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Testimony of

VIETNAM VETERANS OF AMERICA
By

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Concerning

16 Bills on Health Care Issues for Veterans

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Chairman Akaka, Ranking Member Craig, and members of the Senate Committee on Veterans' Affairs, Vietnam Veterans of America (VVA) appreciates the opportunity to testify before you here today. On behalf of our officers, our Board of Directors, our members and their families, we want to thank you for the important work you are doing, and the initiatives you are taking, on behalf of our nation's veterans.

We would like to focus our comments this morning on four of the bills up for your consideration that we endorse: S. 117, the "Lane Evans Veterans Health and Benefits Improvement Act of 2007"; S. 479, the "Joshua Omvig Veterans Suicide Prevention Act"; S. 1233, the "Veterans Traumatic Brain Injury Rehabilitation Act of 2007"; and, most assuredly, S. 1147, the "Honor Our Commitment to Veterans Act." And also one bill, S. 815, the "Veterans Health Care Empowerment Act of 2007," that we feel will only serve to undermine the VA health care system.

S. 1147, the "Honor Our Commitment to Veterans Act," would re-open the VA health care system to Priority 8 veterans. These are veterans with an income of less than $28,000 a year who are not afflicted with a service-connected disability and who agree to make a co-payment for their health care and prescription drugs.

Back in 1996, when Congress passed the Veterans Health Care Eligibility Reform Act, the VA was able to implement major cornerstones of its plan to reform how it provided health care. The rationale behind this initiative was to ensure a patient base that would support the infrastructure needed to develop a modern, integrated health care system. This the VA has accomplished, and in the process a mediocre, inefficient system has been transformed into a national model.

However, the law - that's Public Law 104-262 - gave the Secretary of Veterans Affairs the authority and responsibility to determine eligibility for enrollment based on available resources in any given fiscal year. Although the law did not mandate a level of funding or a standard of care, it did establish an annual enrollment process and categorized veterans into "priority groups" to manage enrollment.

On January 17, 2003, the Secretary made the decision to "temporarily" suspend Priority 8 veterans from enrolling. While this decision may be reconsidered on an annual basis, every budget proposal from the Administration since has omitted funding for Priority 8 veterans not previously enrolled and has attempted to discourage use by and enrollment of those "higher income" veterans.

Priority 8 veterans are, for the most part, working- and middle-class Americans without compensable disabilities incurred during their military service. In its budget proposal for fiscal year 2007, the VA estimated that some 1.1 million of these "higher income" veterans would be discouraged from using their health care system because of an enrollment fee and increased co-pays for prescription drugs. Thankfully, you in Congress have not let this scheme get much beyond the proposal phase.

We strongly urge that you get behind this most important piece of legislation and truly honor the commitment we have made that honors our veterans. Of course, we recognize that the bottom line is funding - the funding Congress provides - to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's health care services. We recognize the realities of "pay-go." But we hope you will recognize the inherent justice in reopening the VA health care system to those who have earned the right to utilize it. They will not overly burden the system; in fact, Priority 7 and 8 veterans account for some 40 percent of all third-party collections by the VA.

TBI/Traumatic brain injury suffered by our troops in Afghanistan and Iraq has become so relatively common that its acronym, TBI, is becoming almost as infamous as PTSD. This affliction is not new; it has only been so codified because of the carnage caused by IEDs, improvised explosive devices, and another acronym that has been incorporated into the dialect of war.

It is our understanding that the Administration is going to order the military to screen all returning troops for mild to moderate cases of TBI; those whose brain injuries are more serious are quite obvious to clinicians. S.1233, the "Veterans Traumatic Brain Injury Treatment Act of 2007," would be instrumental in assuring troops afflicted with this debilitating condition that help will be there for them. It is a sensible, comprehensive piece of legislation for long-term TBI rehabilitation; it should go a long way towards healing the wounded from these latest military ventures.

S. 479, the Joshua Omvig Veterans Suicide Prevention Act, attempts to grapple with one of the unfortunate consequences of war. Too many of our young men and women whom we've sent off to fight halfway around the globe return markedly different. The lingering trauma of things they've experienced haunts them. These memories affect their daily living, and too many

succumb to the emotional numbing and hurt. To not support this bill would do a grave injustice to those troops still fighting their demons.

The potential of S. 815, the "Veterans Health Care Empowerment Act of 2007," to harm veterans by undercutting the VA health care system is simply not worth the risk. If enacted, this bill would effectively erode the Veterans Health Administration (VHA) by permitting service-connected veterans to receive hospital care and medical services for any condition at any hospital or medical facility or from any medical provider eligible to receive payments under either Medicare or the TRICARE program. If you want to destroy the VA system, S. 815 is a good start.

We do not believe the system is inefficient or corrupt. It is at a point in time when the VHA is meeting the needs of the veterans it serves. Besides, one out of every ten VA health care dollars today goes to clinicians and facilities outside the VA system, and through a scheme called Project HERO - the acronym for Healthcare Effectiveness through Resource Optimization -- the VA is attempting to get a better handle on the dollars spent by VA medical centers for care provided outside of the system. We believe that HERO - and S. 815 - would only serve to hurt what has developed into one of the best managed-care systems in the nation.

And keep this in mind: The VA's electronic health records are not matched by other public sector and private hospitals, clinics, and doctors. If you want to create an administrative nightmare, try to maintain an effective, efficient VA health care system and at the same time let veterans go wherever they wish for their health care. This will only create more problems than it solves, and it solves very little.

As for the other bills under consideration by the committee today:

- VVA supports wholeheartedly S. 383, which would extend the period of eligibility for VA health care for combat service from two years to five. This is a no-brainer. With a shooting war going on, we have the obligation and responsibility of keeping our promises to those who don the uniform. When they come home, when they leave the military, they need to know that their government hasn't forgotten about them, that as they establish themselves in civilian life they can avail themselves of VA health care.
- We understand that Congress has previously sought to fix a glitch that occurred in calculating the retirement pay for annuitants who worked part-time as VA nurses. S. 610 would accomplish this. VVA has no opposition to this provision.
- S. 692, the "VA Hospital Quality Report Card Act of 2007," would require the VA to provide grades for its medical centers on measures such as effectiveness, safety, timeliness, efficiency, patient-"centeredness" and equity. Health care quality researchers have long thrived trying to objectively define some of these measures. As this committee knows, the VA has a number of performance measures it regularly assesses in order to reward its medical center and network directors, among others. Some of these outcomes, such as immunizations for flu, foot care and eye care for diabetics, set the "benchmark" for care in the community. In addition to these internal performance measures, VHA voluntarily submits to Joint Commission on Accreditation of Healthcare Organization,

Commission on Accreditation of Rehabilitation Facilities, and managed care quality review standards.

VVA understands the importance of quality measurement; there is an expression with which we agree, "what's measured, matters." We also agree that VA officials should be held to the highest degree of accountability, and whatever measures are available to allow this to better occur we wholeheartedly endorse. But perhaps before enacting this clearly well intended legislation, which could require significant retooling of quality measurement systems in VA, the committee should hold a hearing to identify gaps and deficiencies in current performance and quality measurement systems. It would also be useful to understand how report cards would be used and reported to improve VHA processes and performance rewards. Would poor grades be dealt with by changes in management? With more funding? How would good grades be rewarded? Such questions should be addressed before requiring a significant new quality measurement program to be installed.

- VVA understands that S.874 would pay certain providers for delivering medical care, mental health care, case management and other services to very low-income veterans who have permanent housing. VVA supports efforts to target veterans who may be at risk of becoming homeless, but these individuals are often difficult to identify until it is too late. In addition, funding for VA mental health, in addition to homeless grant and per diem providers, is also already too scarce. VVA supports the addition of this benefit if VA is funded appropriately to provide it without taking resources away from these other programs.
- While the VA Secretary has had the discretion to raise beneficiary travel rates, no Secretary has chosen to do so in decades. The result is an almost meaningless benefit for veterans who seek it. S. 994 would allow the VA to reimburse certain veterans for travel at a rate that the government pays its own employees. That sounds fair to VVA.
- VVA has no objection to S. 1043, under which Congress would require a report on proposed land use changes on the campus of the West LA VA Medical Center.
- S. 1205 would require the VA to develop a pilot program to make grants to veterans' service organizations and other veterans groups to develop peer-support groups to assist with veterans' reintegration. As an organization whose creed is "Never again will one generation of veterans abandon another," VVA has expended considerable resources in assisting newly minted veterans as well as some new veterans groups-particularly Veterans of Modern Warfare-in developing a robust program to advocate for their members' needs. We have certainly not done so contemplating financial gain. Assisting veterans' reintegration with peer-support groups is and should be a function of VSOs; organizations should not have to compete for funding for providing veterans' services, which would significantly change the nature of the game.

• Designating the VA medical center in Augusta, Georgia, the "Charlie Norwood Department of Veterans Affairs Medical Center" acknowledges the contributions of a recently deceased member of Congress who served in the military as well as in the House of Representatives. VVA applauds the spirit and endorses the intent of this bill.

- Additional legislation to enhance the VA's programs for homeless veterans, introduced by Senator Akaka, deserve support, too. It is a national disgrace that so many veterans - upwards of 200,000, according to most estimates - do not have a place to call home. There are many causes of homelessness; in the case of too many veterans, their experiences in combat are likely one of the reasons they have "dropped out" of society and self-medicate with alcohol and other drugs. Furthermore, it is our position that VA Homeless Grant and Per Diem funding must be considered a payment rather than a reimbursement for expenses, an important change that will enable the community-based organizations that deliver the majority of these services to operate effectively.

Per Diem dollars received by service centers are not capable of supporting the "special needs" of the veterans seeking assistance. Currently they are receiving less than $3.50 per hour per veteran that the veteran is on site. The work of assisting the homeless veterans who utilize these services goes on long after they have left the service center, a center that is providing a full array of services and case management.

These service centers are unique and indispensable in the VA process. In many cases they are the front and first exposure to the VA and VA Homeless Grant and Per Diem programs. They are the door from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, and homeless domiciliary placement. Veteran-specific service centers are vital in that most city and municipality social services do not have the knowledge or capacity to provide appropriate supportive services that directly involve the treatment, care, and entitlements of veterans. Additionally, since many local municipalities have removed "supportive services" from their HUD Continuums of Care, providing staffing dollars through a VA Homeless Grant and Per Diem staffing grant program, similar to the Special Needs Grant process, to those agencies operating service centers, would allow the service centers to provide these vital services with appropriate level of qualified personnel. Without consideration of staffing grants the result may well be the demise of these critical services centers. Some are currently assisting upwards of 50 veterans a day, with more than 900 individual veterans seeking services annually.

The VA acknowledges this problem exists. It is yet to be specifically identified by them as to how many awarded service center grantees have been affected by either the inability to establish these centers or retain operation because of this very funding issue. If we intend to fully address the issue of veterans who remain on the streets, then we urge you to not make light of this very important element in this bill. It will be especially critical to the new veterans who find themselves in this very disturbing situation of life. They deserve our best efforts.

In addition, as highlighted in the 2006 recommendations made by the Secretary's Advisory Committee on Women Veterans, a survey of homeless women veterans showed that fewer women veterans are seeking services in VA domiciliary settings and residential treatment facilities because of concerns about safety, privacy, and what is a male- dominated environment. Ideally, separate area/space designed for women veterans will support this need. Flexibility in design will allow appropriate utilization of space.

We also advocate that all VA domiciliary settings be evaluated with regard to gender-specific needs related not only to the safety and security, but also to positive therapeutic environments and successful treatment modalities.

This concludes our testimony. VVA is appreciative of having been afforded the opportunity to testify on the merits of these bills. We would be pleased to respond to any questions you might have.