S. HRG. 109–737

HEALTH CARE LEGISLATIVE INITIATIVES CURRENTLY PENDING BEFORE THE U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

MAY 11, 2006

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE
28–560 PDF WASHINGTON : 2007

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HEALTH CARE LEGISLATIVE INITIATIVES CURRENTLY PENDING BEFORE THE U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

THURSDAY, MAY 11, 2006

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Larry Craig, Chairman of the Committee, presiding.

Present: Senators Craig, Burr, Thune, Akaka, Jeffords, and Salazar.

OPENING STATEMENT OF HON. LARRY E. CRAIG, CHAIRMAN, U.S. SENATOR FROM IDAHO

Chairman CRAIG. Good morning, ladies and gentlemen. The Committee on Veterans' Affairs will come to order.

Today, the Committee meets to receive testimony on several pieces of legislation concerning health care matters that have been referred to us for consideration. Our legislative agenda is fairly long, and we will have a number of witnesses to hear from this morning, so I will try to be very brief and ask my colleagues to do the same.

First, of course, I want to welcome all of our witnesses, and thank you for being with us today. We have a very large group on Panel II, so I will ask all of you to be mindful of the clock as you give your oral testimony. And, of course, as most of you know, your written comments will be included in the record and will be available for review by all Members.

Second, as I have noted, we have many bills on the agenda. Of course, I would like to direct your attention to two bills that I have introduced. One bill would make changes in the term limits now imposed on VA Under Secretaries for Health and Benefits. The other is a bill that I have sponsored along with my distinguished colleague, Senator Danny Akaka, and that is Senate bill 2736.

My first bill, S. 2634, would repeal the term limits on the two Under Secretaries at VA that I have just mentioned. Further, the bill would eliminate the requirement that there be a search commission to identify candidates for the President to consider for nomination to those positions. On the term limits, I just believe that the executive branch officials should serve at the pleasure of the President once confirmed. That means they are subject to re-

moval for poor performance, a very important part of the accountability, or they can continue to serve until such time as their services are no longer needed.

As for the search commission, I know some of our witnesses today from the veteran service organizations oppose that portion of the bill, partly because they have a role in the search commission's process, and partly because they believe the commission makes the position apolitical. I understand that, and I respect that it is an important process for your organizations and others. I hope we can work together to see if we can find some common ground in that area.

My second bill, introduced along with Senator Akaka, would direct VA to designate at least five amputation and prosthetic rehabilitation centers across the country to help coordinate care and services for veterans with amputations.

As all of you know, many of the men and women serving in our Armed Forces today are surviving injuries that they would not have lived through just 20 years ago. Most of that is attributed to amazing battlefield medicine. When I visited Iraq with Secretary Nicholson last year, I was struck by the assertion of a doctor in Germany, when we were there at Landstuhl, who told me that servicemembers that would be treated in that hospital in Germany that very night had not yet been injured in Iraq. Of course, the high survival rate also brings significant challenges. Challenges for men and women who survive these debilitating injuries and challenges for our medical system. Coordinating the medical, rehabilitative and psychological needs of our heroes with amputations are among the greatest of those challenges.

My hope is that the Craig-Akaka bill will create regional facilities that can serve as the specialty centers for the treatment and the rehabilitation of servicemen and women with amputation. I know VA is making tremendous strides in the care and treatment of these patients. The legislation is not intended to take those accomplishments away from VA. But I also think that the model we have employed for spinal cord injury and blind rehabilitation has fostered developments in the technology and treatment of those conditions that simply could not have been imagined at the outset of those endeavors. I also think the same will be true for these centers.

Today's newest veterans can live very active and productive lives even with their injuries. Activities like skiing, and kayaking, and mountain climbing, and employment, are well within the reach of these young men and women with amputations. The question is not whether they will do these things, it is whether their prosthesis, training and confidence will be up to the challenges of those activities.

These centers will help us answer the question or develop products that will answer the questions. I welcome VA to work with me and our Ranking Member to enhance this legislation, if necessary, so in the end we can have wide support for these centers.

Finally, I want the Senators to know that as the Chairman of the Committee, I truly appreciate the active engagement of so many Members of the Senate on matters that they believe are important to the care and treatment of America's veterans. I know every one

of the bills on our agenda today was submitted with the intention and goal of bettering the lives of our veterans or the system that provides benefits and services for these deserving citizens.

That said, I want to make my colleagues aware that in putting this agenda together today, we have erred on the side of listing bills for testimony and comments. But I want to caution everyone that their presence on the agenda would not be taken as a signal that I support all of the provisions of all the bills. In fact, I have concerns with many of the bills on today's agenda. We will work out our differences. Some of them may not be able to move forward past the point of the Committee process without minor, or in some cases, substantive changes. My concern centers on both cost and policy. I am committed to ensuring that we do not add significant new costs to the operations of VA health care system this year unless these costs are directly related to providing care and service to service-connected veterans, or will enhance the services provided to those returning from Iraq and Afghanistan.

I know many of you have heard my comments about VA's large budget increases, so I will not restate them. I just want to simply say that I do not wish to make our budget difficulties even worse next year. I hope Members will be willing to work with us, the Ranking Member and our staffs, to make changes where necessary so that we can move this legislation forward.

With that, let me turn to my colleague, the Ranking Member, Senator Danny Akaka.

Senator.

STATEMENT OF HON. DANIEL K. AKAKA,
RANKING MEMBER, U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you very much, Mr. Chairman, for holding this important hearing on our health care legislation. As we have a full legislative agenda before us today, I want to thank the Chairman for his work in preparing this, and also our staff for doing it.

I would like to just take a minute or so to highlight some key initiatives. Over the last few months, I have introduced several pieces of legislation, and they do share a common theme. The goal of each is to make sure that both returning servicemembers, as well as veterans already in the system, get the care they need and the care they deserve.

I am very pleased to have the opportunity to work closely with our Chairman on a bill that will create at least five amputation and prosthetic rehabilitation centers within the VA system. As he already discussed, these centers will provide cutting edge care and assistance to Veterans who have suffered from an amputation. With the current conflicts abroad resulting in a higher rate of amputations than any others before, it is imperative that VA move in this direction. We are ready to do our part to assist VA in this endeavor.

We also have legislation before us to specifically address the demand for long-term care. As the veteran population ages, the demand for long-term care has increased accordingly. As we all know, this trend will only continue as our Vietnam-era veterans get older.

Within the goal of encouraging more and smarter long-term care, I have introduced two bills.

One bill is specifically designed to give VA's local providers an incentive to develop creative ways to help alleviate the burden on caregivers while expanding services to veterans. This approach is based on a very successful mental health grant program launched by our Committee 7 years ago as part of the Millennium Act. Ensuring caregivers have the support and tools they need to care for their family members makes economic sense, and more importantly, makes policy sense. I would like to thank the Coalition to Salute America's Heroes for bringing this innovative idea to my attention.

The second long-term care bill is directed at State homes. These facilities are universally regarded as providers of high quality and cost-effective care to veterans, yet the Administration's proposals last year would have decimated the state-owned program by reducing its reimbursement. Through a bipartisan effort, we were able to stop those cuts. I want to make sure that such a proposal could never be advanced without more input from Congress and more thought by the Administration.

In addition, I believe we need to address some inequities that exist in the state-owned program. I also think there are ways we can use the State homes model to address gaps in nursing home care without building large new nursing homes, which do not make sense in certain small rural areas.

In January of this year, Chairman Craig and I held field hearings in my home State of Hawaii. The hearing on the island of Kauai focused exclusively on long-term care in rural settings. We heard testimony about an innovative approach to fill significant gaps in long-term care services to veterans due to the nature and geography of certain States. Bob Shaw, the National Legislative Chairman for the National Association of State Veterans Homes, who is here with us today, testified at the time that large State homes are not appropriate for the more remote locations in Hawaii. Instead, he argued, we should look to how Alaska has managed the challenges.

Rather than building new large homes, the State of Alaska is using its own Pioneer homes, which provide nursing care to older Alaskans, to provide care for veterans. Similarly, Hawaii could use existing beds in the community and deem such beds as part of the State Home program. Doing so would trigger per diem payments from the VA to help defray the cost of nursing home care.

Accordingly, my legislation would authorize VA to provide construction grants and per diem payments for small long-term care units, approximately 10 to 30 beds, in pre-existing health care facilities. Such units would address gaps in long-term care services for veterans living in the remote and rural regions, including Alaska, Wyoming, Idaho, Montana, Kansas, and other large rural States.

Mr. Chairman, I look forward to working with you in the days ahead to move this agenda forward. I look forward to hearing from all the witnesses today.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator Akaka, Thank you very much. We have been joined by our colleague, Senator Ken Salazar, of the great urban-rural State of Colorado.

Senator SALAZAR. I think more rural than urban, but I will say Idaho is still more rural than Colorado.

STATEMENT OF HON. KEN SALAZAR,
U.S. SENATOR FROM COLORADO

Thank you very much, Chairman Craig and Ranking Member Akaka, for your graciousness, for your leadership, and for your example on bipartisanship here in the U.S. Senate. I appreciate your leadership on veterans' issues.

The VA health care system is a critical component, both of our Government's obligation to veterans and of our Nation's health care system as a whole.

The legislation we will consider today is important in a number of respects. We will not only be discussing ideas for specific means we can improve the way we deliver health care to veterans, but we will also be talking about the fundamental shape and nature of the VA health care system, and whether and how we can take it to exciting new directions.

I often go out on the trail, as I was in Craig, Colorado, up in Moffat County, in the northwest part of the State, talking to over 200 veterans there this weekend, and extolling the virtues of what has been accomplished with VA health care. I am very proud of the efforts that we have already put on the table and have been a real example for others to follow.

Given the fiscal constraints we know we face in the coming years, we all know that we need to make some difficult decisions on how to weigh the health care needs of our veterans against the myriad of other very important Federal programs. Today's hearing, hopefully, will lay the groundwork for many of the decisions, and I am honored to have the opportunity to participate.

I want to extend my gratitude to the Chairman and Ranking Member for including my Rural Veterans Care Act as part of today's agenda. This legislation is based on many of the findings from last year's hearing of this Committee in Grand Junction, Colorado, where I heard about the challenges that many of our veterans in rural America face.

In 2004, a study of over 750,000 veterans residing in rural America was conducted by the VA which was headed by Dr. Perlin. The study found, in its essence, that veterans living in rural areas are in poorer health than their urban counterparts. That key finding is something that, I think, should have every Member of this Committee and every member of the VA concerned about, because at the end of the day, about 25 percent of the veterans of America live in the rural parts of our country. We ought not to have a disparity like that because it is a dishonor to the commitment that we all make to ensure that we honor the sacrifices that the veterans have made for our Nation.

The bill that I have proposed will take a series of steps to enhance the VA's ability to deliver care to rural veterans by helping veterans get to and from existing facilities and explore ways to bring VA health care services to their communities and homes, and

improve the quality of care they receive. Most importantly, it will ensure VA policies are sufficiently focused on the needs of rural veterans by creating a new position within the Department, an Assistant Secretary for Rural Veterans Affairs.

I want to thank my good friend and colleague, Senator Thune, for his work on this legislation, and for helping us craft it. I want to thank Senator Akaka and Senator Burr and Senator Murray, Members of this Committee, for their participation and their sponsorship of the legislation. In addition, my colleague from Wyoming, Senator Enzi; and other colleagues, Senators Lincoln, Dorgan, Conrad, Johnson, Murkowski, Burns, and Baucus. All of whom recognize the reality that the disparity that exists between veterans health care in urban and rural areas ought to be something that we make something of the past.

I know that there are some issues and concerns that have been raised about the legislation that we have proposed. I am looking forward to working with the VA, as well as the Members of this Committee and the staff, to see how we can work through those issues and make the Rural Veterans Health Care Act a reality this year.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Ken, thank you very much.

Now let us turn to our witnesses, and our first panel, Dr. Michael Kussman, Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs here in Washington. He is accompanied by Jack Thompson, Deputy General Counsel, Department of Veterans Affairs, along with Tom Pamperin, Director of Policy for Compensation and Pension Service, VBA.

Dr. Kussman, again, welcome before the Committee. Please proceed.

STATEMENT OF MICHAEL KUSSMAN, M.D., M.S., M.A.C.P, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY JACK THOMPSON, DEPUTY GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; AND THOMAS J. PAMPERIN, DIRECTOR, POLICY FOR COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION

Dr. KUSSMAN. Good morning, and thank you, Mr. Chairman, Ranking Member Akaka, and Senator Salazar. It is an honor for me to be here today to present the Administration's views on several bills that would affect the Department of Veterans Affairs programs that provide veterans benefits and services. I am accompanied, Mr. Chairman, as you mentioned, by Mr. Thompson and Mr. Pamperin.

I would like to submit my written statement for the record.

Chairman CRAIG. Without objection, it will be.

Dr. KUSSMAN. Mr. Chairman, I would like to start by discussing S. 1537, which would require VA to establish six Parkinson's Disease Research Education and Clinical Centers, also known as PADRECCs, and two Multiple Sclerosis Centers of Excellence. The bill prescribes detailed requirements for the centers.

First, I want to assure the Committee that the VA is fully committed to providing high-quality patient care to all veterans who suffer from Parkinson's Disease and other movement disorders, and we appreciate the efforts of House Veterans' Affairs Ranking Member, Lane Evans, for his strong support for the PADRECCs and their activities, and veterans in general.

I testified before the House Veterans' Affairs Subcommittee on Oversight and Investigations in 2004. The VA took major steps toward improving patient care and outcomes, while over the longer term, pursuing a cure for Parkinson's Disease when the PADRECCs were started in fiscal year 2001. VA now supports PADRECCs at six sites across the country, caring for 18,500 patients in fiscal year 2004. To ensure that the sites are effectively achieving their missions, we are currently evaluating the PADRECCs and expect to complete this evaluation and share the results with Congress in late fiscal year 2007.

Because the Department is currently working to achieve many of the objectives of the proposed legislation, we ask that the Committee defer action until after the evaluation results are available so they can be considered. This is especially true since one of the original goals of the PADRECCs was to evaluate deep brain stimulation as a modality of therapy for Parkinson's Disease. During this time, DBS, or deep brain stimulation, has been accepted as a mainstream treatment and is no longer experimental.

The VA is also concerned about the statutory mandates for disease specific centers, such as PADRECCs and MS Centers of Excellence—the PADRECCs and the MS Centers of Excellence were based on the successful Geriatrics Research, Education and Clinical Centers, the GRECC, and Mental Illness Research, Education and Clinical Center, the MIRECC models. The GRECCs and the MIRECCs focus on a wide scope of conditions facing a significant portion of the veteran population from a multidisciplinary approach. The VA is concerned that disease specific centers may work to fragment care which is otherwise well designed in our well designed world class integrated health care system.

Bill S. 2433, the Rural Veterans Care Act of 2006 is an ambitious measure to improve access to VA health care and other veterans benefits for veterans living in rural and remote areas. We share your commitment to provide veterans who live in these areas with adequate access to VA health care and services. However, we do not agree that this bill would effectively achieve this. The written statement outlines specifics about our concerns.

Nonetheless, we are very sensitive to the needs of Americans who live in rural areas for many of the same reasons that Senator Salazar mentioned. It is a national concern. Many rural areas throughout the United States lack professionals who can provide specialized service, and in some cases, even primary care. It is important to note that this situation is not unique to the VA.

We have taken special efforts to improve patient care for veterans living in rural areas with the establishment of community-based outpatient clinics, attention to care coordination, and expansion of tele-health initiatives. By leveraging new advances in technology, we expect to be able to expand our capability to provide

services in veterans' homes and decrease the need for long and arduous travel to a facility.

In addition, we regularly cooperate and collaborate with veteran service organizations, the Indian Health Service and the Department of Health and Human Services, to serve veterans who live in rural areas. For example, many facilities partner with VSOs to provide an external transportation system, which is vital to many veterans obtaining their health care at VA facilities in remote, rural or frontier areas. Also, a primary focus of the CARES process has been to consider how to best serve veterans in rural areas.

I would also suggest that it is important to consider this perspective in regard to veterans receiving health care. While it is important and is reported that 23 percent of enrollees live in rural areas, based on the census definition of rural health, only 4 percent of enrollees live in a rural area that necessitates travel for more than 60 minutes to a VA facility for care.

I do want to note that we believe that the demonstration projects and pilot projects included in the legislation could be achieved to a large extent within the current VA structure and existing authority.

Bill S. 2500, the Healing of Invisible Wounds Act of 2006, would prohibit the VA from implementing any modification of the manner in which VA handles the ratings for Post-Traumatic Stress Disorder compensation claims until 6 months after the Secretary submits a report to VA's authorizing committees on such modification. As VA currently has no plan to change this procedure for handling ratings for PTSD claims, we believe that legislation in this area is unnecessary at this time.

The bill would also require the VA, in consultation with the Department of Defense, to provide each member of the National Guard and Reserves who serves in active duty in a combat theater with readjustment counseling services within 14 days of their return from deployment in a combat theater. From a clinical perspective we have learned that mental health treatment must be individualized. We also know that 14 days may not be sufficient time for returning combat veterans to recognize their needs for readjustment counseling and related mental health services. We believe mandating this evaluation violates the basic principle of allowing patients to choose when, how and where to seek medical care. In addition, mandating evaluation and treatment could be counterproductive if the servicemember is not ready or is unaware of their potential problems.

Furthermore, to address the need for follow-on evaluation, DOD has initiated the post-deployment health risk assessment, the PDHRA program, that is designed to identify and offer individuals a full gamut of mental and physical services, 90 to 180 days post-deployment. The VA utilizes our Vet Centers' services as well as our full medical center services in support of this program.

Mr. Chairman, you and Senator Akaka have introduced Bill S. 2736, with the goal of enhancing rehabilitation services to veterans with amputations and prosthetic devices. I want to assure you that the VA shares your concerns and is committed to provide high-quality amputation care involving interdisciplinary amputation clinic teams, prosthetic and orthotic laboratories, and preservation

amputation care and treatment programs. Providing this type of care throughout our system and closer to the veterans homes is one of our goals. In many instances amputation care and prosthetic services are only part of the needs of the wounded warrior. In this vein, you are aware of our four polytrauma centers, which have been heroic in providing the interdisciplinary care needed for seriously injured servicemembers.

We have identified a need for a further dissemination of this expertise in areas closer to where the veterans live. As a result, we are in the process of developing 17 more network sites, one per network, the 4 polytrauma centers and 17 more, to provide similar but less intensive care to the veteran to include expanded prosthetic and amputation services. Teams at these sites are or will be trained to provide the rehabilitation services across the full spectrum of impairments commonly associated with combat injury. We believe that the work of these centers will meet the requirements of your proposed legislation. We invite and strongly encourage you to visit these centers to see for yourself the progress that has already been made, and to learn more about VA's plans to extend this care.

Furthermore, VA is partnering with DOD at the Intrepid Center in San Antonio, and the new Walter Reed Amputation Center, to do what your legislation proposes. We fear that to add new centers of excellence, as described in the legislation, will be redundant, and replicate already existing services. We owe the 450 servicemembers who have suffered an amputation in this conflict the very best.

Consequently, we ask that you defer action on this legislation so we can form a partnership and work jointly to achieve the best care for these amputees. We believe that the 21 centers are better than 5.

VA supports S. 2634, which will eliminate the statutory limits for the Under Secretaries of Health and Benefits. This bill is important to provide the Secretary with needed flexibility as well as decrease the time required to fill these vacancies.

Mr. Chairman, we are still in the process of clearing views on S. 2753 and S. 2762, and we are in the process of doing cost estimates for these and most of the bills discussed. Once we do, we will supply those for the record.

I am pleased to see that while we may differ in our approach to some of the issues, the VA and the Committee both have the same conviction and dedication to meet the health care needs of our veterans and to provide the best care for all the veterans throughout the Nation.

This concludes my oral statement, Mr. Chairman, and I will be happy to answer any questions that you or other Members of the Committee have.

[The prepared statement of Mr. Kussman follows:]

PREPARED STATEMENT OF MICHAEL KUSSMAN, M.D., M.S., M.A.C.P, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION

Good Morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services.

S. 1537

Parkinson's Disease Research Education and Clinical Centers; Multiple Sclerosis Research Education and Clinical Centers

Mr. Chairman, I will begin by addressing S. 1537. This bill would require VA to establish six Parkinson's Disease Research, Education, and Clinical Centers (PADRECCs) and two Multiple Sclerosis Centers of Excellence (MS Centers). The bill prescribes detailed requirements for the centers. It would provide that any such center in existence on January 1, 2005, must be designated as a PADRECC or MS Center under this law unless the Secretary determines that it does not meet the bill's requirements, has otherwise not demonstrated effectiveness in carrying out the purposes of a PADRECC or MS Center, or has not demonstrated the potential to carry out those purposes effectively in the reasonably foreseeable future. The centers would also need to be geographically distributed. Finally, the Secretary could designate a facility as a new PADRECC or MS Center only if a peer review panel finds that the facility meets the requirements of the law, and recommends designation.

VA does not support S. 1537 because it is unnecessary; the Department is already in full compliance with the substantive requirements of this bill. VA recommends that Congress await an ongoing evaluation of the existing PADRECCs before it considers whether to mandate that VA either continue their operation or designate new centers. Additionally, VA is concerned that statutory mandates for these "disease specific" centers have the potential to fragment care in what is otherwise a well-designed, world class integrated health care system. I am increasingly concerned about the proliferation of this disease specific model and its impact on patient care and VA's integrated health care model. As it relates to a particular disease, I believe that it is much more important for VA to disseminate the best in evidence based practices across its health care system than to establish centers that provide care for a particular disease. VA currently has PADRECCs at six sites—San Francisco, California; Richmond, Virginia; Philadelphia, Pennsylvania; Houston, Texas; Los Angeles, California, and Puget Sound/Portland, Oregon (a combined site). Those sites served a total of 18,500 patients in fiscal year 2004. We are currently conducting an evaluation of PADRECCs' effectiveness in disseminating best practices, impact on patient outcomes, and the types of organizational structures that contribute to effectiveness. The study will be completed in 2007. Until this study is complete, VA believes that it would be unwise to mandate continued operation of these or additional PADRECCs . VA will, of course, share the results of the evaluation with Congress to assist in determining the need for legislation in the future.

For similar reasons, VA also does not support establishing new specialty centers for the care of veterans with multiple sclerosis. VA is well aware that Parkinson's disease and multiple sclerosis are prevalent in the veteran population, particularly among aging veterans. However, the nature of battlefield injuries is changing, and VA is now treating many new veteran patients with complex polytrauma syndromes, including brain injuries, limb loss, and sensory loss. Treating such disorders, and the mental and emotional disorders that accompany them, requires an interdisciplinary approach that moves beyond the focus on a single disease. By mandating new "education, research, and clinical centers" that are disease-specific, flexibility to respond to changing combinations of related conditions is reduced. It is also important to note that the "models" on which PADRECCs and MS Centers are based, the successful Geriatric Research, Education and Clinical Center (GRECC) and Mental Illness Research, Education and Clinical Center (MIRECC) programs, were not as narrowly focused on a disease process but addressed a wide gamut of issues facing a significant portion of the veteran population.

S. 2433, RURAL VETERANS CARE ACT OF 2006

Mr. Chairman, S. 2433 is an ambitious measure to improve access to VA health care and other VA benefits by veterans living in rural and remote areas by creating a new Assistant Secretary who would be responsible for formulating, coordinating, and overseeing all VA benefits, policies, and procedures affecting such veterans. This would include overseeing and coordinating personnel and policies of the three Administrations (i.e., Veterans Health Administration (VHA), Veterans Benefits Administration, National Cemetery Administration) to the extent such programs affect veterans living in rural areas.

Section 2 of the bill would establish a new Assistant Secretary for Rural Veterans (AS) to formulate, coordinate, and implement all policies and procedures of the Department that affect veterans living in rural areas. It would require the new Assistant Secretary to oversee, coordinate, promote, and disseminate research into issues affecting veterans living in rural areas, in cooperation with VHA and the centers

that would be established under section 6 of the bill, as well as ensure maximum effectiveness and efficiency in the provision of benefits to these veterans in coordination with the Departments of Health and Human Services (HHS), Labor, Agriculture and local government agencies.

In addition, section 2 would require the Assistant Secretary to identify a Rural Veterans Coordinator in each VHA Integrated Service Network (VISN), who would report directly to the Assistant Secretary and coordinate all the functions authorized under section 2 within his respective VISN. It would also require the Assistant Secretary, under the direction of Secretary, to supervise the VA employees who are responsible for implementing these policies and procedures.

Section 3 of the bill would require the Assistant Secretary to carry out demonstration projects to examine alternatives for expanding care in rural areas. In so doing, the Assistant Secretary would have to work with the Department of Health and Human Services to coordinate care that is delivered through the Indian Health Service, Critical Access hospitals, or Community Health Centers. One such program would have to involve expanded use of fee-basis care for veterans living in rural or remote areas. Not later than 1 year after the date of enactment of this Act, the Assistant Secretary would be further required to re-evaluate VA policy on the use of fee basis care nationwide and to revise established policies to extend health care services to rural and remote rural areas.

Section 4 of the bill would require the Secretary to conduct a 3-year pilot program in 3 VISNs to evaluate various means to improve access to care in highly rural or geographically remote areas for all enrolled veterans and those with service-connected disabilities who live in such areas. In carrying out the pilot, the Secretary would be required to provide these veterans with acute or chronic symptom management, non-therapeutic medical services, and any other medical services jointly determined to be appropriate by the individual veteran's VA primary care physician and the respective VISN Director. The Secretary would also have to allocate 0.9 percent of the appropriated medical care funds to carry out this section before allocating any other medical funds.

Section 5 would amend VA's authority to provide beneficiary travel benefits to require that covered lodging and subsistence be determined at the same rates that apply to Federal employees. It would also require that VA's mileage allowance be determined in accordance with the rates that apply to Federal employees.

Finally, section 6 of the bill would require the new Assistant Secretary to establish up to five Centers of Excellence for rural health research, education, and clinical activities. These centers would be required to: conduct research on rural health services; allow for use of specific models of furnishing services to this population; provide education and training for health care professionals; and, develop and implement innovative clinical activities and systems of care.

We share the concern that rural veterans have adequate access to VA health care and other VA services; however, we do not agree that the bill would effectively achieve this and, so, oppose S. 2433.

First, the Under Secretaries of the three VA Administrations are responsible for formulating and implementing program policy in their respective areas. The proposed Assistant Secretary could have no direct authority over them or their organizations. The proposed role and responsibilities of the Assistant Secretary, as provided for in this legislation, would cause significant confusion and disruption across organizational lines—both among, and within, the Administrations.

Assuming there were some way to operationalize the responsibilities of the Assistant Secretary, the ability of the Under Secretaries to manage their employees and respective programs efficiently and effectively would be significantly reduced. The bill would dilute control from the Administrations with respect to specified activities, personnel, and resources. This would increase the potential for fragmented services, waste, and inconsistent, if not unequal, treatment of veterans based solely on their geographic location. For instance, 23 percent of enrollees live in rural areas based on the Census' definition of a rural area. However, only 4 percent of enrollees live in a rural area and travel more than 60 minutes to a VA facility. Under the bill, a disproportionate share of health care resources would be directed to this population. The planning and delivery of services to rural veteran-enrollees would be inconsistent and incoherent with respect to the total population of enrolled veterans. The possibility of fragmentation in the delivery of benefits cannot be overstated.

Second, S. 2433 would adversely dilute the ability of the Under Secretary for Health to manage not only the delivery of VA health care to rural veterans but also the delivery of health care to all veterans because of the significant costs associated with enactment of this bill. The proposed demonstration projects would cost $225 million based on the President's Budget for fiscal year 2007. The additional beneficiary travel benefits would cost approximately $550 million (based on current em-

ployee-related rates), and that estimate accounts only for the proposed increase in VA's mileage allowance. Providing per diem (lodging and subsistence) at the proposed rates in addition to the mileage allowance would raise the estimate to well over $1 billion. Moreover, these increases would assist only the limited categories of veterans who are eligible for beneficiary travel benefits. We believe medical care funds are better directed to the delivery of direct health care for all eligible veterans.

We note that the mandate to expand the use of fee-basis care in the proposed demonstration projects may not be possible, because VA's authority to provide fee-basis care (meaning contract care other than care furnished under a sharing or scarce-medical-specialist agreement) is limited by statute. Further, the mandate ignores the economic impact of expanding the use of fee basis care. The cost of care in fee settings is typically significantly greater than the cost of the same care provided in VA settings. As a result, while fee-basis expansion may make care accessible for some rural veterans, it would disproportionately reduce the resources available for care of all other veterans. Moreover, we do not understand the mandate to provide non-therapeutic medical services as part of the pilot program and would question the wisdom of providing such service from the three medical care appropriations.

Finally, the demonstration projects and pilot project could be achieved, to a large extent, within the current VHA structure and existing authority. It does not require an organizational restructuring, which, again, would create significant risk of fragmentation and lack of continuity of care and benefits.

S. 2500, HEALING THE INVISIBLE WOUNDS ACT OF 2006

Section 2 of S. 2500 would prohibit VA from implementing any modification of the manner in which VA handles ratings for post-traumatic stress disorder (PTSD) claims for purposes of the payment of compensation until 6 months after the Secretary submits to the Senate and House Committees on Veterans' Affairs a report on such modification. We do not support enactment of this section of the bill for several reasons. First, VA believes that this legislation is unnecessary because VA currently has no plan to change its procedures for handling ratings for PTSD claims. Second, the bill would represent an unwarranted restriction on the Secretary's Congressionally delegated authority to issue regulations governing veterans' benefits matters, which must be based upon statutory authority, and to manage the implementation of statutorily authorized benefit programs. Finally, VA is already required to report to Congress on its rulemaking. Under 5 U.S.C. S. 801, before a rule can take effect, VA must submit to both Houses of Congress a report on the rule.

Section 3 of this bill would require the Secretary of Veterans Affairs, in consultation with the Secretary of Defense, to provide each member of the National Guard and Reserves who serves on active duty in a combat theater with readjustment counseling services within 14 days of their return from deployment in a combat theater. Such services would have to be provided through VA's Vet Centers. Services would have to include group counseling, a 1-hour session of private counseling, and outreach concerning VA readjustment counseling services and mental health services. Section 3 would also require that the National Guard member or reservist be retained on active duty until receipt of the readjustment counseling services required under the section.

VA does not support section 3 of S. 2500. A returning combat-veteran's need for readjustment counseling and related mental health services will be case-specific. Mandating that all such servicemembers receive this counseling and related mental health services is counter-productive and inefficient in the absence of an individual needs assessment being conducted by an appropriate VA professional. It also violates a fundamental liberty of the servicemember to be able to choose whether to receive such services, thus violating the hallmark bioethical principle of patient autonomy. Further, we object to legislatively mandating the type of counseling to be provided, including the treatment milieu. Not all of these servicemembers would want or benefit from group sessions, for instance. Indeed, such sessions might be contraindicated in particular cases. We strongly believe that only VA's health care and counseling professionals can and should determine who among the cohort of returning combat soldiers needs readjustment counseling and/or other appropriate related care. Finally, as to the proposal that they retain their active duty status until receipt of VA services, we must defer to the Department of Defense (DoD).

S. 2634, ELIMINATING STATUTORY TERM LIMITS OF UNDER SECRETARY FOR HEALTH AND UNDER SECRETARY FOR BENEFITS

Mr. Chairman, S. 2634 would eliminate the current statutory 4-year term limit that applies to both the Under Secretary for Health and the Under Secretary for Benefits position, as well as the currently mandated search-commission processes for identifying candidates to recommend to the President for these positions. VA supports S. 2634 as it would provide the Secretary with needed flexibility as well as decrease the time required to fill these vacancies.

S. 1731, REDESIGNATION OF VAMC MUSKOGEE, OKLAHOMA

This bill would designate the Department of Veterans Affairs Medical Center in Muskogee, Oklahoma as the "Jack C. Montgomery Department of Veterans Affairs Medical Center." We defer to Congress in the naming of Federal property in honor of individuals.

S. 2736 AMPUTATION CENTERS OF EXCELLENCE

S. 2736 would require the Secretary to establish not less than five centers that provide enhanced rehabilitation services to veterans with amputations and prosthetic devices. Each such center would provide special expertise in prosthetics, rehabilitation with the use of prosthetics, treatment, and coordination of care for veterans with any amputation. They would also be responsible for providing information and supportive services to all other Department facilities concerning the care and treatment of these veterans. Each center would have to meet specific staffing and resource requirements set out in the bill. Finally, these centers would not be able to duplicate the services currently being provided by the Department's polytrauma centers.

The Department does not support S. 2736 because it is unnecessary in light of the recent and notable progress VA has made to address the needs of patients with amputations and more complex injuries. VA recognizes the Committee's concern regarding this important issue, not only as it relates to veterans already in the healthcare system but also as it relates to returning OIF/OEF combat veterans. We would like to work with the Committee Members to make sure their concerns are addressed and plans to keep the Committee apprised of the progress we make as we continue to integrate the amputation system of care with the polytrauma system of care. VA first developed the amputation system of care in 2004, but as the war progressed and VA saw the dramatic increase in patients with complex, multiple injuries as a result of Improvised Explosive Devices (IEDs), VA developed a comprehensive, integrated system of care to provide rehabilitation to these patients with severe and lasting injuries. Teams at these sites are being trained to provide rehabilitation services across the full continuum of impairments commonly associated with combat injury including prosthetics and amputation. Given our recent decision to open up the additional 17 Level II Polytrauma Network Sites, we believe this legislation is unnecessary, but would be pleased to continue the discussions with the Committee on this important subject.

I would now like to address some of the specific clinical, educational, and research initiatives that are currently underway that obviate the need for this legislation.

CLINICAL CARE

VA has a long-standing history of providing amputation care, which involves interdisciplinary amputation clinic teams, prosthetic and orthotic laboratories, and Preservation-Amputation Care and Treatment Programs (PACT). We are enhancing our delivery of amputation care to address the needs of returning combat injured veterans who have suffered amputations. These veterans are younger, were previously active and healthy, and have high expectations and goals for life after amputation. Such enhancements include: addition of staff; advanced specialized training for staff; use of advanced prosthetic devices, equipment, and techniques in the rehabilitation process; and, long-range case management services to provide care coordination.

These enhancements are being developed as a complement to, and in coordination with, the polytrauma system of care—not as duplicative efforts. This coordination is necessary because many of the returning amputee-veterans have additional injuries, such as traumatic brain injury, PTSD, or hearing loss, requiring expanded rehabilitation services. The polytrauma system of care is designed to provide lifelong rehabilitation services across the full continuum of care. Four Polytrauma Rehabilitation Centers (PRC) and 17 Polytrauma Network Sites (PNS) have been established. The PRCs are located in Tampa, Florida; Richmond, Virginia; Minneapolis,

Minnesota; and, Palo Alto, California. These Centers provide acute inpatient rehabilitation services to veterans with multiple impairments, including amputation. The interdisciplinary teams at the Centers include: physicians; physical therapists; occupational therapists; prosthetists; social workers; case managers; nurses; psychologists; speech therapists; and, recreation therapists.

The 21 Polytrauma Centers (4 PRCs and 17 Network Sites), one in each VISN, address long-range care needs and case management. PNS sites were identified based on specific amputation, rehabilitation, and mental health expertise including:

1. Comprehensive Physical Medicine and Rehabilitation Service;
2. Inpatient Rehabilitation Unit accredited by the Rehabilitation Commission (CARF);
3. Prosthetic/Orthotic Lab accredited by ABC or BOC; certified prosthetist on staff;
4. Surgical expertise in the area of amputation care and polytrauma;
5. Specialized PTSD programming;
6. Presence of Driver's Training Program; and
7. Access to telerehabilitation technology.

These sites provide access to specialized services either directly, or via consultation, within a reasonable geographic distance of veterans' home. This interdisciplinary approach is used throughout the continuum of care not just in the patient's acute rehabilitation setting.

As servicemembers progress from the acute care setting to their home environment, their needs for services will change. To meet these demands, our clinical teams must be well versed in evaluation techniques, rehabilitation methods and prescription of equipment.

To that end, VA is working closely with Walter Reed Army Medical Center and Brooke Army Medical Center (BAMC) to provide advanced training in amputation care to VA clinicians. For example, VA has entered into a Memorandum of Agreement with BAMC to provide advanced rehabilitation for patients with amputations at BAMC's newly designed Center for the Intrepid (CFI). The agreement provides for VA staff to be based at the CFI. This staff will have access to state-of-the-art equipment and techniques for amputation rehabilitation. Their duties will include providing regular training sessions to other VA employees. Veterans and military servicemembers will have access to this specialized center for high level rehabilitation.

EDUCATION AND TRAINING

Specialized training for prosthetists and therapists in the Polytrauma System of Care has been provided in a number of venues. VA clinicians have received advanced skills training though Walter Reed Army Medical Center and BAMC. At present, VA has 12 teams of prosthetists and physical therapist scheduled to attend the Military Amputation Advanced Skills Training, on May 10–12, 2006. (Teams attended similar training at WRAMC 1 year ago.) Finally, a joint DoD-VA Amputation Clinical Practice Guideline is being developed to provide guidance to the field in the area of amputation rehabilitation.

RESEARCH

VA has three research Centers of Excellence related to amputation. These Centers address state-of-the-art discoveries in prosthetic equipment, biohybrid limbs, microelectronics and nanotechnology. By collaborating with Rehabilitation Research and Development, the Centers and PNSs will be on the cutting edge of new technology in amputation care. The three Centers are identified below.

- Seattle

Limb Loss Prevention and Prosthetic Engineering.

- Providence

Tissue Engineering to Rebuild, Regenerate and Restore Function after Limb Loss.

- Cleveland

ADVANCED PLATFORM TECHNOLOGY

Elsewhere, the Miami VAMC has established a Research Center for Amputation Rehabilitation. Professionals at Miami are actively involved in the development of advanced rehabilitation strategies in amputation care and provide excellent outreach and education to the larger VA community. In addition, the Salt Lake VAMC and the University of Utah have recently been given grants to evaluate strategies related to osseointegrated implants.

OTHER BILLS

Mr. Chairman, we do not yet have cleared views on S. 2753 or on Senator Akaka's draft bill on State Homes. Nor do we have cost estimates for these and most of the bills we have discussed. Once we do, we will supply those for the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

RESPONSES TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. MICHAEL KUSSMAN

Question 1. With regard to Vet Centers and S. 2500, you mentioned in your statement that while VA appreciates the intent of the legislation, it is not necessary to mandate post-deployment mental health counseling. Yet, we have seen tremendous results from the work done by Vet Centers in conjunction with the Reunion and Reentry Program in New Hampshire. We are all aware of the recent GAO report which raised the concern that soldiers screened may not be getting the care they need. What is being done to replicate the success of the New Hampshire model at other sites across the country?

Answer. Failed to respond before publication.

Question 2. While I understand that VA did not have time to submit formal views on my caregiver assistance bill, S. 2753, I would like to inquire about a related program that VA recently implemented. As you know, last year's $100 million set aside for mental health initiatives was distributed to incentivize providers in the field to come up with innovative proposals for treating veterans who require mental health services. We saw great success from that effort, and I am proud that Hawaii's veterans were able to benefit as well. I think we all know that there are gaps in VA non-institutional care, as GAO has previously found. In that case, why not try a similar program for long-term care?

Answer. Failed to respond before publication.

Question 3. VA did not submit formal views on my State Veterans Home legislation, S. 2762. I would like to ask about the per diem rates that VA allocates to State Homes for the care of veterans. Can you please explain the rationale behind the current policy of only partially reimbursing State Homes for the cost of caring for service-connected veterans? It is my understanding that VA pays community nursing homes almost three times as much per day to care for the same veteran patients.

Answer. Failed to respond before publication.

Chairman CRAIG. Dr. Kussman, thank you very much for that detailed testimony, and we trust you will get positions on S. 2753 and S. 2762 to the Committee as soon as possible.

We have been joined by two of our colleagues. If you do not mind, I will allow you to make any opening and additional comments you wish to make inside the questioning period. Is that fine with both of you?

Let us proceed then with questions. Dr. Kussman, I understand that the Administration opposes—and you have just stated so—the legislation introduced by Senator Akaka and myself to create the amputation and prosthetic rehabilitation centers on the grounds that the centers are not necessary in relation to the work you are currently doing. Your argument is the VA generally has greatly expanded its services to these veterans. Witnesses on our second panel today argue that the care for amputees is still hit or miss, depending upon where you live. How does VA approach, work toward ensuring that the care and treatment of amputees, especially those with service connected disabilities, will be topnotch and consistent across the country?

Dr. KUSSMAN. Thank you, Mr. Chairman, for the question. Let me say it is an awesome challenge to come here and basically say, no, to most of the legislations that were initiated, but I hope you understand that we are in support of much of what was done, it is just the manner in which we should do this.

The answer to your question, the VA, in order to specifically talk about the hit and miss, I will be the first one to say that we are not perfect. That there are challenges in a large system like ours to be sure that we provide as much care as we can throughout the system, and that is really the purpose of a lot of the things that we are doing.

However, in order to maintain quality, we have mandated that all VA prosthetic and orthotic laboratories become accredited by either the American Board of Certification, the ABC, or the Board of Orthotics and/or Prosthetics certification, the BOC. The process of accrediting labs ensures that the state-of-the-art equipment and educated employees are able to meet the quality standards of what our veterans need.

This ensures that we are comparable to anything that is going on in the civilian community. And working with DOD, we are sending teams to Brooke Army Medical Center, and Walter Reed Army Medical Center to brush up on the new technologies and the state-of-the-art equipment that really only exist at a place like Walter Reed where the research is being done, and it does not exist anyplace else in the country. Irrespective of the VA, it does not exist in the civilian community. But we want to be sure that working with DOD, we can provide that full gamut of care.

Chairman CRAIG. Does a clinician treating an amputee in Boise, Idaho or in Lake City, Florida know where to send a veteran with a prosthetic complication that is beyond the expertise of the local facility to treat? That would be my first question.

And do they know who to call for information on the latest prosthetic devices for specialized amputations?

Dr. KUSSMAN. Yes, sir. Thank you. I believe that the clinicians treating the amputees, whether it is in Boise or in Lake City or in any place in our system, have access to the prosthetic personnel in each of these facilities, who are readily available to help the clinician if they have questions on how and where to provide the information and care to any of our veterans, new or old, for prosthetic care.

As far as who to call for information, Mr. Fred Downs, I think whom you know, runs our prosthetics and orthotics system, has a very intensive and involved network, where anybody who has any questions can call him directly. As I said, we are training our people with Walter Reed and Brooke Army Medical Center, and will participate directly in the care at the specialized centers at Walter Reed and the Intrepid Center, so we believe that information will be disseminated throughout the system.

Chairman CRAIG. As you know, it is not just Iraq and Afghanistan. We have hundreds, if not thousands, of veterans from previous wars who have prosthetic devices for amputations. The devices wear out and they break down over time, or literally just break. It is my understanding that replacement services can be lengthy. What system does VA employ today to track all of those veterans, on a regular basis, to ensure that they are seen in regular intervals for prosthetic assessments and/or replacements of aging or broken devices? And, of course, you, as well as most Members of this Committee, are witness to this new generation of de-

vices that are phenomenally better, and will these veterans have those devices made available to them?

Dr. KUSSMAN. Yes, sir. Thank you for the question. I would be the first one to admit that as far as a tracking mechanism, we have not put in place a tracking mechanism as thorough as we would like to see. That has been a challenge to our PACT program that is actually establishing a registry that we will be able to track both new and old—I don't mean old in age, although I am getting older every minute—but as far as previous wars' veterans. And we will know where they are and how often they are being seen and what devices they have. Each veteran is assigned a primary care provider who would see them clinically and refer them to whatever specialty clinics or prosthetic services that they need.

As far as replacing aging and broken devices, again, the system is not perfect, but all service connected amputees are provided a prosthetic or orthotic device, and they are given a prosthetic service card. This card allows the veteran to seek repairs of his or her device at the point of service or emergencies without any prior authorization. They can just go to whoever has serviced them, wherever they are in the country. Should the determination be made at the point of service that additional services are needed, these cards contain the VA point of contact to get additional authorization.

Veterans who are not service connected may call their local prosthetic service vendor and authorization can be provided to the vendor via purchase card. Veterans who live within close proximity of the VA can simply report to the prosthetics department, and repairs are processed immediately.

We are very anxious to learn about situations where the system does not work well, and that we would commit ourselves to making sure that there are not long delays and frustrations for veterans who need our services.

Chairman CRAIG. Dr. Kussman, thank you very much. You are correct, you and I are not aging.

[Laughter.]

Chairman CRAIG. I once Chaired the Aging Committee here. We are maturing.

Dr. KUSSMAN. I do not really mind getting older, considering the alternative.

[Laughter.]

Chairman CRAIG. Thank you very much. Let me turn to my colleague, Senator Akaka.

Dan.

Senator AKAKA. Thank you very much, Mr. Chairman.

Dr. Kussman, of all items on the agenda, only one bill garners VA support. I would like to add that the one bill you support is an Administration bill, and with a smile, I want to commend you for your courage.

[Laughter.]

Dr. KUSSMAN. You notice who is here today.

[Laughter.]

Senator AKAKA. Am I to infer that there is nothing the Administration has or needs from Congress other than authority for higher copayments. I would like to think that Congress has valuable input to be made, especially in those areas where the GAO and others

have found shortcomings, like long-term care, mental health, and seamless transition.

Today, GAO came out with findings which showed that the majority of soldiers at risk to PTSD were never referred by clinicians for further help. We have long pressured DOD to screen returning soldiers with the assumption that care be forthcoming. From your perspective, doctor, is the interaction between VA and DOD working to reach and treat veterans in need of mental health care?

Dr. KUSSMAN. Thank you for the question. Yes, having had a previous career on the south side of the Potomac, and now being on the north side, I think I have a little bit of perspective on—I have been encouraged, and I think most of us who understand the dynamic feel that partnership is as good as it has ever been.

In reference to your comments about the GAO report that was in the Washington Post this morning, if I remember the statistics exactly, they looked at 179,000 people who came back, and 9,000 or so were ones that with the post-deployment questionnaire that is done on everybody who redeploys, answered three of the critical questions enough that they would potentially need—that is 5 percent of the total number of people. Of that 5 percent, only 22 percent got direct follow up, and 78 percent they could not document.

It is not clear from that, the GAO study—and we have been aware of that—of how many are active duty that are still staying on active duty of that 179,000 or the 9,000 who filled out the questionnaire. And they would be picked up potentially later in the active duty component. The ones that I think you are most interested in are the National Guard and Reserves, who are leaving active duty. That has been a challenge all along with our partnering because many of these—particularly the National Guard and Reserves—after deployment, want to go home. Some of them refuse to get the evaluation because they know that they have to stay. That is why the post-deployment health risk assessment program was established by DOD, partnering with us, where we leverage our Vet Centers and our traditional facilities in support.

So I believe that there is ample opportunity for people to get the care that they need, but to some degree the servicemember has to acknowledge and be willing to get some help. The problem with this is that they do not want to, or they do not see it as a problem.

We are well aware of the challenges of getting people in for mental health, but we give them wallet cards and all kinds of information when they leave the post-deployment arena to allow us to help them when they need care.

So I believe we are working very closely with DOD on multiple levels and multiple arenas to provide mental health services. This is very important to us.

Senator AKAKA. Yes. And this is the reason why this Committee has stressed a seamless transition because of this kind of need. And you are correct that we are also concerned about the National Guard and Reserves, because those are the troops that when they go home, they go back to work instead of continuing in active service at a base, and therefore, may need some attention that we cannot give them.

Mr. Chairman, my time has expired, and I will continue with questions.

Chairman CRAIG. Senator, I am pleased you brought that up, and I am glad, Dr. Kussman, you commented on the GAO study. We will spend some time with this to better understand it. The good news/bad news part of this, if it is accurate, the good news is that a substantially lower percentage are recognizing or having to deal with PTSD, that 5 percent versus some talked about 30 plus percent. The bad news is the discrepancy in referral and follow up. And, of course, some of your explanation for it, we all understand is a reality, but this is also, in the long term, very serious business for these veterans who might experience this.

Let me turn to Senator Salazar.

Ken.

Senator SALAZAR. I want to return to the Rural Veterans Health Care Act which you say you oppose for a number of reasons on the part of the VA. Let me ask you a question with a prefatory comment here.

It seems to me that what you are seeing out of the Senate and what you will see out of this Senator, for as long as he has a breath in him, is that we need to put a spotlight on the problems that we face with veterans in rural America. For those of us who come from rural States, we recognize that sometimes the golden curtain drops at the end of the largest suburban city in our State, and that a great part of rural areas of our States is forgotten.

When I look at the findings of the VA itself, and recognize that there was a study very comprehensively done on 767,000 veterans, and the basic conclusion of that study was that our rural veterans were not receiving the same kind of health care as their urban counterparts. To me, that says that we have a problem. I recognize that there are 6 million veterans who live in rural America and who are receiving a second-class health care because of the place where they reside. That means that we have a problem. When I look at the dozen or more Senators that have signed up, including Senator Burr, Senator Thune, Senator Murray, Senator Akaka, and others who have signed up to say that this is an issue, that we have a problem, it tells me that we need to do something about it.

I recognize that for other groups of veterans, including minority veterans and women veterans, we have created an office within VA. I wholeheartedly support those offices. It seems to me that with 6 million veterans living in rural America, that we ought to figure out a way of shining a spotlight on them by creating some kind of an organization within VA that does that. And yet, the response in your opposition to our modest legislative proposal is that it would create chaos and confusion among VA. I, frankly, do not believe that, because it seems to me that VA is the kind of organization that has shown its quality and its ability to respond to the special challenges that face our rural veterans. I would hope that the VA can work with me and with my Democratic and Republican colleagues to figure out a way of putting a spotlight on that issue.

My question to you is, do you have some thoughts on how we might be able to put that spotlight on the challenges faced out in rural America?

Dr. KUSSMAN. Thank you, sir. I couldn't agree more with our partnering. We need to do this. I mean, please, I hope you understand that my comments were not in any way try to diminish the

issue. The bill itself, the way it was written for an Assistant Secretary to do that, would be significantly different than the offices that you described with women's or minority health issues. There are not Assistant Secretaries, I do not believe, at that level.

But I think that we will commit ourselves to work with you and the other Senators that are supporting this bill, to try to work out a system that will put spotlight on these rural veterans, and to maximize our ability to provide them the best level of care.

Senator SALAZAR. Let me ask you a question relating to the costs associated with the disparity of health care provided to veterans in rural America versus urban America. In places like Craig, Colorado, where I met with 200 veterans on Saturday, one of the concerns that was raised by some veterans, some of the World War II generation, was that their travel to receive health care some several hundred miles away, would actually result them in getting into a worse health condition than if they did not go to the VA itself. And so part of the problem we have is that veterans in rural America are not getting access to the kind of preventive health care that they need. And also the difficulty in accessing health care service where it actually exists is something that creates a great burden on them.

How would you respond to how the VA should address that reality?

Dr. KUSSMAN. Yes, sir. As I mentioned, I think this is a reality for the country. There are non-veterans who live in those rural areas that have equal problem in getting care. As mentioned, we believe that we want to make it easy for them to travel if they have to, maximize with technology our care coordination program, telemedicine, make it as easy as possible for them to get care, preventive medicine services, even in their own home and not to have to go anywhere, with the technology that is available.

As mentioned—and numbers can be used any way they want, it is our understanding that 96 percent of veterans do not have to travel more than 60 minutes to a site of care, whether it is a CBOC or whether it is a facility, and it is not that those 4 percent of veterans are not important. We will continue to work with you to try to maximize the ability, because we certainly do not want a subsegment of our veteran population to get substandard care.

Senator SALAZAR. I know my time is up, and I appreciate that comment, Dr. Kussman. I do not believe the 4 percent number, and I know that it is far different from having a CBOC in someplace in a remote part of Colorado versus having some of the other facilities we have in places like Grand Junction. I can only assure you and Secretary Nicholson—if you will pass this on to him—that I think for Senators, like Senator Thune, who know what it is like to live in those broad stretches of the Dakotas, or the other colleagues that we have on this legislation, that this is not an issue that is going to go away. We need to find a way to put a spotlight on the issue and make sure that we are not creating two Americas with the kind of health care system that we are providing veterans in rural areas.

Dr. KUSSMAN. Yes, sir. Thank you.

Chairman CRAIG. Senator, Thank you very much.
Let me turn now to Senator Jim Jeffords.
Jim.

STATEMENT OF HON. JAMES M. JEFFORDS,
U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Thank you, Mr. Chairman.

Dr. Kussman, you state in your testimony, regarding Senator Salazar's rural health bill, that 23 percent of enrollees live in rural areas as defined by the census data, yet only 4 percent of enrollees live more than 60 miles from a VA facility. The VA objects to the legislation because it focuses too many resources on too small a percentage of the veteran population. Could this objection to the legislation easily be overcome by choosing a pilot site that would involve delivery of care to the more typical rural veteran, a veteran who lives in a rural area where access to care is diminished and where a fee-basis approach might provide some significant benefits to care for specialized or tertiary services?

Dr. KUSSMAN. Thank you, sir. Just as a point of clarification, I think that we said 4 percent would have to travel more than 60 minutes to care, not 60 miles.

But as I mentioned in my testimony, I think that there are pilot projects that we can do with the existing infrastructure and existing things that are necessary with the legislation. Issues related to fee-based care are very complicated and somewhat limited for us to do under the existing rules of engagement, but I might ask Mr. Thompson to comment on that.

Mr. THOMPSON. Well, yes. Our authority to pay for care is quite limited under current law. Essentially, it can be authorized only where VA lacks the ability to perform a certain procedure such as an organ transplant, for example, or when it would be more costly for VA, in terms of the beneficiary travel reimbursement it would have to pay the veteran, then we could do the care ourselves. In other words, where it would be more economical for the Department to contract for the care elsewhere than to perform it itself. So current law authorizing fee-basis care is quite limited, and so some of the provisions, for example, for the pilot that would require us to expand our use of it, we would be limited by current law from performing.

Senator JEFFORDS. Dr. Kussman, in the next few months Vermont will welcome home some 300 National Guard members known as Task Force Saver. This Guard unit is currently stationed in Ramadi, and has had a very high casualty rate. I think that these men and women are going to need significant help with readjustment upon their return. Unless we put more money into these programs, I am worried that the servicemembers who do not live near any military installations will fall through the cracks.

Do you have a plan for treating these veterans within existing funding levels?

Dr. KUSSMAN. Yes, sir. We have worked very hard with our Seamless Transition Office, and coordinating with the different States. I think that one of your neighbor States, New Hampshire, had a very good program that was put together with the State Adjutant General and the State Veterans' Affairs people, when the

unit came back, very quickly when they had their first organization, the families were brought in, the Vet Centers were there, members of the VBA and VHA were there from our regional centers, as well as the hospitals, to provide them the full depth and breadth of services. This is regularly being coordinated. I think we have been reasonably successful in other States.

This is something that is new to us. Each war has different things in it that we have to learn. One is what the Chairman mentioned about the survival and the polytrauma that we are seeing. I think the number is, if you do not die on the battlefield and you can get to somebody beyond your buddy, you have a 98.7 percent chance of survival, unheard of. The only unfortunate thing related to it is that many people who would have died from chest and abdominal wounds are not, and are surviving with that.

And the other things that we are learning is how to deal with large numbers of National Guard and Reserves, and how we assist people dealing with the full spectrum of readjustment issues. Most people do not get PTSD, but most people have some readjustment issues that are normal responses to abnormal situations. And we have to provide the infrastructure and the people to allow people to get to whatever they need. Most people seem to do fine, when they reintegrate themselves, having a supportive family, clergy, friends, and they do get by after a short period of time of maybe some lack of sleep or adjustments. Myself, from my previous life, I had the same things.

There are others along that spectrum who need some specialized assistance with psychologists, social workers, psychiatrists. But they frequently only need one or two short interventions to realize that the symptoms they are having do not mean they are sick, and the last thing we want to do it stigmatize it. And then along that spectrum, there are people who have true major issues related to PTSD, and we certainly have to be ready to treat that.

We spent a lot of money and effort putting together infrastructure to adjust this. And actually, I think that we are very proud of what we have put together to take care of the readjustment issues related to the full spectrum of servicemembers.

So we will stand ready to help Vermont, just like we have with any other State in the union.

Senator JEFFORDS. Thank you. I have another question, but——

Chairman CRAIG. Go ahead, proceed.

Senator JEFFORDS. Dr. Kussman, Senator Salazar's rural health legislation would establish up to five Centers of Excellence for rural health research. I am sure you are aware that some of the research that has illuminated the problems comes from a paper authored by the VA's on Dr. Jonathan Perlin, and Vermonter Bill Weeks, at the White River Junction VA Center for Outcomes Research.

In 1999, Dr. Kaiser realized that delivery of care to veterans in rural areas was a problem for the VA. He set aside $7.25 million each year for several years to fund the Rural Health Initiative Study, this problem, and provided suggestions for addressing it.

The significant work that has been produced by Dr. Weeks in the Center for Outcomes Research is now invaluable as the VA focuses on the gap in care. It seems to me that creating the centers as de-

signed in Senator Salazar's legislation would augment the work that has already been done by VA, and bring this research into sharper focus.

Are you aware of the work done by the Rural Health Initiative? And if the VA does not plan to support Senator Salazar's entire bill, would you support the creation of these Centers of Excellence?

Dr. KUSSMAN. Thank you for the question. Yes, I am aware of the study, and Senator Salazar mentioned it several times already. I think that the issues that have come out of that study are important things. They are the focus of what we need to do in support of rural health. I think that the concept of a Center of Excellence—I do not know whether it is 5 or 1 that we need—is certainly something that we could work together on to move forward in assisting this, and trying to solve issues related to this issue.

Chairman CRAIG. Jim, Thank you very much.

Let's now turn to Senator Richard Burr.

Richard.

STATEMENT OF HON. RICHARD BURR,
U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Dr. Kussman, I find it quite intriguing that there are five pages of testimony as it relates to S. 2433, but Mr. Thompson summed it up in one sentence. He said, "We do not have the authority to do what you have suggested in this bill." But there are five pages in your testimony that suggest the reasons why the VA could not be supportive or should not be supportive of this. Let me read some of them.

"This would cause significant confusion and disruption across the organizational lines, both among and within the Administration.

"This bill would dilute control from the Administration with respect to specific activities, personnel, resources.

"This would increase the potential for fragmented services, wastes, inconsistency, if not unequal treatment of veterans based solely on their geographical location."

The bill was written because of their geographical location. That is, in fact, what the whole thing is about. Clearly, the second panel does not share the confidence of the Veterans' Administration either on prosthetics, which the Chairman is interested in. I would hope there would be some that would express some concerns about our inability to provide an equal level of care to the rural veterans.

Now, we may not have it perfect. I am not sure that we are off by five pages. Let me assure you, Mr. Thompson, if it is the authority that you need, you are in the right spot for us to be able to fix it.

But I would ask you to focus, for just a second, on the veteran that lives in the rural area, not on your organizational flow chart and whether we screw that up. I would ask you to focus on the veteran and ask yourself: are we providing them the level of care that we are providing everybody else? Inequality may exist today, but not after implementation of this legislation. I think that is why, in fact, we have raised the question.

You went into great depth to talk about the cost of implementation of this, and I think you ended up with a final cost of well over $1 billion. That very well could be the case. I mean, I, as much as

anybody in here, respect the progress that the VA has made, the passion that each one of you puts into the job, what I truly think is the focus on the population that you are charged with servicing. What I do not see is a cost estimate on what happens if we do not deliver the care to those individuals in a preventive way. If in fact, because they cannot travel to where they get that preventive care at the earliest stage of a problem, they become an inpatient participant for an extended period of time, and it was all because they could not get there. They did not have the resources. They did not have the means.

Let me suggest to you that I think we can do a better job with rural veterans. 60 minutes is 60 miles where I live. That is how rural it is. You are not dodging stoplights. But I see, literally, every time I go home, individuals that tell me they cannot get to the VA facilities. I am in a State that has the fastest growing veteran retiree population in America. It probably will not be rural tomorrow, or 10 years from now. It is all going to be urban if it continues the way that it is going to. But I take a little bit of offense that any of the points of why this legislation would be inappropriate is because it would screw up the organizational flow chart at the VA.

I give you those words to share with you a little bit of frustration in the points that you have brought up. And I challenge you, and Dr. Perlin, and the Secretary, that if you do not like this, come back to us with something that does address what we think is a real concern. Don't just come up and suggest you are not going to be supportive of the legislation because it changes things in a way that people might be uncomfortable with inside the Veterans' Administration, because our focus, day in and day out, are the people on the outside of the Veterans' Administration.

I thank the Chair.

Chairman CRAIG. Thank you.

Let us now turn to Senator Thune.

John.

STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman, and I appreciate as well the panel for being here and the veteran service organizations that are represented here today and that will testify later. I appreciate your input. And, Mr. Chairman, having a hearing on these pieces of legislation that Members of this Committee have introduced, I echo what my colleague from North Carolina in many respects said about the criticisms of the bill that he and I and Senator Salazar have introduced regarding rural veterans. The only thing, I think, I would say maybe is in South Dakota 60 minutes is about 80 miles, perhaps, instead of 60 miles in North Carolina.

Chairman CRAIG. That is all depending on who is watching, isn't it?

[Laughter.]

Senator THUNE. Exactly. But, in any case, the distances are vast, and one of the things that I am concerned about, too, being from a very rural State—in fact, South Dakota is within the largest and most rural VISN in the country, and it is an area that is made up of a lot of veterans. We have a high proportion of our population

that have served the country in my State, and many of these veterans do live in very rural, geographically remote areas. And one of the things that I hear, probably more often than anything else from veterans as I travel across South Dakota, is access to facilities. And we have been working for an amendment to the supplemental last week that would have put more money into facilities so that we could do a better job of building some of the community-based outpatient clinics which have served as, I think, a very effective model when it comes to outpatient care in rural areas.

But we still have an awful lot of people who travel several hours to access care, and I think that there are measures proposed in some of these bills that would address that. With respect to Senator Salazar's bill—and as I said, Senator Burr and I are cosponsors of that—one of the criticism that has been leveled—and I agree, I cannot imagine that a criticism of that would be that it somehow messes up an organizational chart. But one of the arguments or criticisms that has been leveled is the cost, that it would cost about $1 billion to enact that legislation. And one other issue that has been raised is the issue of fee-basis care. I know that veteran service organizations are concerned about a provision in the bill that would strengthen the use of fee-basis care because it runs counter to the principle of reducing the amount of funding that the VA spends on higher cost contracted services.

But I am interested in hearing, I guess, in greater detail a little bit about some of those criticisms. First, with respect to the issue of cost, could you perhaps explain to us how you arrived at that additional $1 billion cost associated with Senate bill 2433. And then perhaps second, why, when it comes to serving the needs of veterans in very rural areas, giving them access to contract care would not make some sense? When you get out in rural parts of South Dakota or Colorado, or North Carolina, for that matter, certainly in Idaho, it seems to me that would be a reasonable, sensible approach to take.

So I am interested in hearing your reaction both to the issue of cost, the $1 billion cost that you have said this would entail; and, second, your thoughts on the issue of contract services.

Dr. KUSSMAN. Thank you, Senator. The specifics of how this was generated, it had to do with the demonstration projects and the additional beneficiary costs as well as fee-basing. And I don't have the specifics with me, but I would be happy to get those to you of how that was specifically developed.

You know, both from your questions and Senator Burr's questions, I don't—and, again, I feel a little awkward because we are not against dealing with rural health, and we are not insensitive to the needs of all the things that you have articulated. The question is how to go about doing that.

I don't think that any of us are hung up on wire diagrams, but the issue is how do we maximally benefit the veteran with our ability to do our job. Developing an Assistant Secretary at the VA level would not be perceived by us as a form and function that would be advantageous to the veteran. This is the responsibility of the Under Secretaries to the Secretary of VBA and the VHA. So if it appears that we are against it on the basis of some arbitrary and capricious wire diagramming, that is not the case. The question is

how do we provide our mission and maximally utilize our ability to meet the mission.

As far as fee-basing, clearly that is an issue, and we again would appreciate the opportunity to work with you and Senator Salazar and Senator Burr to work on some of the strengths of the bill and some of the things that we find that would not be exactly where we would find the best way to do the job.

Senator THUNE. Well, I appreciate that, and any detail you can provide on the cost estimates that you have done associated with the bill would be helpful, if you could. And I would accept that offer to work with you, but with an eye toward the veteran out there and what can we do to improve quality of services to veterans across this country and making sure that all have good access to care rather than, again, how it might impact the organizational structure in Washington. Ultimately, we want to do what is in the best interest of the veteran. We want to have an eye on the veteran out there across the country. But we would certainly welcome your input on how we might address the concerns that you have raised within our bill. But clearly, I think that this is an effort which is based upon a very valid concern raised by veteran constituents that we have, that we represent in some of the more rural areas of the country, and a need that I think we would like to see more fully addressed.

So that was the purpose of the legislation, and we look forward to working with you on it.

Thank you, Mr. Chairman.

Chairman CRAIG. Dr. Kussman, I would like to do another round, but I think time is going to be limited, so we are going to hold the record open a certain period of time. If any of our colleagues have additional questions to ask, we will be submitting them to you in writing. These are obviously very important issues. You can hear the concern and passion expressed here as it relates to at least one area, our rural veterans. I think it is something that, obviously, this Committee and Members will pursue in working with you so that we can make sure we get it right and those services are delivered.

Gentlemen, thank you very much for your time. We will dismiss you and ask the second panel to come forward.

Dr. KUSSMAN. Thank you, sir.

Chairman CRAIG. Dr. Kussman, thank you.

Gentlemen, thank you very much. If the Committee would come to order, please.

Our second panel is made up of Robert Shaw, Legislative Chairman, National Association of State Veterans Homes from Rifle, Colorado. Robert, we are pleased to have you with us. John Melia, Executive Director, Wounded Warrior Project, from Roanoke, Virginia. Carl Blake, Associate Legislative Director, Paralyzed Veterans of America here in Washington. Juan Lara—Juan, welcome—Assistant Director, National Legislative Commission, the American Legion, here in Washington. And Adrian Atizado, Assistant Legislative Director, Disabled American Veterans.

Gentlemen, thank you for being with us today.

Mr. Shaw, we will start with you.

STATEMENT OF ROBERT SHAW, NATIONAL LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; AND ADMINISTRATOR, STATE VETERANS CENTER, RIFLE, COLORADO

Mr. SHAW. Chairman Craig, Ranking Member Akaka, Senator Burr, Senator Salazar, Senator Jeffords, and other distinguished Members of the Senate Veterans' Affairs Committee, thank you for inviting me to testify today on behalf of the National Association of State Veterans Homes. As the Legislative Chair of NASVH, I want to express our strongest support for Senate bill 2762, the Veterans Long-Term Care Security Act of 2006.

Mr. Chairman, I have testified before the Committee earlier this year at a field hearing that you and Senator Akaka conducted in Hawaii looking at that State's particular health care needs for veterans. At that time, I raised several issues of concern for the State Home system, in general, and also offered a possible model to help improve delivery of long-term care services in States like Hawaii, where you have a veterans population that is dispersed over a large rural area.

Over the past several months, we have been working with both your staff and Senator Akaka's staff in a bipartisan manner to assemble legislation that would address these concerns. In that spirit, we are grateful to Senator Akaka for introducing Senate bill 2762, the Veterans Long-Term Care Security Act of 2006, earlier this week, and to you, for including it on today's agenda.

Mr. Chairman, the State Home program is an essential partnership between the Federal Government and the States, both of whom have made major and lasting investments in providing benefits and services to veterans. The Veterans Long-Term Care Security Act respects that commitment, enhances it, and extends continuing support for the work done by the State Homes. Let me briefly highlight why this legislation is so important to veterans.

S. 2762 would help protect the State Home program per diem from sudden and disruptive reductions by requiring the VA Secretary to consult with stakeholders and report to Congress before implementing such changes to the per diem program. Mr. Chairman, as I am sure you will recall, last year the Administration made budget proposals that would have dramatically reduced Federal support for the State Home program, changes that would have drastically altered the current system of State home care. We are pleased that those proposals were wisely rejected by Congress and not resurrected this year in this year's budget submission. Given the significant and growing long-term care needs of veterans, as well as the significant investment in the State Home program made by the States, we believe it is prudent to ensure that significant reductions of support of the State Home program should only be made in coordination with the States as well as with full and informed consent of Congress.

S. 2762 would also help provide equity of access to VA resources for service-connected veterans residing in State Homes. Currently, VA is not authorized to place or pay for service-connected veterans in State Homes, nor provide them with prescription medications. This legislation would authorize but not require the VA to place service-connected veterans in State Home facilities, specifically

those who need long-term care due to a service-connected disability or who have a service-connected disability rating of 70 percent or greater. The bill would then require VA to reimburse State Veterans Homes the same amount VA pays to private nursing homes when VA places service-connected veterans in those facilities.

To correct a similar inequity, S. 2762 would authorize VA to furnish prescription medications to service-connected veterans residing in State Veterans Homes for service-connected conditions and for any conditions of veterans rated 50 percent or more disabled. Currently, this benefit is denied to service-connected veterans residing in State Homes, even though non-service-connected veterans who are housebound or in receipt of aid-and-attendance benefits do receive them.

Finally, S. 2762 includes provisions designed to address gaps in State home care, particularly in rural and remote areas such as the Neighbor Islands of Hawaii, Idaho, Alaska, South Dakota, North Carolina, Wyoming, Kansas, and other rural States. In order to fill in these gaps and provide additional options to veterans and flexibility to States, S. 2762 would allow VA the option to deem an existing facility to be a State Home for purposes of product in the VA per diem grant program. This would allow a State to create smaller long-term care units within larger health care facilities when this would better serve the needs of veterans in that State. The bill contains safeguards to ensure that no State would use this deeming authority to exceed its allotted ceiling of State Home beds under the Millennium Health Care Act regulations.

S. 2762 would build upon the successful model employed by Alaska through their "Pioneer Homes" system. It would allow States to pursue innovative collaborations with existing health care systems in order to expand availability of long-term care services for veterans when such States are unable to cost-effectively justify the establishment of large, stand-alone State Veterans Homes in remote areas.

Mr. Chairman and Members of the Committee, we look forward to working with you to strengthen veteran's long-term care services administered by the State Veterans Home network and VA. The quality care provided by our members in our association is an indispensable, cost-effective, and successful element of the Nation's provision of comprehensive health care to veterans, and S. 2762, the Veterans Long-Term Care Security Act, would help ensure the continuation of this vital State-Federal partnership.

Mr. Chairman, this concludes my statement. Thank you for permitting me to testify today on behalf of the National Association of State Veterans Homes. I am pleased to answer any questions that you may have.

[The prepared statement of Mr. Shaw follows:]

PREPARED STATEMENT OF ROBERT SHAW, NATIONAL LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; AND ADMINISTRATOR, STATE VETERANS CENTER, RIFLE, COLORADO

Chairman Craig, Ranking Member Akaka and other distinguished Members of the Senate Veterans' Affairs Committee, thank you for inviting the National Association of State Veterans Homes (NASVH) to testify at this legislative hearing. As the Legislative Chair of NASVH, I am honored to be here with you this morning to express our support for legislation that we believe would significantly contribute to strengthening the delivery of long term care services to veterans.

Our Association is an all-volunteer, non-profit organization founded over a half-century ago by administrators of State Veterans Homes to promote the common interests of the Homes and the elderly, disabled veterans and their family members that we serve. The membership of NASVH consists of the administrators and senior staffs of 119 state-operated Veterans Homes in 47 States and the Commonwealth of Puerto Rico. We will soon add a new home in a 48th State, which happens to be the State Veterans Home in Hilo, now under construction on the Big Island of Hawaii.

State Homes provide nursing home care in 114 homes, domiciliary care in 52 locations, and hospital-type care in five of our homes. Our State Homes presently provide over 27,500 resident beds for veterans, of which more than 21,000 are nursing home beds. VA supports State Homes through payment of a per diem allowance for each veteran VA certifies to be in need of the types of care we provide.

Earlier this year on January 9th, I was honored to testify at a field hearing the Committee held in Hawaii looking at that State's particular health care needs for veterans. Since that time, we have been working with Senator Akaka's staff and the Committee's staff to assemble a bill that would address many of the concerns we raised at that hearing. I will not repeat all those concerns in detail here, but I invite the Committee to review our legislative goals discussed during that hearing; goals that were recently confirmed by resolutions adopted unanimously at our association's mid-winter conference held here in Washington, DC this past March.

Mr. Chairman, we have always appreciated the bipartisan spirit of the Veterans' Affairs Committee, and we are pleased to see that longstanding tradition continue under your leadership. In that spirit, we are grateful to Senator Akaka for introducing the "Veterans Long Term Care Security Act of 2006." This legislation offers three important changes in VA long term care policy that we hope the Committee will favorably consider:

- Essential communications and planning with stakeholders;
- Equity of access to VA resources and benefits; and,
- An alternative model to traditional construction of new State Homes.

The State Home program is a partnership between the Federal Government and the States, both of whom have made major and lasting investments in providing benefits and services to veterans. The Veterans Long Term Care Security Act respects that commitment, enhances it and extends continuing support for the work our Homes do for elderly and disabled veterans and their dependents. The bill certainly confirms what the Senate itself expressed in passing S. RES. 417 earlier this year, a bipartisan resolution introduced by Senator Lautenberg with 35 cosponsors, and we want to thank you, Mr. Chairman, Senators Akaka, Isakson, Hutchison, and Salazar, as well as Majority Leader Frist and several former Members of this Committee for your cosponsorship of this resolution. We sincerely appreciate that support and expression of trust in what we do for veterans.

Mr. Chairman, let me briefly explain the major provisions of the Veterans Long Term Care Security Act, which we believe will help to stabilize and strengthen the State Home program.

The first policy enhancement would protect the per diem program from sudden cuts that could prove extremely disruptive to providing care to elderly veterans. This provision would require the Secretary of the Department of Veterans Affairs to consult with stakeholders and report to Congress before implementing any reductions of Federal support for per diem payments. The bill would require VA to consult directly with those most responsible for the management of State Home programs—the Governors of the States, the State Homes themselves, and other national veterans' service organizations with expertise. The Secretary would then have to submit a report to the Veterans Affairs' Committees in the Senate and House explaining the reasons for, and affect of, such proposed reductions at least twelve months prior to their taking affect.

Mr. Chairman, as you will recall, last year the Administration made several budget proposals to dramatically reduce Federal support for the State Home program; cuts that would have had severe and lasting negative consequences for long term care services for veterans. Those ill-fated proposals, which were wisely rejected by Congress, would have drastically altered the current system of State Home care as authorized in Chapters 17 and 81 of Title 38, United States Code. Given the significant and growing long term care needs of veterans, as well as the significant investment in the State Home program by the States, we believe it is prudent to ensure that significant reductions of support for the State Home program should be made in coordination with the States, and with the full and informed consent of Congress. The proposed consultation and reporting requirements contained in the legislation would help ensure just that and we strongly support these provisions.

The second policy would help to provide equity of access to VA resources for service-connected veterans residing in State Homes. Currently, VA is not authorized to place or pay for service-connected veterans in State Homes, nor provide them with prescription medications. For several years we have discussed with VA officials our interest in both these issues, but VA has not taken any actions to remedy these inequities. The legislation would authorize—but would not require—VA to place service-connected veterans in State Home facilities; specifically those who need long term care due to a service-connected disability or who have a service-connected disability rating of 70 percent or greater. The bill would also require VA to reimburse State Veterans Homes the same amounts VA pays to private nursing homes when VA places veterans in those facilities under the authority of section 1720 of Title 38, United States Code.

To correct a similar inequity, the bill would authorize VA to furnish prescription medications to service-connected veterans residing in State veterans homes who need such medications for those service-connected conditions, and for any conditions of veterans with service-connected disabilities rated at 50 percent disabling or higher. These service-connected veterans are denied that benefit today in State Homes, even though nonservice-connected veterans who reside in our Homes for whom VA has granted a "housebound" adjudication or who are in receipt of VA regular aid-and-attendance benefits, do receive their continuing VA medications. We believe service-connected veterans should receive equitable benefits compared to nonservice-connected veterans and strongly support this change in policy.

The third policy change in the bill is designed to address gaps in State home care coverage, particularly in rural and remote areas such as the Neighbor Islands of Hawaii, or parts of Idaho, Alaska, Montana, Wyoming, Kansas and other large rural States. Given the current system for funding construction of new State Homes, care is too often unavailable to many veterans as a practical matter due to sparse populations, long travel distances, remoteness and even cultural barriers. In order to fill in these gaps and provide additional options to veterans and flexibility to States, the bill would allow VA to deem a preexisting health care facility to be a State Home for purposes of participation in the VA per diem program. This would allow a State to create smaller long term care units within larger health care facilities when this would better serve the needs of veterans in that State. The bill contains safeguards to ensure that no State could use this deeming authority to exceed its allotted ceiling of State Home beds under the Millennium Act regulations.

Mr. Chairman, you will recall that we offered extensive testimony supporting this concept at your January 9, 2006 hearing where we reported this model had been successfully employed in Alaska through Alaska's "Pioneer Homes." I testified then, and want to reiterate now, that this concept could be applied directly to the Hawaiian Neighbor Islands and possibly to other remote areas in other large, rural States. This provision would allow some States to pursue innovative collaborations with existing health care systems in order to provide long term care services for veterans where they are needed, and we strongly support this provision of the bill.

Mr. Chairman, NASVH is committed to doing our part to help meet the long-term care needs of veterans, whether they live in major metropolitan areas or in geographically dispersed, rural and remote places such as Idaho, Hawaii, Alaska, and States. Although a rural State may not be able to cost-effectively justify the establishment of large, stand-alone State veterans' nursing home, other creative solutions such as the "Pioneer Homes" model we have described are worth pursuing in existing health care facilities that meet all other VA standards for State Home care. If enacted this legislation could be an effective tool to bring about innovative new ways of meeting these veterans' needs.

Mr. Chairman and Members the Committee, we look forward to working with you to strengthen veterans' long-term care services administered by the State Veteran Homes network. The quality care provided by our member Homes is an indispensable, cost-effective, and successful element of the Nation's provision of comprehensive health care to veterans. We want to continue the very successful partnership between our State Veterans Homes and VA in order to meet the needs of veterans who are going to need long-term care in the years ahead. We want to be sure that the State Veterans Home program remains an important partner and viable option to help VA meet their obligations and the Veterans Long Term Care Security Act would move us forward in that direction.

Mr. Chairman, this concludes my statement. Thank you for permitting me to testify today on behalf of the National Association of State Veterans Homes. I will be pleased to answer any questions.

Chairman CRAIG. Thank you very much.
Now let us turn to John Melia.
John.

STATEMENT OF JOHN MELIA, EXECUTIVE DIRECTOR, WOUNDED WARRIOR PROJECT, ROANOKE, VIRGINIA

Mr. MELIA. Chairman Craig, Ranking Member Akaka, and Members of the Committee, I thank you for convening this hearing and for allowing me to comment on various pieces of legislation pending before you. I would like to limit my remarks to Senate bill 2736, which would create five Department of Veterans Affairs Amputee and Prosthetic Rehabilitation Centers. Wounded Warrior Project recently proposed the creation of these centers, and we strongly support this bill. We commit to you our assistance to seeing this bill through to passage and enactment.

The Wounded Warrior Project assists the men and women of the United States Armed Forces who have been severely injured during the ongoing global war on terror.

In assisting these wounded warriors as they reintegrate back to civilian life, we have the opportunity to observe systems in place and to identify where these systems may need improvement to meet the growing patient needs. Our conversations with literally hundreds of new amputees have led us to one conclusion: The VA system of providing amputee rehabilitation and prosthetic devices such as limbs, wheelchairs, and adaptive equipment, is in dire need of modernization and restructuring if VA is going to have any chance of achieving its goal of providing quality health care and fostering employability for seriously wounded veterans.

The system must be revamped in order to ensure these men and women will have the opportunity to live full and productive lives, including joining the modern workforce without being hindered, by long waits for equipment, endless fittings and refittings, and consultations with outside vendors.

The VA health care system currently finds itself, for the first time in many years, inundated with young servicemembers who have lost limbs in the war and who are looking to VA for their long-term health care and prosthetic and assistive device needs. This new amputee population is made up of people, who just months or years ago, were in peak physical condition. Rightfully, many still consider themselves warriors and athletes and are determined to live active and productive lives that include a myriad of recreational activities including skiing, kayaking, hunting, and more. Unfortunately, unless the VA changes the way it offers these services, it will not be able to provide the level of care that these soldiers need and now expect.

Let me tell you about the experiences of Staff Sergeant Heath Calhoun and his difficulty in accessing prosthetic services and equipment from his local VA Medical Center. On November 7, 2003, Heath, a member of the 101st Airborne, lost both of his legs in Iraq when his convoy was hit by a rocket-propelled grenade. This past summer Heath rode a hand-cycle over 4,200 miles as part of a cross-country bike ride called Soldier Ride, which raises public awareness and support for severely wounded servicemembers. At the completion of the ride, Heath's hand-cycle was in desperate

need of repairs, and in late 2005, he took his bike to the local VA for repair. Heath did not receive his bike back from them until 2 weeks ago, meaning he was unable to ride it for 5 months.

Heath is also an active skier, and in early December of 2005, he attempted to procure a "sit-ski" through the VA so that he could participate in several skiing events between December and April, the prime ski season. Heath was told that the first appointment he could schedule was not until February 1, 2006. Additionally, he was informed that should the doctor approve his request for the equipment, it would take an additional 10 days for VA approval before the purchase could be made. And he was then told that it would take an additional 4 to 6 weeks from that point until the equipment could be provided, in essence killing any chance that he would be able to participate in ski activities this past winter.

When asked about his struggle, Heath had these words: "As an amputee I can't just take off jogging down the street to keep in shape. I get my exercise by skiing and cycling and using adaptive equipment provided by the VA. By making it hard to get my equipment and exercise, it was like my doctor was taking away my gym pass for 6 months. These people are supposed to encourage my health and fitness, not stymie it."

We know for a fact that Heath is not our only constituent who has found himself frustrated as a result of seeking VA prosthetic and rehabilitation services. Others have attempted to access prosthetic care from their local VA medical centers and found themselves completely dissatisfied with their experience. Unless VA reconfigures its prosthetic system, it runs the risk of alienating this new amputee population and having them seek their care from non-VA providers.

Additionally, the current system runs the risk of precluding these men and women from reentering the civilian workforce as no employer is going to give the employee the necessary time off necessary to navigate VA's prosthetic system in its current structure. The VA's goal of veteran reemployment will be seriously hindered for these wounded warriors should they be required to spend such long periods of time navigating the system.

The biggest problem VA's prosthetic program is facing is that there is no systemwide consistency and coordination from medical center to medical center. Some centers are well equipped to evaluate the needs of servicemembers with fully functioning prosthetic laboratories, a full range of occupational and physical therapies, and a well-versed prosthetic staff. Others are simply not able to evaluate or provide for their prosthetic needs. In many cases, today's advanced prosthetic and assistive device technology has left local VA employees in need of substantial retraining, and these employees often find themselves heavily reliant on the limited expertise of outside vendors or, worse yet, salesmen.

All of this means that a wounded servicemember's ultimate success in having a positive VA experience hinges upon their proximity to a location with a strong prosthetic program and a knowledgeable prosthetic representative. The creation of amputee and prosthetic rehabilitation centers will rectify many of these issues.

While Wounded Warrior Project is seeking these new centers on behalf of the new generation of injured servicemembers, it should

be noted that creating these centers will greatly assist the entire population of veterans with amputations, including those injured in previous conflicts or later in life. All veterans in need of prosthetic and amputee rehabilitation, regardless of age, will benefit as a result of the legislation.

Again, we thank Chairman Craig and Ranking Member Akaka for their sponsorship of this bill, and we pledge to work with you on seeing this through to enactment.

[The prepared statement of Mr. Melia follows:]

PREPARED STATEMENT OF JOHN MELIA, EXECUTIVE DIRECTOR, WOUNDED WARRIOR PROJECT, ROANOKE, VIRGINIA

Chairman Craig, Ranking Member Akaka, and Members of the Committee, I thank you for convening this hearing and for allowing me the opportunity to comment on various pieces of legislation pending before the Committee. I would like to limit my remarks to Senate Bill 2736 (S. 2736) which would create five Department of Veterans Affairs Amputee and Prosthetic Rehabilitation Centers. Wounded Warrior Project recently proposed the creation of these centers and we strongly support the bill. We commit to you our assistance to seeing this bill through to passage and enactment.

The Wounded Warrior Project (WWP) is a nonprofit organization aimed at assisting the men and women of the United States armed forces who have been severely injured during the war on terrorism in Iraq, Afghanistan and other hot spots around the world. Beginning at the bedside of the severely wounded, WWP provides programs and services designated to ease the burdens of these heroes and their families, aid in the recovery process and smooth the transition back to civilian life. We strive to fill the vital need for a coordinated, united effort to enable wounded veterans to aid and assist each other and to readjust to civilian life.

In assisting these wounded warriors as they reintegrate back to civilian life we have the opportunity to observe various systems in place and to identify where these systems may need improvement to meet the growing patient needs that have arisen as a result of the ongoing war on terror. One program in need of modernization and restructuring is the system through which the Department of Veterans Affairs (VA) provides all veterans who have lost limbs, including newly injured servicemembers from the ongoing military conflicts, with the necessary long term physical and occupational therapy as well as their prosthetic appliances. These appliances include all of the prosthetic limbs, wheelchairs, and adaptive sports equipment these injured heroes rely on to help put their broken lives and bodies back together.

As a result of the current Global War on Terror the VA Healthcare system finds itself, for the first time in many years, inundated with young servicemembers who have lost limbs in the war and who are looking to the VA for their long-term health care and prosthetic and assistive device needs. This new amputee population is made up of young men and women who, just months ago, were in peak physical condition on the battlefields of war prior to the traumatic event that has taken their limbs. Other than their amputations, many are still in, or are close to, that prime physical conditioning and they are now looking to the VA to maintain that lifestyle as they move forward. Rightfully, many still view themselves as warriors or athletes and they are more determined than ever to live active and productive lives that include a myriad of recreational activities such as skiing, kayaking, hunting, etc. Unfortunately, unless the VA changes the way it offers the full range of prosthetic devices and rehabilitation services, it is simply not going to be able to provide the level of care that these soldiers are in need of.

I would like to tell you about the experiences of wounded warrior Heath Calhoun in accessing prosthetic services and equipment from his local VA Medical Center as an example of the struggle that severely injured servicemembers are facing as they transition out of the Department of Defense medical system and into the VA health care system. On November 7, 2003, Heath, a Staff Sergeant in the United States Army, lost both of his legs in Iraq when his convoy was hit by a rocket propelled grenade. This past summer Heath rode a hand-cycle over 4,200 miles as part of a cross country bike riding program called Soldier Ride which raises public awareness and support for severely wounded servicemembers. Upon completion of the ride Heath's hand-cycle was in need of repairs so, in late December 2005, he took his bike to the VA Medical Center in Salem, VA. Heath did not receive his bike back from the VA until 2 weeks ago, meaning that he was unable to ride for 5 months.

Heath is also an active skier. In early December of 2005, Heath attempted to procure a "sit-ski" through the Salem VAMC so that he could participate in several skiing events that run between December and April which is prime ski season. Upon reaching out to the VA for this equipment, Heath was told that the first appointment he could schedule was not until February 1st, 2006. Additionally, he was informed that upon his appointment, should the Doctor approve his request for this equipment, it would then take an additional 10 days for full VA approval to be obtained before the purchase could be made. Heath was then told it would take an additional 4–6 weeks from that point until the equipment would be provided, in essence killing any chance he would be able to participate in any of that season's ski events.

When asked about his struggles with his local VA, Heath said,

> "As an amputee I can't just take off jogging down the street to keep in shape. I get my exercise by skiing and cycling. By making it hard to get my equipment and exercise it was like my doctor was taking away my gym pass for 6 months. These people are supposed to encourage health and fitness, not stymie it."

Fortunately for Heath, WWP was able to put him in contact with a high-ranking VA prosthetic specialist who assisted him in obtaining the equipment in just 5 weeks. Heath was then able to ski in several events in February, March and April. Not all wounded servicemembers will be that fortunate and we know for a fact that Heath is not the only one of our constituents who has found himself frustrated as a result of seeking VA prosthetic and rehabilitation services. VA must reconfigure its prosthetic system in order to meet the needs and expectations of Heath Calhoun and his fellow amputees or it runs the risk of alienating this population and having them seek all of their care from non-VA providers.

The biggest problem facing the VA's prosthetics program is that there is no system wide consistency and coordination from medical center to medical center. Some centers are well equipped to evaluate the needs of the individual servicemember with fully functioning prosthetic laboratories, a full range of physical and occupational therapies, and a well-versed prosthetic representative or prosthetist. Others simply are not able to evaluate or provide the prosthetic needs of the newly injured servicemember. Therefore, a wounded servicemember's ultimate success hinges upon their proximity to a location with a strong prosthetic program and a knowledgeable prosthetic representative.

The creation of Amputee and Prosthetic Rehabilitation Centers, as proposed in S. 2736, would rectify many of these issues. While these Centers would in no way replace the current prosthetic system at each medical center, they would be responsible for the system-wide coordination of the physical and occupational therapy and prosthetic care provided to veterans with amputations and would ensure the quality of care regardless of where the patient was physically located. They would be the central location for the development and implementation of standardized referral protocols for servicemembers in need of higher levels of physical or occupational therapy as well as higher level prosthetic needs. They would be responsible for the standards of education and training of the prosthetic representatives and prosthetists at all of the VA Medical Centers around the country and would ensure they were able to easily refer patients to the Amputee Centers whenever appropriate. It is also our hope that much of the amputee or prosthetic related research and development projects will be facilitated at these Centers to ensure the projects are consistent with the needs and issues of the related patient population.

With respect to infrastructure and construction we believe these new centers can be created using existing VA infrastructure with the realignment of certain facilities. Startup funding would be utilized for minor construction projects, establishment of Gait Labs, new equipment, recruitment, new salary dollars, continuing education, and travel dollars for staff and potential patients.

Finally, while Wounded Warrior Project is seeking these new centers on behalf of the new generation of injured soldiers it should be noted that creating these centers will greatly assist the entire population of veterans with amputations, including those injured in previous conflicts or later in life. All veterans in need of prosthetic and amputee rehabilitation, regardless of age, will benefit as a result of this legislation. Again, we thank Chairman Craig and Ranking Member Akaka for their sponsorship of this bill and we pledge to work with you on seeing it through to enactment.

Chairman CRAIG. John, thank you.

Now let's turn to Carl Blake. Welcome before the Committee again. Good to see you.

STATEMENT OF CARL BLAKE, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, WASHINGTON, DC

Mr. BLAKE. Thank you, Mr. Chairman, Ranking Member Akaka, and Members of the Committee, PVA would like to thank you for the opportunity to testify today on the proposed legislation.

PVA opposes the provisions of S. 2634 that would repeal the term of office and the appointment commission for both the Under Secretary for Health and the Under Secretary for Benefits. We are particularly concerned about the provision in the draft bill to eliminate the role of the appointment commission. 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. By eliminating this commission, there would be no counterbalance at all in a future Secretary's choice or a future White House's choice in seeking appointment purely by partisan objective or potential preconceived disinterest in the mission of the VA.

PVA is fully aware of the challenge that the VA faces in trying to address the health care needs of rural veterans. We have no objections to the establishment of an Assistant Secretary as outlined in S. 2433. We do, however, have some concerns about the pilot program authorized by this legislation.

The program would give VA additional leverage to broadened contracting out of health care services to veterans in geographically remote or rural areas. We believe that this pilot program could set a dangerous precedent, encouraging those who would like to see the VA ultimately privatized.

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 emergency medical services prevents a veteran from receiving care in a VA facility, or to complete an episode of VA care. The VA could better meet the demands of rural veterans if it was more judicious in its application of the fee-for-service program that it already has the authority to do.

We also believe that the VA could address the needs of veterans through broad application of the hub-and-spoke model used by other services within the VA. A veteran can get his or her basic care at a community-based outpatient clinic. However, if the veteran requires more intensive care or a special procedure or needs some other type of care, he or she can then be referred to a larger VA medical center. Even spinal cord-injured patients within the VA rely on the hub-and-spoke model.

PVA strongly supports S. 1537, a bill that would codify the Parkinson's Disease and Multiple Sclerosis Centers of Excellence. We would like to express our sincere thanks to Senator Akaka for introducing this legislation, and to you, Senator Craig, for placing it on the agenda today. This proposal appropriately recognizes the successful strategy of the VHA to focus its systemwide 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.

The designation of two MS Centers of Excellence located in Baltimore and in 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 same hub-and-spoke model which I have spoken of.

PVA supports S. 2500, a bill that would enhance the counseling and readjustment services provided by the VA. It only makes sense that National Guardsmen and reservists, who are playing a significant role in the combat operations overseas, would have access to this counseling.

PVA also supports the creation of the Amputation and Prosthetic Rehabilitation Centers outlined by the proposed legislation. 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 America (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.

PVA supports S. 2762. We believe that this legislation is both timely and necessary to preserve and protect the State Veterans Home program and the thousands of veterans who depend on it. PVA urges the Committee to preserve VA per diem rates and construction funding for State Veterans Homes.

Mr. Chairman, I would like to thank you again for the opportunity to testify today, and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, WASHINGTON, DC

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 4-year term. PVA believes that the 4-year term requirement serves a very valuable function. Under current law, once the Under Secretary has served the 4-year term, that individual, wishing to continue service, must be re-confirmed by the U.S. 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 4-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 fiscal year 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.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO CARL BLAKE

Question 1. One of the real practical problems I have with the commission process is that people other than the elected President and Senators identify the executive branch officials. But, once those officials are nominated and confirmed, the public holds Senators and the President accountable for the executive branch officials' action.

Does it not strike you as just a little unreasonable, frankly, that we are being held accountable for the performance of an official who was chosen by members of your organizations? Without getting too unserious, why shouldn't we hold you accountable since you picked them?

Answer. The recommendation from the search commission to the Secretary of Veterans Affairs (VA) does not come solely from representatives of veterans' service organizations. Title 38 U.S.C. S. 305 states that only two persons representing veterans served by the Veterans Health Administration (VHA) shall be made part of the search commission to select the Under Secretary for Health. The remaining members of the selection commission include: (1) three persons representing clinical care and medical research and education activities affected by the VHA; (2) two persons who have experience in the management of veterans health services and research programs, or programs of similar content and scope; (3) the Deputy Secretary of Veterans Affairs; (4) the Chairman of the Special Medical Advisory Group established under 38 U.S.C. S. 7312; and (4) one person who has held the position of Under Secretary for Health (including service as Chief Medical Director of the Department), if the Secretary determines that it is desirable for such person to be a member of the commission.

Correspondingly, 38 U.S.C. S. 306 indicates only two persons representing veterans served by the Veterans Benefits Administration shall be made part of the commission to select the Under Secretary for Benefits with similar remaining staff requirements as those established for the Under Secretary for Health. In both cases, of the ten person search commission, only two are representatives from veterans' service organizations.

Furthermore, the recommendations of the search commission are forwarded to the VA Secretary for review. The Secretary then has responsibility to forward the recommendations to the President with any comments that he deems necessary. If the President does not agree with the list of persons provided by the Secretary, the President may request that additional individuals be recommended from which he can choose a nominee. Ultimately, none of the recommendations made by the commission are binding to the President.

Clearly, members of our organizations do not pick the individuals for the positions of the Department of Veterans Affairs (VA) Under Secretaries for Health or Benefits. In the end, it is the President's prerogative to choose whomever he wishes, and responsibility rests with the Senate to confirm or deny that choice. Representatives from veterans' service organizations who serve on the selection commission act as advisors and nothing more. We find it disappointing that you would seem to imply that you should not be held responsible if you confirm an unsatisfactory choice for one of the Under Secretary positions.

Question 2. Mr. Blake, in your testimony you mention that the Amputation and Prosthetic Rehabilitation Centers should focus some attention on partnering with manufacturers, dealers, and payers of amputation devices to develop some standards of care and service. You mention specifically your experience with wheelchairs and how that program has been successful.

Can you talk a little more about PVA's role in the program pertaining to wheelchairs and how improvements in the evaluation process and standards have really revolutionized care for spinal cord injured veterans and the wheelchair industry?

Answer. In the early 1980s, PVA became involved with a number of likeminded advocates for the development of "performance" standards for wheelchairs. Working with academic rehabilitation engineers, manufacturers and the VA, PVA recognized that the development of tests to examine various performance features of a wheelchair could improve everyone's ability to determine just what a wheelchair could do. For example, we discovered that not all manufacturers measured the components of a wheelchair the same. Not all manufacturers recognized the turning radius of a wheelchair with cambered wheels. Not all electrical components provided the same power. It was a consensus of these advocates that the development of performance standards could bring some uniformity to the field of wheelchairs. For example, when someone asks about measurement of the foot pedals from the seat on different chairs, there might be some comparability.

Today, wheelchair performance standards are listed as ANSI/RESNA wheelchair standards. Compliance with these tests are required in the marketplace if a manufacturer wishes to report to consumers, professionals or payers how their product stacks up against other chairs available in the marketplace. These standards apply to manual chairs, power chairs, scooters and mobility platforms. The standards address endurance, temperature, seating, tires and all components. It is important to note that these are "performance" standards; therefore, they do not have a predetermined answer. Rather, they tell the manufacturer how to measure or test the chair or component and how to report the results of the test or measurement. These individual results are the basis for comparison with similar chairs. It is not a goal of these standards that every chair be identical. Instead, the desired outcome is standardization of the calculation or test procedures so answers can be compared.

The outcome of wheelchair standards has been uniformity in the description of products in the marketplace. This achievement works for consumers, manufacturers and payers alike. Each party derives from the ensuing disclosure what the performance and suitability of a product for an individual's needs are as expressed by the consumer, manufacturer or payer.

PVA believes that the development of performance testing standards for amputation devices would stimulate the consumer, manufacturer and payer fields to know what products deliver. Presently, we hear that the field needs a better device, and we ask "better than what?" Since performance testing standards do not currently exist, what is the basis for comparison among products? What would need to be improved if we don't know what current products are capable of doing? PVA believes that the development of scientifically based performance test standards would revolutionize the entire field as consumers seek information, manufacturers test their products and payers recognize what performance they can expect for their funding.

Chairman CRAIG. Carl, thank you very much.

Juan, we will now turn to you.

STATEMENT OF JUAN LARA, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. LARA. Thank you, Mr. Chairman.

Mr. Chairman, Ranking Member Akaka, Members of the Committee, thank you for the opportunity to present the American Legion's views on the veterans' health care legislation before us today. It is indeed an honor and a privilege to present these views on behalf of the Nation's largest veterans service organization.

The American Legion does not support the proposed changes in S. 2634. The American Legion has concerns regarding the changes in the appointment process and the suggested repeal of term limits. The American Legion wants to ensure that the appointment process is adequate in determining that only the most highly qualified individuals are selected.

The American Legion would like to support the creation of additional polytrauma centers to meet the increased demand by severely injured veterans located across the Nation. Our concern is that in the funding of any new center, we would like to see real

dollars, as Mr. Blake previously stated. We also would like to see more details on how the new prosthetic centers will fit in to the existing medical system.

The issue of providing safe and adequate health care to rural veterans is not a small one. S. 2433, Section 2 would establish the position of the Assistant Secretary for Rural Veterans within the VA to address this problem. The American Legion supports the establishment of this position, but adequate resources must be allocated in order to meet the health care needs of all veterans. We are concerned with the current health care model and methodology used to fund VA, which is clearly flawed. This fact was apparent when faulty assumptions and questions cost projections forced Congress to secure an additional $1.5 billion in an emergency spending bill to cover the VA health care shortfall for fiscal year 2005.

We support the measures outlined in Sections 3, 4, 5, and 6. However, there must be clear-cut objectives and details on the measures for success or failure of the projects.

S. 1537 would require the Secretary of VA to designate at least six VA health care facilities for Parkinson's disease research and at least two for multiple sclerosis if sufficient funding is appropriated. We support the VA's research because it serves the veteran population and is a natural step toward improving veterans' health care.

Under the Veterans Long-Term Security Act, Section 2 would require the VA to submit a detailed report to Congress before implementation of a reduction in per diem rates for care provided to veterans in State homes.

The American Legion supports stronger oversight of VA's handling of payments to State homes and the requirement that the Secretary will report in detail a justification for reducing payments and that VA will consult with the appropriate State officials and local agencies responsible for the supervision of State homes in each State.

Section 3 would increase payment rates for nursing home care provided in State homes to veterans with service-connected disabilities. The American legion has long supported full reimbursement of nursing home care furnished to 70 percent service-connected veterans or higher, if the veteran resides in a State home.

The American Legion is pleased to support the provision in Section 4 which would allow for the provision of prescription medicines for veterans with service-connected disabilities receiving care in State homes. Currently, they are required to travel unnecessarily to VA facilities to receive their prescription medications.

Section 5 authorizes certain health care facilities to be treated as State homes. The American Legion supports the measure for more State homes to meet the needs of veterans. These facilities must meet the proper guidelines with proper oversight and should have sufficient funding. The VA should be prudent in the approval of any applications submitted.

THE AMERICAN LEGION HAS NO OFFICIAL POSITION ON S. 1731

S. 2500, Section 2 requires the VA to submit a report to the Committees on Veterans' Affairs in the Senate and House on proposed PTSD modification ratings for service connection for compensation

payments and wait 6 months after the report is submitted before a change is implemented.

The American Legion supports stronger congressional oversight, especially in matters involving PTSD and other psychiatric conditions, given the increased volume of these types of cases in the VA. The American Legion would welcome an opportunity to present its views if a report is submitted to Congress and to comment on the impact that any change may have on the veterans' community before it is actually implemented.

Section 3 would require the Secretaries of VA and Defense to extend mental health care services to National Guard and reservists who served on active duty in a theater of combat. The current conflicts in Afghanistan and Iraq are producing a new generation of veterans. These conflicts have necessitated the call-up of the National Guard and Reserves in record numbers. The prevalence of mental health problems is well documented within the ranks of these servicemembers. Many of the Guard and Reserve are slipping through the crack of the VA safety net due to a myriad of factors. These injured veterans and their families and the American Legion would support and welcome the mental health care services. We believe this legislation will address some of the transition problems that the Guard and Reserve encounter due to the uniqueness of their situation.

Section 4, of course, authorizes $180 million to be appropriated to the VA for fiscal year 2007 for readjustment counseling and other mental health services. The American Legion appreciates, welcomes, and supports the additional funding in this measure which would help the Vet Centers carry out this important mission.

Caregivers are a critical part of the continuum of care for the VA. The American Legion supports S. 2753.

Mr. Chairman, Ranking Member Akaka, and Members of the Committee, the American Legion would like to thank you and the Committee for putting forth very comprehensive legislation to address some of the monumental problems the VA faces today in providing quality, accessible health care to the Nation's veterans. We look forward to working with this Committee and its Members in the future.

I would be happy to answer any questions the Committee may have.

[The prepared statement of Mr. Lara follows:]

PREPARED STATEMENT OF JUAN LARA, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the American Legion's views on the veterans' health care legislation before us today. It is indeed an honor and a privilege to present these views on behalf of the Nation's largest veterans service organization.

S. 2634, REPEAL TERM LIMITS AND SIMPLIFY APPOINTMENTS FOR THE OFFICES OF UNDER SECRETARY FOR HEALTH AND UNDER SECRETARY FOR BENEFITS

This legislation seeks to amend sections 305 and 306 of title 38, United States Code, by eliminating subsections that set terms of office and establish procedure for filling vacancies in the positions of Under Secretary for Health and Under Secretary for Benefits for the Department of Veterans Affairs (VA).

The American Legion does not support any of the proposed changes to the existing law that governs the appointments for the offices of the Under Secretary for Health

and Under Secretary for Benefits. Having participated in the selection process, the American Legion has concerns regarding the changes in the appointment process and the suggested repeal of term limits outlined in this legislation. The American Legion wants to ensure that the appointment process is adequate in determining that only the most highly qualified individuals are selected.

While the American Legion cannot support either elements of this proposed legislation concerning on the offices of Under Secretary of Health and the Under Secretary of Benefits as a result of this legislation.

S. 2736, AMPUTATION AND PROSTHETICS REHABILITATION CENTERS FOR VETERANS

This legislation requires the Secretary of the VA to establish at least five regionally dispersed centers that would provide rehabilitation services to veterans with amputations or prosthetic devices. These centers would have expertise in prosthetic, rehabilitation, treatment and coordination of care for veterans with amputations of any functional part of the body; and provide information and supportive services addressing care and treatment of veterans with amputations to all facilities of the VA.

The American Legion would support the creation of additional Polytrauma Centers to meeting the increased demand by severely injured veterans located across the Nation. This would greatly improve accessibility and convenience.

S. 2433, RURAL VETERANS CARE ACT OF 2006

This bill seeks to improve services available to veterans residing in rural areas.

If enacted, Section 2 of the proposed legislation would establish the position and responsibilities of the Assistant Secretary for Rural Veterans within VA.

The American Legion does not object to the establishment of this position. The issue of providing safe and adequate health care to rural veterans is not a small one. The creation of an Assistant Secretary for Rural Veterans will allow VA to directly and thoroughly address the problem. The provision of health care to the rural veterans population needs that type of undivided attention. The current health care model and methodology used to fund VA is clearly flawed. This fact was apparent when faulty assumptions and questionable cost projections forced Congress to secure an additional $1.5 billion in an emergency-spending bill to cover the VA health care shortfall for fiscal year 2005. We do not object to the addition of this post to the VA, but adequate resources are critical in order to meet the health care needs of all veterans.

Section 3 of this measure would mandate that the Assistant Secretary for Rural Veterans conduct demonstration projects exploring alternatives for expanding care in rural areas, including creating partnerships with other Federal health care providers under the Department of Health and Human Services (HHS), as well as, private health care providers.

The American Legion would also recommend including the Department of Defense (DoD) since there are a number of military installations in rural communities. This would be consistent with the recommendations from the President's Task Force to Improve the Delivery of Health Care for America's Veterans with called specifically for increase collaborative efforts between VA and DoD health care delivery systems. However, there must be clear-cut objectives and details that will be used to measure the success or failure of the projects.

Section 4 of the bill would require the Secretary of VA to conduct a pilot program to evaluate the feasibility and advisability of utilizing various means to improve access to health care services for veterans who reside in highly rural or geographically remote areas. The program will be conducted in three VISNs chosen by the Secretary, based on recommendations made by the Assistant Secretary for Rural Veterans.

Section 5 of this measure would authorize veterans to receive travel reimbursement equivalent to the rate set for Federal employees.

Section 6. Section 6 would mandate the Assistant Secretary for Rural Veterans establish up to five Centers of Excellence for rural health research, education and clinical activities; geographically disperse the health care facilities throughout the United States; and define selection criteria.

S. 1537, PARKINSON'S DISEASE RESEARCH AND EDUCATION CLINICAL CENTERS

This legislation requires the Secretary of VA to designate at least six VA health care facilities as locations for centers of Parkinson's Disease Research, Education, and Clinical activities and at least two facilities as locations for Multiple Sclerosis Centers of Excellence, if sufficient funding is appropriated to do so. It also requires that existing (as of January 1, 2005) facilities operating as such be designated as Centers of Excellence, unless the Under Secretary of Health advises otherwise.

Funding will be appropriated from the VA's medical services account and medical and prosthetics research account as appropriate.

One of the recruitment and retention tools for physicians is the robust research program that VA has and the affiliation VA enjoys with many medical schools throughout the country. VA's research not only serves the veteran population, but also contributes to the Nation as a whole. Expansion of research centers such as for Parkinson's and Multiple Sclerosis is a natural step forward toward the betterment of veterans' health care. It is also the sign of a healthy and viable program.

VETERANS LONG-TERM CARE SECURITY ACT

This legislation would ensure appropriate payment for the cost of long-term care provided to veterans in State veterans homes.

Section 2 would require VA to submit a detailed report to Congress before implementation of a reduction in per diem rates for care provided to veterans in State homes.

The American Legion welcomes stronger oversight of VA's handling of payments to State homes. The most critical aspect of this section is the requirement of the Secretary to report in detail a justification for reducing payments and that VA will consult with the heads and appropriate officials of the State and local agencies responsible for the supervision of State homes in each State.

Section 3 would increase payment rates for nursing home care provided in State homes to veterans with service-connected disabilities.

The American Legion has long supported full reimbursement of nursing home care furnished to 70 percent service-connected veterans or higher, if the veteran resides in a State home.

Section 4 would allow the provision of prescription medicines for veterans with service-connected disabilities receiving care in State homes.

The American Legion is pleased to support the provision for prescription medicines. Veterans with a rating of 50 percent or greater service-connection receive VA pharmaceutical benefits at no cost. Currently, pharmaceutical services are available at the State veterans' homes for these veterans, but they are required to unnecessarily travel to VA facilities to receive their prescription medications.

This legislation will help to alleviate that unnecessary and sometimes undue hardship on the veteran.

SECTION 5 AUTHORIZES CERTAIN HEALTH FACILITIES TO BE TREATED AS STATE HOMES.

The American Legion believes VA has the responsibility to provide long-term care to America's veterans. Along with that comes the responsibility of ensuring the quality and effectiveness of the treatment provided by facilities that are not necessarily under VA's jurisdiction. The American Legion also believes VA should be prudent in the approval of the applications submitted by the States with respect to the health facility.

S. 1731, JACK C. MONTGOMERY DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

This legislation renames the VA Medical Center in Muskogee, Oklahoma as the Jack C. Montgomery Department of Veteran Affairs Medical Center in honor of Medal of Honor recipient Jack C. Montgomery for his service and dedication to the military and the VA.

The American Legion has no official position on this legislation.

S. 2500, HEALING THE INVISIBLE WOUNDS ACT OF 2006

Section 2. requires that the Secretary of VA, before modifying the manner in which post-traumatic stress disorder (PTSD) is handled with regards to rating of service-connection for compensation payments, submit a report on the proposed modification to the Committees on Veterans' Affairs in the Senate and House of Representatives and wait 6 months after the report is submitted before the change is implemented.

We, The American Legion, supports stronger congressional oversight, especially in matters involving PTSD and other psychiatric conditions, given the increased volume of these types of cases in VA. The American Legion would welcome an opportunity to present its views if a report is submitted to Congress and to comment on the impact that any change may have on the veterans' community before it is actually implemented. The American Legion voiced concerns over VA's initiative to conduct a major case review regarding PTSD in response to the May 2005 VA Inspector General (IG) report on variances in VA's disability compensation payments. While they did not complete the review, the handling of the situation caused undue hard-

ship and anxiety for an untold number of veterans with serious psychiatric conditions and needlessly exacerbated their illness.

Section 3 prescribes that the Secretary of VA, in consultation with the Secretary of the Defense, extend mental health care services to National Guard and Reservists who served on active duty in a theater of combat.

The current conflicts in Afghanistan and Iraq are producing a new generation of veterans who will be forever changed because of their service to this Nation. These conflicts have necessitated the call up of the National Guard and Reserve in record numbers. The prevalence of mental health problems is well documented within the ranks of these service men and women. Further, many of the Guard and Reserve are slipping through the cracks of the VA safety net due to a myriad of factors. These injured veterans and their families would welcome the mental health care services.

The American Legion believes this legislation will address some of the transition problems that the Guard and Reserve encounter due to the uniqueness of their situation.

Section 4 authorizes $180,000,000 to be appropriated to the VA for fiscal year 2007 for readjustment counseling and other mental health services through the Vet Centers.

The American Legion appreciates the additional funding requested in this legislation for the Vet Centers to carry out this important mission.

S. 2753, CAREGIVER EXPANSION

This legislation would require VA to make $10 million available as a grant program to expand the services available to veterans for non-institutional care services.

The American Legion supports the intent of this legislation.

Mr. Chairman, The American Legion would like to thank you and the Committee for putting forth very comprehensive legislation to address some of the monumental problems VA faces today in providing quality, accessible health care to the Nation's veterans. We look forward to working with you in the future. Thank you.

Chairman CRAIG. Juan, thank you very much.

And our last witness, Adrian, please proceed.

STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Chairman Craig, Ranking Member Akaka, Members of the Committee, on behalf of the more than 1.5 million members of the Disabled American Veterans and its Auxiliary, I wish to express our sincere appreciation for the opportunity to present our views on health care legislation before the Committee.

Beginning with S. 2634, which would repeal the 4-year term limits of both VA Under Secretaries for Health and Benefits and repeal the search commission requirements for both positions under current law, while the DAV is not opposed to eliminating the term limits, we have some concerns with repealing the provision for a search commission. And while current law merely formalizes the search for prospective candidates, it does enhance this process by involving a select group of recognized individuals who are from various fields and interests particularly relevant to VA and its mission. And, equally important, it isolates the process from political influences. It is for these reasons that we urge the Committee not to support the provision of this bill.

DAV does support S. 2500, Healing the Invisible Wounds Act of 2006. However, we do recommend some modification of Section 1 as it may be limiting for any change in rules or standards for the purpose of expanding entitlement or providing for more liberal disability ratings.

S. 2433, the Rural Veterans Care Act of 2006, is a comprehensive and thoughtful bill which clearly attempts to address complex

issues surrounding rural veterans' access to VA health care. We support Section 5, which would increase travel reimbursements to veterans seeking VA care. In fact, DAV Resolution 183 urges the VA to include a line item in its budget for the cost of increasing the travel reimbursement rate to a more reasonable amount so that it can make the needed adjustments without reduction in funds for direct medical care.

With respect to the remaining provisions in this bill, though beneficial to an underserved veteran population, the DAV has serious concerns about its impact on the VA health care system. DAV does not believe VA has been provided sufficient funding to care for the veterans currently enrolled in the system. It has a growing list of thousands of veterans waiting to be seen by a health care provider, as we speak. Until Congress is willing to guarantee full funding for such a comprehensive initiative as proposed, we cannot support this measure.

Existing VA research and education clinical centers and Centers of Excellence have proven to be a valuable resource to educate sick and disabled veterans as well as VA health care providers on new and effective treatment regimes. DAV does support S. 2763 and S. 1537, which would create two Multiple Sclerosis Centers of Excellence and Centers for Clinical Research and Education specific to veterans suffering from amputations and Parkinson's disease.

DAV fully supports S. 2762, the Veterans Long-Term Care Security Act of 2006, which seeks to curb untenable attacks to limit the provision of institutional extended care services to service-connected disabled veterans in State Veterans Homes.

While DAV does not have a specific resolution to support S. 2753, we would like to take precious time to highlight the need for this legislation. It is critical to note that families, not government, provide 80 percent of long-term care for older persons in the United States. With VA's increased emphasis to provide non-institutional extended care services, caregivers become a crucial element for success in caring for our Nation's sick and disabled veterans. The aging veteran population is causing more and more families to face the stress and financial difficulties that come with caring for veterans who are not only old but young as well, particularly the veterans from this current war.

This bill would move VA in the direction to meet caregivers' needs who endure emotional and personal health strains by providing VA facilities and frontline health care providers the seed to produce high-quality, cost-effective approaches in providing the much needed relief to caregivers.

Mr. Chairman, this completes my testimony. I would be happy to answer any questions this Committee may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

On behalf of the more than 1.3 million members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the views of our organization on health care legislation before the Committee.

These measures cover a range of issues important to veterans and their families. The DAV is an organization devoted to advancing the interests of service-connected

disabled veterans, their dependents and survivors. For the past eight decades, the DAV has been devoted to one single purpose: building better lives for our Nation's disabled veterans and their families.

S. 2634

This legislation would repeal the 4-year terms for the Department of Veterans Affairs (VA) Under Secretaries for Health and Benefits and repeal the search commission requirements for both positions under current law.

While the DAV is not opposed to eliminating the term limits for both Under Secretary positions, we are concerned that repealing the provision for a commission would be detrimental to the fundamental process. Whether the process is formal or informal, it is fundamental in the search and selection of a candidate for any position. In the case of either of the Under Secretary positions, the search commission is formalized under current law. Moreover, the search commission's process of selection involves careful deliberation, examination, and consideration by a selected group of recognized individuals who are from various fields and interests particularly relevant to VA and its mission. Not only does current law regarding the search commission enhance the selection process, but equally important, isolates the process from political influences. The DAV urges the Committee not to support the provision of this bill that would abolish the search commission.

S. 2736

The DAV supports this legislation, which would require VA to establish five Amputation and Prosthetic Rehabilitation Centers to address a gap in VA's specialized services for the newest generation of veterans with amputations. The growing number of Operation Iraqi and Enduring Freedom veterans who survive these debilitating injuries should be allowed every advantage that equals their desire to integrate into civilian life and become a productive member of society.

Veterans who seek medical care from VA and require prosthetics to enhance their quality of life consist of two distinct populations: our newest veterans with technologically advanced prosthesis and veterans of past wars utilizing older prosthetics devices. The new level of service such centers could provide, coupled with the research, development, and innovation in this area of medicine would be an invaluable resource to disabled veterans of today and tomorrow.

S. 2433

The Rural Veterans Care Act of 2006 is a comprehensive bill to improve the care provided to veterans living in rural areas. It would establish an Assistant Secretary for Rural Veterans in the Department of Veterans Affairs (VA) to: (1) formulate and implement all policies and procedures that affect veterans living in rural areas; (2) identify a Rural Veterans Coordinator in each Veterans Integrated Service Network (VISN); (3) coordinate demonstration projects to examine alternatives for expanding care in rural areas; (4) establish partnerships with other Federal agencies to coordinate health care services for veterans living in rural and geographically remote locations; (5) reevaluate directives and procedures related to the use of fee-basis care nationwide and strengthen the use of fee-basis care to extend health care services to rural and remote areas; (6) conduct a pilot program in three VISNs to evaluate the feasibility of utilizing various means to improve access to care for veterans living in highly rural or remote geographical areas dedicating an amount equal to 0.9 percent of the total health care appropriation in that fiscal year for each year of the program; and (7) establish one to five Centers of Excellence dedicated to rural health research, educational and clinical activities.

S. 2433 is a very thoughtful bill which clearly attempts to address the complex issue of rural veterans' access to VA health care. Without question, this measure is the most comprehensive plan put forward to date to fully address the health care needs of veterans living in rural areas. Although we acknowledge it would be beneficial to veterans living in remote areas of the country, we have serious concerns about the impact it would have on the VA health care system. Most likely, this bill would dramatically increase contracted or fee-based care based on the provision in Section 4 of the measure which relates to veterans approximate driving distance to the nearest VA facility and sets out parameters for care under this initiative. There is also the provision in Section 3 of the bill that calls for reevaluating the VA's fee-basis program on a nationwide basis and to revise established policies to strengthen the use of fee-basis care to extend health care services to rural and remote areas. Although S. 2433 proposes to explore various alternative means to provide care for veterans living in rural areas of the country, it is likely most of such care would have to be provided on a contract basis in the private sector. This appears to be

in conflict with another demonstration project VA is moving forward with, project HERO, an initiative aimed at reducing the amount of funding it spends on higher cost contracted services.

DAV's position on contracted or fee-based care is well known. In general, 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. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support any broad contracting for populations of veterans. DAV believes that VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health problems. We are concerned that the contracted care element as provided for in this bill (particularly if it were focused on acute and primary care to significant populations) would inevitably grow over time, and place at risk VA's well-recognized qualities as a renowned and comprehensive direct provider of health care.

Specifically, we do not believe VA has been provided a sufficient funding level to care for the veterans currently enrolled in the system. Waiting lists are once again growing and timely access to services is delayed for thousands of veterans. Putting additional budget pressures on the system would only exacerbate the problem. Until Congress is willing to guarantee full funding for such a comprehensive initiative as proposed in S. 2433, we can not support this measure.

Section 5 of S. 2433, would increase travel reimbursements to veterans traveling to VA facilities for treatment. DAV would support this provision in the bill in accordance with DAV Resolution 183, which urges VA to include a line item in its budget for the cost of increasing veterans' beneficiary travel reimbursement rate to a more reasonable amount so that it can make the needed adjustment without reduction in funds for direct medical care to sick and disabled veterans.

S. 1537

The DAV supports S. 1537, which would direct VA to designate, establish, and operate at selected VA Medical Centers at least six centers for Parkinson's disease research, education, and clinical activities, and at least two Multiple Sclerosis Centers of Excellence. Additionally, it would require the Under Secretary for Health to assure appropriate geographical distribution of such facilities, and establish a panel to assess the scientific and clinical merit of proposals submitted by a facility for the establishment of such a center.

The VA annually cares for over 40,000 veterans suffering from Parkinson's disease; however, the incidence of Parkinsonism increases with age. While there is currently no cure for Parkinson's disease and despite advances in treatment, relentless progression of neuronal damage frequently leads to total disability. Further research into fundamental mechanisms of neuronal degeneration is needed for the development of improved diagnostic and treatment regimens.

Multiple Sclerosis (MS) is a chronic, unpredictable neurological disease that affects the central nervous system. Like Parkinson's disease, there is no cure for MS yet, although pharmaceuticals can help slow the course of the disease or ease symptoms in some patients. The symptoms of MS are highly variable, depending on the areas of the central nervous system that have been affected. An MS Center of Excellence contemplated in this legislation would take advantage of VA's strengths. As a system of medical facilities linked through technology with academic affiliations, these centers provide an opportunity for significant progress toward understanding and treating MS.

Existing VA research and education clinical centers and Centers of Excellence have proven to be a valuable resource to educate sick and disabled veterans as well as VA health care providers on new and effective treatment regimes. Following this successful template, the proposed centers would not only attract an array of world class health care providers and researchers to VA, they would also provide fertile ground for collaboration and development in the areas of clinical care, scientific research, and educational outreach. They would ensure specialized care will be embedded throughout the continuum of care provided by the VA health care system.

STATE HOME LEGISLATION (SEN. AKAKA)

Mr. Chairman, we applaud Ranking Member Akaka and Senator Burr for the draft legislation to help both service-connected veterans and the State Veterans Home system, and we appreciate the Committee considering it today.

Section 1 of this bill would require a future VA Secretary to consult with the Governors, State Homes, and other stakeholders in long-term care, such as the DAV and other veterans service organizations, if a proposal were being considered that would jeopardize the future of the State Veterans Home system. The Committee will recall, in the fiscal year 2006 budget, the Administration made just such a proposal—to revamp eligibility by greatly restricting admission to State Veterans Homes and to propose a moratorium on the construction grant program to support those homes, without any prior warning or communication with those most affected. Thankfully, these ill-advised proposals were rejected by Congress but they certainly could be made again. If so, we believe stakeholders have a right to expect consultation before the fact and assistance from VA in preparing for any such significant changes.

For the purpose of equity, we believe sections 2 and 3 of the Akaka bill are especially important. Providing service-disabled veterans a State Home placement option to meet their long-term care needs, and providing their necessary prescription medications for service-connected disabilities, are overdue extensions of support for veterans who have made great sacrifices due to injuries or illnesses incurred in military service.

Section 4 of the bill would enable a State and VA to establish small State Home bed units in pre-existing health care facilities where a full-blown State Veterans Home could not be justified under current regulatory criteria. We believe this provides a reasonable option for states such as Hawaii and other parts of the country that have remote and rural environments. In summary, the DAV fully supports the purposes of this bill.

S. 1731

This bill would rename the VA Medical Center in Muskogee, Oklahoma, as the Jack C. Montgomery Department of Veterans Affairs Medical Center. The DAV has no resolution on this issue, but we do not oppose its enactment.

S. 2500

This measure would enhance the counseling and readjustment services provided by the VA for members of the National Guard and Reserves. Section 3 and 4 of the "Healing the Invisible Wounds Act of 2006," would ensure that these men and women receive the readjustment counseling and mental health services necessary to transition into what we hope will be a full and productive life after return from a combat theater. Specifically, the bill provides for greater cooperation between VA and the Department of Defense, through the expansion of Reunion and Reentry activities of Vet Centers. A report from VA is required that includes, among other things, the cost and effectiveness of the program as well as an assessment of servicemember satisfaction. Additional funds would be authorized to provide these services.

In general, the DAV supports this measure; however, we recommend modification of language in section 1 of this bill to include standards for service connection of post-traumatic stress disorder, and to permit any change in rules or standards for the purpose of expanding entitlement or providing for more liberal disability ratings.

Mr. Chairman, this completes my testimony. I'll be happy to answer any questions the Members of this Committee might have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO ADRIAN M. ATIZADO

Question. One of the real practical problems I have with the commission process is that people other than the elected President and Senators identify the executive branch officials. But, once those officials are nominated and confirmed, the public holds Senators and the President accountable for the executive branch officials' actions.

Does it not strike you as just a little unreasonable, frankly, that we are being held accountable for the performance of an official who was chosen by members of your organizations? Without getting too unserious, why shouldn't we hold you accountable since you picked them?

Answer. The recommendation from the search commission to the VA Secretary does not come solely from representatives of veterans service organizations. As is reflected in your floor statement when introducing this measure, "the Secretary of Veterans Affairs must establish a commission made up of various interested individuals . . ." Moreover, title 38, United States Code S. 305, prescribes only two persons representing veterans served by the Veterans Health Administration shall be made part of the search commission. Correspondingly, S. 306 indicates only two persons representing veterans served by the Veterans Benefits Administration shall be made part of that commission. In both cases, of the ten person search commission, only two are representatives from veterans service organizations. It is worthwhile to note that the legislative language for the search commission originated from the amended text of S. 533 as a substitute to H.R. 3471, which was then passed by the Senate. Specifically, the conference report filed in the House (H. Rept. 100–1036) describes that the conferees "agree to follow the Senate amendment with regard to the establishment of a Commission to recommend individuals to fill vacancies in the Chief Benefits Director and the Chief Medical Director positions." The statutory language has remained relatively unchanged in nature or purpose regarding the issue at hand since passage of H.R. 3471 (Public Law 100–527).

Furthermore, the recommendation of not less than three persons by the search commission is sent to the VA Secretary who then forwards the recommendation to the President with any comments the Secretary considers appropriate. If the President does not agree with the list of persons provided by the Secretary, the President may request that additional individuals be recommended from which he can choose a nominee. Undoubtedly, the search commission's recommendation is non-binding to the President.

Clearly, members of our organizations do not "pick" the individual for the positions of the Department of Veterans Affairs (VA) Under Secretaries for Health or Benefits. As portrayed in my written testimony, one of the many strengths of the search commission is the actual process of selection, which involves careful deliberation, examination, and consideration among a group of individuals selected from various fields and interests particularly relevant to VA and its mission. Unlike the information before the search commission such as the candidate's curriculum vitae, the President and Senate Committee on Veterans' Affairs have the benefit of additional pertinent information on the candidate such as the Federal Bureau of Investigation background check of their employment, professional, personal, travel, medical, financial, legal, military and educational histories from which to decide. The Senate has the final say in whether to confirm the nominee.

Chairman CRAIG. Thank you very much, Adrian, for that testimony, and, again, to all of you, thank you for your time and your preparedness, because we handed you a fairly full slate of different legislative initiatives by this Committee.

Mr. Melia, let me ask you a couple of questions. I think all of us are concerned by your testimony and by the experience that our veterans who are amputees are having. You noted that there is a huge difference in service provided to veterans with amputations, depending on VA's medical facility he or she happens to be the closest to. Clearly, we should strive for greater consistency.

You have given us one example. Can you give us an example of the types of services an amputee can receive at one of the "good facilities" and what type of trouble he or she is likely to encounter in a less adequate facility?

Mr. MELIA. Thank you, Senator. Thank you for that question.

I think what we are finding is that this is a system that is essentially run by human beings and run by budgets, and that anytime that you have those two things mixed together, there is a recipe for inconsistency. The people that are getting the money and the people that are getting the best people are providing the best service.

My feeling and the feeling of the Wounded Warrior Project is that we have seen big disparities in things like access to care, the amount of time that it takes servicemembers to access the system.

Practitioner skill level is a major problem. Earlier testimony spoke of certification for prosthetic representatives. We have found that is highly inconsistent throughout the system and that there is really no system in place for continuing education of prosthetists and prosthetic representatives. Some of the certification statistics were spoken of earlier, including the ABC certification, is nothing more than a sign-off by the chief of prosthetics in a particular department and does not require anything like continuing education in an institution of higher learning like we may find with doctors and lawyers. Obviously, our servicemembers deserve much more than that.

Also, things like gait labs and occupational therapy and physical therapy are also very important and having the best people doing that. This is a very small population, Senator; 450-some servicemembers have been wounded. If we cannot provide excellence to this group in the VA system, who do we provide excellence to? The VA right now has a problem with marketing and with public relations within this group. It only takes one or two servicemembers having a bad experience for most of them to hear it and move on to another system. These folks have choices through TriCare. Many of them are allowed to use fee-basis, and Heath Calhoun, whom I spoke of previously, had to be refitted for his prosthetics recently. And at that smaller site, a VA site, he actually was referred to an outside vendor for that service. So the service was not even provided within the VA system. Possibly he may be brought back for physical therapy and occupational therapy, but not in that site. He would actually have to go to Richmond, Virginia, some 3½ hours away.

My biggest concern is employability and, you know, 10 to 15 appointments a year is what the standard new amputee is faced with. As an employer of four combat wounded disabled veterans of this conflict, I can tell you that 15 days is too much for most employers in this country to give people off. It does not leave them much time for vacation either. When they have an appointment, it is not for an hour. It is for a day.

So I think that the hub-and-spoke model that Mr. Blake spoke about earlier that is used within the VA system—within the SEI system—is really the type of system we need here where there is a Center for Excellence, where somebody goes for a yearly review, and then maybe is referred back to the smaller facility.

Chairman CRAIG. We certainly appreciate your testimony, your focus on it, along with Carl Blake's testimony and focus on it. We do not disagree with you. That is why the legislation is here. We cannot provide this level of expertise in every VA facility. It simply would not be cost-effective, but it has got to be there. It has got to be reasonably accessible as adjustments and changes occur. I think that with these new modern devices, older veterans are going to be great beneficiaries of it, too, clearly, as these devices become more available and as they are constantly refined and tuned, if you will, of the kind that I have certainly seen and viewed over the last several years. So we thank you for that testimony.

Let me turn to Senator Akaka.

Danny.

Senator AKAKA. Thank you very much, Mr. Chairman.

Mr. Lara and Mr. Shaw, I certainly appreciate your support of the State Home bill and its goal to expand the furnishing of long-term care. Along those lines, the legislation requires full cost reimbursement for the so-called Millennium bill veterans in State Homes. The question is: Is this just a matter of equity or do you also believe that veterans will benefit from receiving care in State Homes? Mr. Shaw?

Mr. SHAW. I believe it is both. It is a matter of equity, and it is a matter of the veteran's individual choice. Currently, we do have some 70 percent and higher service-connected veterans who have to pay their cost of care in State Homes. They choose to be in those State Homes with the friendship and the families that they have developed there, and I do not think it is fair or equitable for them to have to leave those home environments and go to another site to get their cost paid for by the VA.

So I believe it is both an equity issue and it is a fairness issue for the veteran to be able to have a right to choose.

Senator AKAKA. Mr. Lara.

Mr. LARA. I concur with his statement, and we believe that the more choices that the veterans have, the better that will be. And we definitely agree with your bill, and thank you for putting that forward, Mr. Akaka.

Senator AKAKA. Mr. Lara, regarding the caregivers grant program, the idea is to incentivize or encourage local VA providers to develop ways to help caregivers of veterans and to be innovative in doing this.

What is your view about the manner in which VA is providing non-nursing home care? In other words, is VA fully complying with the mandate in the Millennium Health Care Act?

Mr. LARA. We believe that the caregivers are very critical to the continuum of care for veterans, Senator, and that is a great question. And it is something that we are closely looking at. We believe that, so far, the caregivers are not really getting all the credit that they have because they give a lot of volunteer hours in providing the care for the veterans. So we believe that the $10 million grant would be very welcomed. I think that the only concern would be on how it was going to be implemented.

As far as what the VA is doing, I think that more can be done, and the more that we look out for the veterans—their cares and needs—and the more we improve our delivery of services to them, I think we are going to have a better end product for all our veterans.

Senator AKAKA. Thank you.

Mr. Shaw, in their testimony, other witnesses expressed concern about Section 5 of the State Home legislation which would allow VA to deem unused beds as State Homes for the purposes of placing veterans in long-term care. In my mind, this section would ensure that there is a long-term care capacity in places currently lacking nursing home care. But it would also obviate the need for building new homes.

There is some concern that quality would not be monitored in these de facto homes. How is this currently working in Alaska?

Mr. SHAW. It is currently working in Alaska the same way it is working in all State Homes. They all have the same set of rules and regulations for health care delivery.

What we are asking for in the deem status would be no different. Alaska delivers quality care inside the Pioneer model, inside the homes they currently have. The VA, once those are fully certified, will also survey and oversee all the care that is delivered in those sites. The deem homes would be no different. There is no separate set of regulatory standards that would be applied. They would be applied the same all the way across the board.

So I do not understand the concern, knowing that we would all live under the same set of regulatory rules.

Senator AKAKA. Well, I thank you so much for your response.

Mr. Chairman, if I may ask another question here? My time has expired.

Chairman CRAIG. Please proceed.

Senator AKAKA. Mr. Atizado, in your testimony, you suggest changing Section 2 of the Healing the Invisible Wounds Act to permit any changes in rules or standards to expand PTSD entitlement for more liberal disability ratings. I want to thank you for your suggestion, because the purpose of this section is to protect against any diminishment in PTSD compensation and not to hinder an expansion of the benefit. And I agree that this change should be made.

You also recommend a modification of the language to include standards for service connection of PTSD. Now, my question to you is: How do you suggest that these standards be developed?

Mr. ATIZADO. Ranking Member Akaka, thank you for that question. The suggested recommendation with regard to standard service connection primarily deals with protecting the current standard. It is funny to note that no other title or code provides for adjudication of a claim that would allow the Government agency to err on the side of a veteran. And we would like to make sure that is protected with any modifications of the bill.

With regard to actual changes or enhancements in standards, I would be happy to send that back to my office to have our service staff look at it. But if I were to speculate, I would assume that they would include some kind of standardization of training in the area of adjudication for service connection for PTSD. It would eliminate, I think, quite a bit of subjectivity that would negate the spirit of the law to err on the side of the veteran.

Senator AKAKA. Well, thank you so much for your response, and we would look forward to comment from your organization on that.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Danny, thank you.

Senator Salazar. Ken.

Senator SALAZAR. Thank you very much, Chairman Craig, and to our witnesses, thank you for appearing before us today.

Let me also thank you for having conducted the review that you did of Senate bill 2433, the Rural Veterans Act. I think the one thing that we can all agree here is that shining a light on what is happening with 8 million veterans in rural America is something that is, in fact, important. You see the bipartisan support that we have for this legislation with over a dozen Senators, Republicans

and Democrats alike. And I know that this Chairman and this Ranking Member of this Committee are very sensitive to the reality of rural veterans. I am hopeful that this Committee can move forward with legislation that addresses this disparity. For me, it is un-American to think that we have essentially two Americas, two systems of health care with respect to how we provide health care to veterans in America. If you live in an urban area, you are going to get one set of health care; if you live in a rural area, you are going to get a second-class set of health care.

So I appreciate the general comments you have made about this bill. I know there are concerns that have been raised here today about some provisions of the legislation. But I look forward to working with the VA and also with your organizations to see how we might be able to streamline some of the concerns that have been raised.

I have a question—I will direct this to you, Mr. Blake, on the fee-for-service aspect of Senate bill 2433. I have heard the concerns from people who have said we do not want to privatize the VA. I understand those concerns. But I also have heard concerns in places like Craig, Colorado, where some of the veterans there have said we have great health care facilities, we are so far removed from Grand Junction some 150 miles away, why can't we just go to the local hospital?

I heard your comment that essentially said that you believe that under the existing authority of the VA, they could actually engage in contracting for services for those veterans that live in those very remote areas.

Can you elaborate on that? Or do you think that the—I guess your conclusion is the VA does not need additional authority in those circumstances. But I have heard from others that perhaps it is important for the VA to examine the authority that it is using for these fee-for-service programs in these very far outlying areas.

Mr. BLAKE. Thank you for that question, Senator Salazar. If there isn't a tougher issue to deal with, this might be it because it calls into question—I think we have made clear in the past our position on the privatization of health care, and yet we understand that probably the ultimate easiest way to address this issue for rural veterans is contracting out care in the most geographically remote areas.

A number of spinal cord-injured veterans who live in rural areas, as an example, use fee-for-service. Not every spinal cord-injured veteran chooses to live right near a spinal cord injury center. Now, granted, the spinal cord injury centers provide at least some degree of access beyond what some veterans just in general rural areas have. But there are a number of spinal cord-injured veterans that choose the fee-for-service program for access to care. Granted, they also have access because they have special needs, and so they get some degree of priority for that reason.

I don't really understand why the VA said they do not have the authority. What I quoted in my testimony is the exact language for the different circumstances which would allow them to use the fee-for-service program. I guess it is all in the interpretation of the statement "when VA facilities are geographically inaccessible to a veteran for necessary care."

Well, that calls into question maybe the idea of what is rural, and I address this a little bit in my written statement. The challenge with trying to determine what is considered rural, well, as an example, myself, I live down in Virginia. I would like to believe that I live in a rural area, but 10 minutes away is the hub of suburbia now. I mean, that is just the way things are in this particular area.

I have seen in the past years how ways of addressing this issue of rural are done in terms of minutes. There was discussion earlier about 60 minutes and how far that is. Well, on the right day at the right time, I work in an office in downtown DC and it could take 60 minutes to get to the DC VA Medical Center. That is only 4 or 5 miles in distance. So I think "rural" is a function of many things—time, distance, population density. So maybe it is just interpretation of what or how the VA interprets the regulations for what is geographically inaccessible.

Outside of that, using the parameters that are already there, I believe that they could open fee-for-service within reason. We always maintain the concern that privatization ultimately would harm the greater VA system. But if the fee-for-service program is the only option or the best option they have, we certainly could not reject that.

Senator SALAZAR. I thank you very much, Mr. Blake, and I would appreciate working with all of your organizations as we move forward with this bipartisan legislation.

Let me just end by saying that, it is very clear that this disparity of health services exists. We have this very extensive study that was conducted by the VA, which the findings, I think, are glaringly obvious. But it also can sometimes simply come down to this question of living or dying. If you have accidents and you are far away from the health care facilities and you live in a place like my native San Luis Valley, it may be 3 or 4 hours before you get to the right kind of medical care. Whereas, if you happen to live in a 2 or 3 million population area, like Denver, Colorado, somehow or other, you will find the health care within 5 minutes.

And so this disparity of health care is something that is of great concern to me, and I look forward to working with all of you, and with the great leadership of Chairman Craig and Senator Akaka, to address this issue in the future.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Ken, thank you very much.

Gentlemen, we thank you for being with us. I think, Carl, you are right. In part, it is how we define "rural." When you look at the standard Federal definition I think that HUD has established over the years, rural is in relation to living inside or outside an incorporated area. With that definition, probably one of our most rural States is our most urban—Nevada. It is by definition the most urban State. Pennsylvania is our most rural State by definition of those living outside incorporated areas. So it is a challenge for us, and I think that the questioning today and the comments are extremely valuable.

I am so disappointed in all of you that you did not jump up cheering and supporting S. 2634. I hope we can find some ground there. I understand the purpose of the commission originally. I am

not so sure that it takes politics out of the process. But I do find that, when you have quality and capable people serving at the pleasure of a President, that to term-limit them is a bit arbitrary, at best. They term-limit themselves either by their failure to act or their actions. This system has a pretty good record of wringing out those who fail to act or act inappropriately to meet the services and demands of their job, whether they be at the level of a Secretary or an Under Secretary.

Anyway, that was part of the reason why I brought this up as a form of legislation. I knew it would stimulate rather vigorous discussion. We will continue that discussion, but I do appreciate your comments on that.

Again, we will leave the record open for a short time for any additional questions that may come in writing from our Members that you may wish to respond to. But, again, we thank you for your preparedness and the time you have spent with us. It is appreciated, obviously, as we attempt to work for the purposes of our veterans with the VA to make sure that which they provide or that which we will ask them to provide is done so in an appropriate fashion.

Thank you all very much. The Committee will stand adjourned.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Thank you, Chairman Craig and Senator Akaka, for pulling together this hearing on these important pieces of legislation.

I want to focus on a bill that is close to my heart. I remember when I first started my campaign for the Senate, Congressman Lane Evans took me around on a tour of his district. Lane was full of energy. By the end of the day I was worn out. I think it is fair to say that had he not supported me early in my election campaign, I would not be here today.

No one has worked harder for this Nation's veterans than Congressman Evans. When Vietnam vets were falling ill from Agent Orange exposure, he led the effort to get them compensation. He was one of the first in Congress to speak out about the health problems facing Persian Gulf War veterans. He has fought to expand benefits to women veterans, he's worked to help those veterans suffering from Post-Traumatic Stress Disorder, and he's also helped to make sure there is a roof over the head of the thousands of homeless veterans.

In 1995, while he was in a Labor Day parade in Galesburg, Illinois, Lane noticed that he had trouble waving his left hand. He was diagnosed with Parkinson's disease, a debilitating illness that attacks the dopamine producing cells in the brain. As the disease progresses, patients become unable to control muscles and suffer from stiffness and tremors. There is no cure for the disease, but symptoms can be managed somewhat with drug therapy. VA medical centers treat at least 40,000 Parkinson's disease patients every year and some experts believe the disease affects as many as 150,000 veterans across the country.

Congressman Evans has managed his disease with grace and courage. And he has been a strong advocate for Parkinson's research and for treatment of veterans with the disease. He helped the VA open new Parkinson's centers and introduced numerous bills to expand that service even further. S. 1537, introduced by Senator Akaka, builds on legislation Rep. Evans introduced last year that passed the House of Representatives. This is a good piece of legislation that would establish six Parkinson's disease research and education clinical centers across the country. I urge this Committee to approve this bill. It is a sign of our commitment to veterans with Parkinson's disease and a fitting tribute to Congressman Evans' legacy of public service.

S. 2433, Senators Salazar and Thune's rural veterans bill, is a comprehensive approach to improving care for our Nation's rural veterans. The VA has not focused enough on the particular needs of the 23 percent of veterans who live in rural areas. More than 234,000 veterans live in Illinois' rural counties. This bill would take a number of steps to improve the VA's bureaucracy and study ways to extend care. I hope that the Committee will seriously consider this bill.

Senator Akaka's other bills on long-term care and PTSD would move the ball forward significantly in addressing these perennially difficult issues.

One piece of legislation that did not make it onto the agenda is S. 2358, a bill I introduced to establish quality report cards for VA hospitals. This is a small, but important piece of legislation that builds on existing data to give those on this Committee and others the tools to objectively measure quality at VA hospitals.

By measuring and reporting on the quality of care in our VA hospitals, medical centers would benefit from identification of areas of need, and opportunities for quality improvement and cost containment. Greater quality reporting and transparency can facilitate an honest dialogue about health care quality and how to reform our VA system.

Several states have already developed and implemented hospital report card initiatives, and I am proud to say that Illinois began its own report card initiative in January of this year—an initiative that I spearheaded when I served in the Illinois State Senate.

The VA Hospital Report Card Act mandates that the Secretary expand and improve upon current quality reporting provisions for VA hospitals. The bill requires the Secretary to take steps to ensure that all reported data is accurate and fairly represents hospital quality. The VA Hospital Quality Report Card Act will take us one step closer to improving health care quality and containing costs, and I hope my colleagues will join me in passing this critical legislation.

PREPARED STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee:

I would like to thank you for the invitation to submit testimony for this important hearing on veterans' health care legislation. The VFW is this Nation's largest organization of combat veterans, with over 2.3 million men and women across the country and in our Auxiliaries. While much of our focus is rightly on the funding and appropriations side of the debate, these bills under consideration recognize that there are many complex issues associated with the VA health care system, and we are happy to provide comments on them.

S. 1537

We are happy to support S. 1537, legislation that would establish six centers for Parkinson's disease research and two Centers of Excellence for Multiple Sclerosis.

VA research has been at the forefront of many medical breakthroughs and an increased emphasis on preventing, treating, and curing these two diseases is extremely important. This legislation would consolidate system-wide research being done on these conditions and would help to streamline research and, perhaps, improve its effectiveness. Since a large number of highly qualified doctors are drawn to VA, in part, for the ability to conduct world-class research, these centers could help recruitment.

We should also keep in mind that any benefits and breakthroughs that these centers would generate would not just affect this Nation's veterans, but all of America. It's a win-win for everyone. We thank Senator Akaka for introducing it, and we would urge this Committee's approval.

S. 1731

This legislation would name the VA Medical Center in Muskogee, Oklahoma after Jack C. Montgomery. We are pleased to support it. Jack Montgomery had a distinguished military record and was a recipient of the Medal of Honor for his valor in 1944. Naming the Medical Center is a fitting tribute to this great man and is the least we can do to honor his memory.

S. 2433

This legislation recognizes the growing access problems that many rural veterans face, and offers many ambitious solutions. Section 2 would create an Assistant Secretary for Rural Veterans within VA. Section 3 would mandate demonstration projects for improving access to care in rural areas by creating partnerships with other government agencies and private health care providers. Section 4 would create a specific pilot program to improve care for veterans in highly rural or geographically remote areas. Section 5 would improve the travel reimbursement for veterans traveling to VA facilities. Section 6 would create from one to five Centers of Excellence for rural health research, education and clinical activities.

We appreciate the intent of this comprehensive legislation. As a nationwide organization, many of our Members face the problems that this legislation aims to solve.

We strongly support Section 5, which would increase the travel reimbursement for veterans seeking care at VA facilities. This is badly needed as the mileage rate has not been increased in many years, and the deductible means that most veterans receive no travel assistance at all. This section would increase the rate to the fair rate provided to Federal employees. It is the proper thing to do.

We have several concerns, however, with sections 3 and 4. While we understand that in some areas it is the only alternative, we are concerned that this bill's reliance on fee-based care is overly broad and that it could adversely impact VA's budget and its ability to provide care to all veterans. Although we completely agree that more must be done to help these underserved veterans, relying primarily on fee-basis care could be a dangerous precedent, and shirks VA of its responsibility to care for all veterans equally.

We feel that many of the problems faced by rural veterans are wrapped up in the larger funding problems that VA has encountered over the last few years. Although we are appreciative of the budget increases, sufficient funding has not been provided for all veterans seeking care. Proper funding, we believe, would fix some of these problems.

S. 2500, HEALING THE INVISIBLE WOUNDS ACT

We happily support this legislation, which aims to improve mental health services for veterans, especially those in the National Guard.

Section 2 mandates that any decision that VA makes to change regulations for Post-Traumatic Stress Disorder (PTSD) would require the notification of Congress and a six- month wait before implementation. Section 3 mandates counseling and readjustment services for National Guard members returning from a combat theater. Section 4 increases funding for Vet Centers to be used on counseling and readjustment services.

We strongly support section 2. With VA's ill-fated PTSD review fresh in our memory, as well as the investigation by the Institute of Medicine lingering, it seems that VA is predisposed to weakening veterans benefits with respect to PTSD. This is an intolerable situation that does more to harm veterans by attaching a stigma, and discouraging those who truly need help from receiving the care and benefits they need to lead productive lives.

Sections 3 and 4 are important parts of meeting the needs of veterans. Despite VA's recent actions, we must encourage more veterans to avail themselves of VA's services. VA's mission is to make veterans whole, and effective mental health treatment is an important part of that. By actively screening returning National Guard members, we can efficiently help those who need treatment and assist them as they transition back into daily life. War is certainly difficult, and the types of conflict our men and women are facing are unique. We need to ensure policies are in place that are adaptable to the current needs of veterans, and this legislation is a step in that direction.

S. 2364

VFW supports this legislation, which would repeal the term of office and the requirement for a search commission for the VA Under Secretary for Health and the VA Under Secretary for Benefits.

With respect to term limits, we feel that they are not necessary, and that, in the cases of an Under Secretary who will remain in office, they are a hindrance. It is noted that the current Under Secretary has been subject to political pressure from some Senators before they will commit to reconfirming him, a practice that would go away without term limits. Additionally, we believe that the Under Secretary should serve at the pleasure of the President, and that that will, in fact, make him more accountable. If he is doing a good job, he can remain in office without facing pressure from the Senate, but if he is doing a poor job, we can hold the Administration accountable for the Under Secretary's actions. If the Under Secretary is not performing up to acceptable standards, he or she cannot hide behind term limits.

We also feel that the search commission is unnecessary. Although we have played a significant role in the process, we feel that its elimination is not going to affect our involvement. In fact, we believe that it may increase our effectiveness. Without a search commission, there will still be accountability, to the President for his appointment and to the Senate for its confirmation. We trust in the Senate's independence and oversight authority, and believe that this body will hold the officeholder accountable. Our members, who come from every State, are sure to hold both the Administration and the Senate accountable for their actions, giving us more direct influence over the process.

One of our constant refrains is that of accountability. We believe that this bill will give us more direct ability to hold VA accountable, and we hope that they continue to improve their responsiveness to the needs of veterans.

S. 2736

VFW is glad to support this legislation, which would create at least five VA centers for rehabilitation for veterans with amputations or prosthetic devices. At a time when war dominates the headlines, it is clear that this is necessary.

Thanks to improvements in technology, many servicemen and women are surviving blasts and injuries that would have killed them years ago, but their survival is coming at a heavy physical price. VA has long been on the forefront of prosthetics and amputation research, but the current conflicts are greatly increasing the demand for these types of services, which allow these servicemembers to easily transi-

tion back into productive society. Losing a limb is not a death sentence, and the uplifting examples that so many men and women provide is powerful evidence of that.

We thank you, Chairman Craig, and Ranking Member Akaka for introducing this important legislation, and we would strongly urge your colleagues to work for its passage.

S. 2753

We support this legislation, which would authorize a $10 million grant program for caregiver assistance to expand services available to veterans for non-institutional care services.

As the veterans' population ages and as there continues to be reticence to fully fund long-term, institutional care, these types of assisted services, such as adult-day health care and hospice care, will prove to be invaluable.

S. 2762

We are pleased to support this legislation, which makes some needed changes in how VA provides long-term care.

Section 2 of the legislation would require VA to report to Congress prior to making changes to the per diem program used to help fund State homes and the long-term care they provide. State homes are an integral part of VA's total long-term care process, and requiring this report will hopefully prevent the elimination or reduction of these critical payments for budget-based reasons. We cannot pinch pennies while the number of veterans needing these kinds of essential services climbs.

Section 3 would require VA to provide medications for veterans with service-connected disabilities regardless of whether they reside in a VA facility or a State Home. While we continue to oppose VA using State Home beds to supplant its statutory obligation to provide long-term care, it only makes sense that, if VA is going to use State Home beds in this way, it affords them the same benefits. It is, in short, part of the full costs of care.

Section 4 would allow VA to treat certain health care facilities as State Homes for purposes of providing long-term care to veterans. In rural or remote areas, especially, this could be helpful to VA. We support the concept, but we must watch to ensure that the same levels of care are being provided and that vigorous oversight is maintained to ensure that these facilities are up to VA's high standards.

Mr. Chairman, we thank you for the opportunity to provide testimony for this important hearing. If you or any Members of this Committee have any questions, I would be happy to answer them.

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