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STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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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 four-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 (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 FY 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.