enacted. I would be happy to answer any questions that you might have.