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Annual Legislative Presentation
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Before a Joint Hearing of the
House and Senate Committees on Veterans' Affairs
March 4, 2010

Chairman Akaka, Chairman Filner and members of the Committees, I appreciate the opportunity to present the legislative priorities for 2010 of Paralyzed Veterans of America (Paralyzed Veterans). Since its founding, Paralyzed Veterans has developed a worthy record of accomplishment, of which we are extremely proud. Again, this year, I come before you with our views on the current state of veterans' programs and services and recommendations for continued improvement in the services and benefits provided to veterans.

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

From the outset the founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing individuals with a spinal cord injury, be they medical, social, or economic. Paralyzed Veterans' founders were determined to create an organization that would be governed by the members, themselves, and address their own unique needs. Being told that their life expectancy could be measured in weeks or months, these individuals set as their primary goal actions that would maximize the quality of life and opportunity for all veterans and individuals with spinal cord injury - it remains so today.
To achieve its goal over the years, Paralyzed Veterans has established ongoing programs of research, sports, service representation to secure our members and other veterans' benefits, advocacy in promoting the rights of all citizens with disabilities, architecture promoting accessibility, and communications to educate the public about individuals with spinal cord injury. We have also developed long-standing partnerships with other \

Paralyzed Veterans, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, co-author The Independent Budget—a comprehensive budget and policy document that has been published for 24years.

Today, Paralyzed Veterans is the only congressionally chartered veterans' service organization dedicated solely to the benefit and representation of veterans with spinal cord injury or disease.
SUFFICIENT, TIMELY AND PREDICTABLE FUNDING FOR VA HEALTH CARE — Despite the fact that Congress has already provided advance appropriations for FY 2011, The Independent Budget—co-authored by AMVETS, Disabled American Veterans, Paralyzed

Veterans of America, and Veterans of Foreign Wars—has chosen to still present budget recommendations for the medical care accounts specifically for FY 2011. Included in P.L 111¬117 was advance appropriations for FY 2011. Congress provided approximately $48.2 billion in discretionary funding for VA medical care. When combined with the $3.3 billion Administration projection for medical care collections in 2010, the total available operating budget provided by the appropriations bill is approximately $51.5 billion.

Accordingly for FY 2011, The Independent Budget recommends approximately $52.0 billion for total medical care, an increase of $4.5 billion over the FY 2010 operating budget level established by P.L. 111-117, the "Consolidated Appropriations Act for FY 2010." We believe that this estimation validates the advance projections that the Administration developed last year and has carried forward into this year. Furthermore, we remain confident that the Administration is headed in a positive direction that will ultimately benefit the veterans who rely on the VA health care system to receive their care.

For Medical and Prosthetic Research, The Independent Budget recommends $700 million. This represents a $119 million increase over the FY 2010 appropriated level, and approximately $110 million above the Administration's request. At a time of war, the government should be investing more, not less, in veterans' biomedical research programs.

We are pleased to see that the Administration has followed through on its responsibility to provide an estimate for the Medical Care accounts of the VA for FY 2012. The Administration recommends $54.3 billion for total medical care budget authority for FY 2012. It is important to note that this is the first year the budget documents have included advance appropriations estimates. This will also be the first time that the GAO examines the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model, and what recommendations or other information the GAO report will include.

Additionally, we believe that Congress must conduct aggressive oversight to ensure that appropriated dollars are being spent the way that Congress intended. We have increasingly received reports from PVA staff members located in medical facilities that funding is running short. We have heard anecdotally that medical facilities have expressed concerns about running out of operating funds prior to the end of the fiscal year. We find this particularly hard to believe in light of the significant increases that have been appropriated for the VA health care system in recent years.
Similarly, we believe Congress needs to examine the Veterans Equitable Resource Allocation (VERA) model. We have heard concerns that allocations for caring for severely disabled veterans, including veterans with spinal cord injury, are decreasing. Without a detailed explanation of these decisions, we remain skeptical that appropriated dollars are getting to the intended end user—the direct providers of health care services.

COMPREHENSIVE VETERANS LEGISLAITON (TO INCLUDE CAREGIVER ASSISTANCE) — PVA and its partners worked extremely hard to get comprehensive veterans' legislation enacted during the first session of the 111th Congress. Unfortunately, with the exception of advance appropriations legislation, little else was finally enacted. Near the end of the first session, PVA advocated for final passage of comprehensive veterans' legislation that

mirrored S. 1963, the "Caregiver and Veterans Omnibus Health Services Act of 2009," as well as several key bills approved in the House.
Of particular importance to PVA are the sections of S. 1963, as well as the House legislation, that would provide needed support to family caregivers of severely disabled veterans and that would eliminate co-payments that Priority Group 4 catastrophically disabled veterans are currently required to pay.

With regard to family caregiver services, we ask that VA continue its effort to enhance the support and educational services provided to family members caring for veterans. There are approximately 44 million individuals across the United States that serve as caregivers on a daily basis. The contributions of caregivers in today's society are invaluable economically as they obviate the rising costs of traditional institutional care.
As the veteran community is aware, family caregivers also provide mental health support for veterans dealing with the emotional, psychological, and physical effects of combat. Many PVA members with spinal cord injury also have a range of co-morbid mental illnesses, therefore, we know that family counseling, and condition specific education is fundamental to the successful reintegration of the veteran into society. Combat exposure coupled with long and frequent deployments are associated with an increased risk for Post Traumatic Stress Disorder (PTSD) and other forms of mental illness. In fact, the VA reports that Operation Enduring Freedom and Operation Iraqi Freedom (OEFIO1F) veterans have sought care for a wide array of possible co-morbid medical and psychological conditions.

We believe that Vet Centers should increase coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues. Paralyzed Veterans believes that an effective mental illness family counseling and education program can improve treatment outcomes for veterans, facilitate family communication, increase understanding of mental illness, and increase the use of effective problem solving and reduce family tension.

The aspects of personal independence and quality care are of particular importance to veterans with spinal cord injury/dysfunction. As a result of today's technological and medical advances, veterans are withstanding combat injuries and returning home in need of medical care on a consistent basis. Such advances are also prolonging and enhancing the lives and physical capabilities of injured veterans from previous conflicts. No matter the progress of modern science, these veterans need the health-care expertise and care from a health team comprised of medical professionals, mental health professionals, and caregivers. As a part of the health care team, caregivers must receive ongoing support to provide quality care to the veteran. It is for this reason, that we strongly urge VA to develop support and educational programs by conducting caregiver assessments that identify the needs and problems of caregivers currently caring for veterans.

Our experience has shown that when the veteran's family unit is left out of the treatment plan, the veteran suffers with long reoccurring medical and social problems. However, when family is

included in the health plan through services such as VA counseling and education services, veterans are more apt to become healthy, independent, and productive members of society.

In 1985, Congress approved legislation that opened the VA health-care system up to all veterans. In 1996, Congress revised that legislation with a system of rankings establishing priority ratings for enrollment. Within that context, Paralyzed Veterans worked hard to ensure that those veterans with catastrophic disabilities, no matter if those disabilities were service- connected or non-service connected, would have a higher enrollment category. If the primary mission of the VA health-care system is to provide for the service disabled, the indigent and those with special needs, catastrophically disabled veterans certainly fit in the latter priority ranking. VA had an obligation to provide care for these veterans. The specialized services, including spinal cord injury care, unique to VA, should be there to serve them.

To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Priority Group Four regardless of their incomes and even though their disabilities were non-service connected. However, unlike other Priority Group Four veterans, if they would otherwise have been in Priority Group Seven or Eight, they would still be required to pay all fees and co-payments, just as others in those categories do now for every service they receive from VA.

Paralyzed Veterans of America believes this is unjust. VA recognizes their unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. On the other hand, the system then makes them pay for those services.

Unfortunately, these veterans are not casual users of VA health-care services. Because of the nature of their disabilities they require extensive care and a lifetime of services. Private providers don't offer the kind of sustaining care for spinal cord injury found at the VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of what VA can provide. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, yet, these veterans, supposedly placed in a priority enrollment category, have to pay fees and co-payments for every service they receive as though they had no priority at all.

MODERNIZING THE CLAIMS PROCESS — PVA appreciates the interest and effort that has been given to updating and modernizing the VA disability system in recent years. We recognize that the claims processing system is in need of change. However, we believe that the current system is a fundamentally good system. While we generally agree that the claims process takes far too long for many veterans, we do not believe simple quick fixes are the solution to overcoming this problem. As such, we would like to make some recommendations that we believe can improve the entire claims process.

The Veterans Benefits Administration (VBA) administers a massive program that handles nearly a million new claims each year. Moreover, these claims are often very complicated, requiring difficult decisions based on detailed evaluations of medical, legal, and vocational issues. Furthermore, the VBA is a complex organization involving multiple steps at the VA regional offices and at the Board of Veterans' Appeals (Board). And this does not take into account the Court level above the Board. In the end, it is important to remember that the claims system is charged with meeting the financial, medical, and vocational needs of the men and women who have served this country honorably, often at great physical and emotional expense.

We are particularly pleased with the fact that Congress has appropriated significant increases in funding for VBA over the last couple of years. Likewise, we appreciate the emphasis placed on hiring many new claims adjudication personnel. We have long argued that the only way to give the VA a fighting chance at overcoming the rapidly growing claims backlog is to provide for adequate staffing.

However, it is important to note that simply hiring additional staff is not enough. Equally important is to ensure proper training and accountability of claims adjudication staff at all levels of the process. While it is easy to blame first-line claims staff for improper ratings decisions, much of the blame also has to fall to the management within VBA. Performance measures for all levels of adjudication staff have wrongly focused too much on quantity of claims decided rather than quality.

We believe that VBA must accelerate the progress toward an electronic claims record system. As long as VA continues to use a paper file shipped around the country, the claims and appeals process will be done in an expensive and antiquated manner. Under the current system, VA staff need the actual claims file to act on claims. In a paperless environment VA staff could act on claims without having to access a claimant's actual claims file. As demonstrated by the Veterans Health Administration's outstanding electronic medical record system, similar gains in access to records can be realized in the claims and appeals process.

Recent hearings have demonstrated how far behind the VBA is in using information technology in its claims adjudication process. While we believe that the entire claims process cannot be automated, there are many aspects and steps that certainly can. We believe that it is essential that VBA expeditiously adjudicate claims that can be adjudicated quickly. By tying into an advanced information technology system, the VA could identify and decide claims that can be granted quickly.

INAPPROPRIATE BILLING — In recent years, as we have seen significant increases in both medical care collections estimates as well as the actual dollars collected, we have received an increasing number of reports from veterans who are being inappropriately billed by the Veterans Health Administration (VHA) for their care. Moreover, this is not a problem being experienced by just service-connected disabled veterans, but non-service connected disabled veterans as well.

The Independent Budget (IB) has repeatedly focused attention on this issue. Unfortunately, little action has been taken to address this problem while medical care collections continue to grow at an alarming rate. Inappropriate charges for VA medical services places unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places the burden for correction directly on the veteran, their families or caregivers.

In order to understand inappropriate billing, it is important to emphasize that service-connected and non-service connected veterans have experienced this problem. However, the problems that these two populations of veterans have faced are uniquely different. Service-connected veterans are faced with a scenario where they, or their insurance company, may be billed for treatment of a service-connected condition. Meanwhile, non-service connected disabled veterans are usually

billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by the VA.

We recently reached out to our national service officers to help us identify why these issues may be occurring. First, it is important to note that the vast majority of PVA members who are service-connected are rated as 100 percent PERMANENT and TOTAL. To be clear, PERMANENT and TOTAL suggests to us that any condition that a veteran experiences is related to his or her service-connected condition. In our opinion, this should mean that 100 percent PERMANENT and TOTAL service-connected disabled veterans should not be billed, nor should their insurance company be billed, for any treatment they receive. However, this is not how the VHA sees it.

In fact, the VA has gone so far as to recommend to veterans who have been billed for treatment of well-known, but non-rated, secondary conditions should re-file or reopen their claims. If the VA thinks it has a problem with the claims backlog now, we can only imagine what the backlog will look like if all veterans experiencing this problem go back to the Veterans Benefits Administration (VBA) for consideration of something that will almost certainly be granted months later.

We recommend that the VA immediately change its regulations to reflect the fact that a PERMANENT and TOTAL rating means exactly that. If the VA is unwilling to make this absolutely necessary change, then we call on these Committees and Congress to fix this statutorily.

While it is shameful that VHA takes advantage of veterans with service-connected conditions like this, it is equally disappointing that veterans who depend on the VA for their care but who are not rated for service-connected conditions are also being taken advantage of. Over-billing and inappropriate charging for co-payments is becoming the norm rather than the exception. Frequently, veterans are experiencing multiple billing episodes for a single medical treatment or health care visit.

It is time that the VA really be taken to task for its billing practices. If Congress and the Administration are going to continue to rely on massive collections estimates and dollars actually collected to support the VA health care budget, then serious examination of how the VA is achieving these numbers is necessary. As long as we know that the VA is taking advantage of veterans and inappropriately billing them, both service-connected and non-service connected, we will continue to express opposition to building VA budgets on collections.

ANCILLARY BENEFITS FOR SEVERELY DISABLED VETERANS — PVA believes that it is time for the Committee to make a concerted effort to improve benefits for the most severely disabled veterans to include an increase in the adaptive automobile grant and an annual index to increase the value of the grant with the cost of inflation, an increase in the rates of Special Monthly Compensation paid to severely disabled veterans, and additional adjustments to the Specially Adapted Housing grant program.

VA provides certain severely disabled veterans and service members with grants for the purchase of automobiles or other conveyances. This grant also provides for adaptive equipment necessary

for safe operation of these vehicles. When the grant was created, Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile.

The automobile grant was created in 1946 to accommodate disabled war veterans returning from World War II. At that time it paid for 85 percent of the cost of a new automobile. The current value of the auto grant is $11,000, or approximately 39 percent of the cost of a new car. A wheelchair accessible van alone can range from $40,000 to $62,000. As such, we urge Congress to enact H.R. 1169 to increase the amount of the automobile grant to $33,000 to represent a significant portion of the cost of a new vehicle.

The purpose of the Specially Adapted Housing Grant (SAH) is twofold; to help the qualified veteran purchase a home to live in and to provide funding to make that home or an existing home accessible for the veteran. The 110th Congress enacted legislation that provided a significant increase in the SAH grant—from $50,000 to $60,000—along with a yearly index to reflect the cost of construction. As a result, the current value of the grant is $63,780. As the average cost of a residence has risen either for building a new home, or for purchasing an existing home and making modifications for accessibility, this average cost has outpaced the value of the grant.

Likewise, the purpose of the Temporary Residents Adaptation Grant (TRA) is to provide assistance for disabled veterans who are temporarily residing in housing owned by a family member. The maximum amount of the grant is $14,000. A recent GAO report indicated very few veterans have used this grant since it was created in 2006. PVA and other veterans' service organizations have repeatedly stressed that the reason this grant is not used is because the dollar amount is subtracted from the veteran's total funds available from the Specially Adapted Housing grant.

PVA urges Congress to consider the provisions of H.R. 1169 that would increase the Specially Adapted Housing Grant from its current value to $180,000 to reflect the current cost of housing and construction. Moreover, Congress should consider legislation that would separate the funding of the TRA grant from the SAH grant. The TRA grant should not reduce the total available money the veteran will need for their permanent residence.
Lastly, we believe that the Committee needs to address the well-established shortfall in the rates of Special Monthly Compensation (SMC) paid to the most severely disabled veterans that the VA serves. SMC represents payments for "quality of life" issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to achieve sexual satisfaction or the need to rely on others for the activities of daily life like bathing, or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, we do not believe that the impact on quality of life can be totally compensated for; however, SMC does at least offset some of the loss of quality of life.

PVA believes that an increase in SMC benefits is essential for our veterans with severe disabilities. Many severely injured veterans do not have the means to function in an independent setting and need intensive care on a daily basis. Many veterans spend more on daily home-based care than they are receiving in SMC benefits. This fact was supported by the testimony of numerous witnesses at a hearing conducted by the Subcommittee on Disability Assistance and Memorial Affairs in July 2009.

One of the most important SMC benefits to PVA is Aid and Attendance (A&A). PVA would like to recommend that Aid and Attendance benefits should be appropriately increased. Attendant care is very expensive and often the Aid and Attendance benefits provided to eligible veterans do not cover this cost. In fact, many PVA members who pay for full-time attendant care incur costs that far exceed the amount they receive as a SMC-Aid and Attendant beneficiaries at the R2 compensation level (the highest rate available). We encourage the Committee to consider the provisions of H.R. 3407, the "Severely Injured Veterans Benefits Improvement Act of 2009," that specifically address increases to the R1 and R2 rates for SMC. Moreover, the bill would authorize aid and attendance payments for certain veterans with severe Traumatic Brain injury

(TBI). Additionally, the proposal authorizes certain veterans with severe burns to receive specially adapted automobile grants. This legislation would ensure that severely injured veterans receive all the support they are owed without forcing them and their loved ones to endure financial strains or hardship.

LONG-TERM CARE — PVA continues to be concerned about the lack of VA's long-term care services for veterans with spinal cord dysfunction (SCD). Approximately 6,000 of our members are now over 65 years of age and another 7,000 are currently between 55 and 64. These aging veterans are experiencing an increasing need for VA's home and community-based services and VA's specialized SCD nursing home care.

The ability to remain home for these veterans is based on their ability to receive VA home and community-based services such as hospital based home care or respite services. For others, their living status and independence is based on the health of a primary caregiver, usually a spouse, who is also aging and may no longer able to provide the level of support they once could. VA's non-institutional long-term care services are key to supporting aging SCD veterans and their caregivers and their desires to remain home as they grow older.

Unfortunately, the ability of veterans with SCD to access a full range of VA home and community-based care varies across the country. Waiting lists exist at almost all VA facility locations and many other VA facilities don't offer the full range of services mandated by the Millennium Health Care Act. Additionally, VA program geographic boundaries often limit access to long-term care services provided by a regional VA SC1 center.

The availability of these services is necessary to support veterans with SCD and their aging caregivers in their own homes, where they most want to be, and at a dramatically lower cost of care to VA. PVA needs action from your Committees to encourage VA to provide the full range of home and community-based long-term care services, as mandated by the Mill Bill, at each and every VA facility within the system.

Regarding specialized SCD nursing home care, VA currently only provides specialized nursing home care services for veterans with SCD in four locations. Combined these four locations only provide 152 staffed specialized nursing home care beds and they are all located east of the Mississippi River. While the VA CARES process called for additional SCD nursing home care beds the VA construction process has been slow to respond. CARES called for additional beds to be located in Cleveland, Ohio, Long Beach, California and in Memphis, Tennessee. However, after almost 10 years, PVA is still pushing VA to proceed with these recommendations.

While additional VA SCD nursing home capacity is on the horizon it will take years for these beds to become a reality. New SCD LTC beds are in the VA preliminary design phase at Brockton, Massachusetts, Dallas, Texas, Bronx, New York, San Diego, California and in Orlando, Florida but it will take years to bring them on line.

Mr. Chairmen, PVA needs you assistance to encourage VA to fast track the construction of these necessary facilities in order to meet current and future demand. The need is now Mr. Chairmen, VA's current non-responsive construction process only forces veterans with SCD to receive sub-standard nursing home care by untrained staff in facilities that were not designed to meet their specialized needs.

VOCATIONAL REHABILITATION AND EMPLOYMENT — PVA has recognized some basic facts that are important in the preparation of a disabled veteran for employment. We know that smaller case loads are absolutely essential. The counselor must know and understand the veteran they are trying to help. They must be able to explain to the employer that veteran's needs for certain accommodations that will enable the veteran to perform the necessary work.

The goal of the VR&E process is to prepare the disabled veteran with the skills needed to find and maintain meaningful employment. Perhaps the entities that receive contracts for this role should be paid for performance. Basic funding must be awarded to enable an organization to function on the day-to-day bases. Funds beyond basic functioning would be paid (rewarded) to the contractor in the form of bonuses paid for placing and keeping the veteran in a career position.

Placing a disabled veteran in a career is the goal behind PVA's new vocational rehabilitation employment program. We first spoke of this program during the 110th Congress when PVA opened its first program in the Richmond, Virginia VA hospital two years ago. PVA has since expanded that program in Minneapolis, Minnesota and San Antonio, Texas VA hospitals. Soon we will open a fourth location in Long Beach, California. PVA's goal is to some day have twenty-two employment counselors, one in each VA spinal cord unit. This expansion of the program will depend on obtaining corporate sponsorship, or other funding sources for each location.

PVA is providing vocational rehabilitation employment service to the segment of VR consumer population that is severely disabled, those veterans that are paraplegic or quadriplegic. Our success rate for placement of this population far exceeds the average placement rate in the vocational rehabilitation field.

PROTECTION OF SPECIALIZED SERVICES — Specialized services, such as spinal cord dysfunction care, are part of the core mission and responsibility of the VA. These services were initially developed to care for the unique health care needs of veterans. The VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. However, these services are often expensive, and are severely threatened by cost-cutting measures and the drive toward achieving management efficiencies.

The provision of specialized services is vital to maintaining a viable VA health care system. Specialized services are part of the primary mission of the VA. The erosion of these services

would lead to the degradation of the larger VA health care mission. Reductions in beds and staff in both VA's acute and extended care settings have been reported, even though Public Law 104-262, "The Veterans' Health Care Eligibility Reform Act of 1996" mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans. In addition, Congress required that VA provide an annual capacity reporting requirement, to be certified or commented upon, by the Inspector General of the Department. Unfortunately, this basic reporting requirement expired in 2004.

Furthermore, restructuring plans and moves by some to begin down the path of privatization heighten the risk not only to specialized services, but to the entire VA health care system. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the possibility that the critical mass of patients needed to keep all services viable could significantly decline. All of the primary care support services are critical to the broader specialized care programs provided to veterans. If primary care services decline, then specialized care is also diminished.

Paralyzed Veterans of America appreciates the opportunity to present our legislative priorities and concerns for the first session of the 111th Congress. We look forward to working with the committees to ensure that sufficient, timely, and predictable resources are provided to the VA health care system so that eligible veterans can receive the care that they have earned and deserve. We also hope that the committees will take the opportunity to make meaningful improvements to the benefits that veterans rely on.
Mr. Chairmen, I would like to again thank you for the opportunity to testify. I would be happy to answer any questions you have.