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ANNUAL LEGISLATIVE
PRESENTATION

PARALYZED VETERANS OF AMERICA

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NATIONAL PRESIDENT

BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

MARCH 9, 2006

Mr. Chairman and members of the committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our legislative priorities for 2006 and this session of the Congress. PVA would like to thank you Chairman Craig and Ranking Member Akaka for allowing us to continue to present our testimony with PVA leadership and members in attendance. It is a great way for us to participate in the legislative process.

I would also like to thank you both for recognizing the accomplishments of The Independent Budget over the last 20 years by attending our anniversary reception recently.

PVA's budget recommendations are part of the joint policy statements contained in this year's Independent Budget. They are the combined recommendations of AMVETS, Disabled American Veterans, PVA and Veterans of Foreign Wars. This year, PVA and our fellow VSOs are proud to mark the 20th Anniversary of this joint effort presenting budget and policy direction to the Congress and the Administration for all benefits and services provided to the veterans of this nation.

FY 2007 VA HEALTH CARE BUDGET

With regards to the Administration's budget proposal, PVA is pleased to see that for the first time, a reasonable starting point was offered by the President to fund the VA health care system. For FY 2007, the Administration has requested $31.5 billion for veterans' health care, a $2.8 billion increase over the FY 2006 appropriation. Although this is a significant step forward, we still have some concerns about proposals contained within the request, as I will later explain. The Independent Budget for FY 2007 recommends approximately $32.4 billion for veterans' health care, an increase of $3.7 billion over the FY 2006 appropriation and about $900 million over the Administration's request.

We believe that the recommendations of The Independent Budget have been validated once again this year as the Administration indicated that it will actually take $25.5 billion to fund Medical Services, an amount very close to what we recommend. However, they only request $24.7 billion in appropriated dollars. The Administration hopes to raise an additional $800 million by instituting the new enrollment fee and the increase in prescription drug co-payments to achieve the necessary funding level.

I would like to single out this particular budget and policy recommendation that continues to receive a great deal of attention, both in the veterans' community and in the Congress. As it has for the past three years, the Administration is insisting on more than doubling fees for prescription co-payments and instituting an annual $250 enrollment fee for certain veterans in the lower eligibility categories.

I would like to take a moment to explain why PVA objects to the proposal. I would also like to explain why we believe this recommendation, if approved, will have a serious impact on many veterans with catastrophic disabilities whose only main health care resource is the VA health care system.

VA has cared for veterans with non service-connected disabilities for a long time. This is not a new phenomenon authorized by eligibility reform in 1996. Veterans health facilities admitted nonservice-connected veterans in large numbers following World War I. The Congress and the VA admitted the nonservice-connected, not just the poor and indigent, in large numbers as the VA health care system grew in size and scope through the middle of the 20th Century and beyond. VA used the rationale that its facilities were there to serve veterans who, because of non availability of comparable services, access, or cost, found VA a reasonable or unique resource for health care services they could not find elsewhere.

VA opened its doors to these veterans for many reasons, the main one being these men and women had served their country just as honorably as anyone else who had worn the uniform. They deserved no less.

Prior to 1986, all veterans, service-connected and non-service connected, over the age of 65 were eligible for VA health care. In 1986, Congress approved legislation which divided the veteran population into three eligibility categories. In 1996, Congress again revised that legislation with a system of seven priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities, no matter if those disabilities were service-connected or nonservice-connected would have a higher enrollment category. If the three implied missions of the VA health care system were to provide for the service disabled, the indigent and those with special needs, the catastrophically disabled certainly fit in the latter priority ranking. The VA had an obligation to provide care for these veterans. The specialized services, such as 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 Category Four even though their disabilities were nonservice-connected and regardless of their incomes. However, unlike other Category Four veterans, if they would otherwise have been in Category 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.

PVA believes this is unjust. VA recognizes their unique specialized status on one hand by providing specialized service for them in accordance with its mission to provide for special needs. The system then makes them pay for those services.

These veterans are not casual users of VA health care services. Because of the nature of their disabilities they require a lot of care and a lifetime of services. Private insurers and providers do not offer the kind of sustaining care for spinal cord injury found at VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury and 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.

The Administration's new fees and new enrollment payments add even higher burdens to penalize these veterans for seeking the only source of the health care they need.

We strongly urge the committee to correct this financial penalty. If a veteran is in Category Four because of a catastrophic disability, then treat that veteran like all other Category Fours and exempt him or her from fees and co-payments.

Our health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system. However, it is included in our bottom line for total discretionary dollars needed by the VA to provide health care to all eligible veterans. Despite our clear desire to have the VA health care system open to these veterans, Congress and the Administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1,000,000 Category 8 veterans will have been denied enrollment into the VA health care system by FY 2007. Assuming a utilization rate of 20 percent, we believe that it would take approximately $684 million to meet the health care needs of these veterans, if the system were reopened. We believe that the system should be reopened to these veterans and this money appropriated on top of our medical care recommendation for this purpose.

Despite a reasonable request this year, the budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of how much money it is going to get and when it is going to get it. In order to address this problem, PVA, in accordance with the recommendation of The Independent Budget, proposes that funding for veterans' health care be removed from the discretionary budget process and be made mandatory.

MEDICAL, PROSTHETIC, AND REHABILITATION RESEARCH

For Medical and Prosthetic Research, the Administration has recommended $399 million, a cut of approximately $13 million below the FY 2006 appropriation. The Independent Budget recommends $460 million. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in comparison to the growth rate of other federal research initiatives. We call on Congress to finally correct this oversight.

We also believe that additional funding needs to be provided for rehabilitation research. The development of new and better techniques allows catastrophically disabled veterans to become more active and independent in society. Furthermore, advanced rehabilitation can only lead to a happier and healthier life for these men and women.

One particular program that is currently taking place that we believe will be highly successful is the Spinal Cord Injury - Vocational Rehabilitation Program (SCI-VIP). This is a new five-year research project that will attempt to greatly improve the employment rate of veterans with spinal cord injury. It will be conducted at four spinal cord injury/dysfunction (SCI/D) centers ? Dallas, Milwaukee, San Diego and Cleveland - with control groups at the Houston SCI center and at the Hines SCI center in Chicago. In short, the project will inject vocational rehabilitation counselors (VRC) directly into the medical rehabilitation process to provide ?hands-on? vocational assistance throughout rehabilitation. The VRCs will make employment a priority component of the rehabilitation process.

PVA has strongly supported this concept since it was first proposed by Dr. Lisa Ottomanelli at the Dallas SCI Center. We hope that the VA will see fit to expand this program to benefit spinal cord injured veterans across the country. We would also urge the Congress to make available additional funds within the research program to support this project.

PHYSICIAN AND NURSE SHORTAGE

PVA is concerned that the VA continues to experience a serious shortage of qualified, board certified spinal cord injury (SCI) physicians, making it difficult to fill the role of chief of an SCI/D service. Several major SCI/D programs are under ?acting? management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged with acting chiefs assigned for indefinite time periods.

We are even more concerned about the continuing shortage of nurses, particularly in spinal cord injury units. PVA believes that the basic salary for nurses who provide bedside care to SCI veterans is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community.

Recruitment and retention bonuses have been effective at several SCI centers, resulting in an improvement in the quality of care for veterans as well as the overall morale of the nursing staff. Unfortunately, these are localized efforts by the individual VA medical facilities. We believe that the Veterans Health Administration (VHA) should authorize substantial recruitment incentives and bonuses.

PVA calls on Congress to conduct more oversight of the VHA in meeting its nurse staffing requirements for SCI units as outlined in VHA Directive 2005-001. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care. Furthermore, not all SCI centers are in full compliance with the regulation for the staffing ratio of professional nurses to other nursing personnel. With proper congressional oversight, these mistakes can be corrected.

LONG-TERM CARE AND ASSISTED LIVING

PVA is concerned with recent trends to reduce the ability of the VA to provide long-term care to a rapidly aging veterans population. We strongly oppose any proposal that would repeal the statute that requires the VA maintain bed and staffing levels at the same level established by P.L. 106-117, the ?Veterans Millennium Health Care and Benefits Act.? Despite an aging veteran population and passage of P.L. 106-117, the VA has continuously failed to maintain its 1998 VA nursing home required average daily census (ADC) mandate of 13,391. VA's average daily census (ADC) for VA nursing homes has continued to decline since 1998 and is projected to decrease to a new low of 9,795 in FY 2006. The VA is ignoring the law by serving fewer and fewer veterans in its nursing home care program.

PVA was deeply troubled by efforts in Congress last year to eliminate the mandatory ADC requirement contained in the Millennium Health Care bill. This proposed change is not driven by current or future veteran nursing home care demand. In fact, the General Accounting Office (GAO) reported ?the numbers of aging veterans is increasing rapidly, and those who are 85 years old and older, who have increased need for nursing home care, are expected to increase from approximately 870,000 to 1.3 million over the next decade.?

PVA strongly feels that the repeal of the capacity mandate will adversely affect veterans and is a step toward allowing VA to reduce its current nursing home capacity. This is not the time for reducing VA nursing home capacity with increased veteran demand looming on the near horizon. We hope that this Committee will reject any such legislation. Furthermore, we urge the Committee to conduct aggressive oversight to ensure that the VA is fulfilling its statutory obligation to provide long-term care.

We believe that assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADL) or the instrumental activities of daily living (IADL). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a home like setting. Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care. Likewise, Congress should authorize the VA to expand its Assisted Living Pilot Program (ALPP) to include an initiative in each VA Veterans Integrated Service Network (VISN). This expanded effort will allow VA to gather important regional program cost and quality information.

Congress should call upon VA to conduct a cost and quality comparison study that compares the ALPP experience to cost and quality information it has compiled for VA nursing home care, community contract nursing home care, and state veterans nursing home care. When completed, this long-term care program cost comparison study should be made available to Congress and veterans service organizations.

MULTIPLE SCLEROSIS (MS) AND PARKINSONS CENTERS OF EXCELLENCE

The VA appropriations subcommittees in the House and Senate inserted language in their VA funding reports for FY 2001 requiring VA to establish centers of excellence to conduct research and study in the field of neurodegenerative diseases. With that instruction, VA identified two fields of inquiry for the centers with particular bearing on medical conditions prevalent in the veteran population, Parkinsons Disease and Multiple Sclerosis. The VA, subsequently, on two

different tracks, proceeded to establish the centers of excellence starting first with the Parkinsons Centers and later with the two MS Centers.

PVA has expressed concern that the centers, established only through VA good faith and resources available in any one budget cycle could eventually be in jeopardy. Therefore, last year an effort was launched to take what was only an authorization or recommendation for the centers and actually codify them. The House of Representatives approved H.R. 1220 which addressed the codification of the Parkinsons centers. Senator Daniel Akaka introduced S. 1537 which would codify both Parkinsons and MS Centers.

When both the House and Senate Appropriations Subcommittees directed VA to establish these centers they made no distinction between them. The report language in both Appropriations bills only directed VA to establish centers of excellence in neurodegenerative diseases to spur the Department along in research and treatment in this overall field of medicine. While studying uniquely different diseases, both Parkinsons and MS Centers serve together in the overall study of neuroscience. It would be inappropriate in our view to put the centers on separate tracks, codifying one and not the other.

We urge the committee to adopt legislation which can address and codify these centers in Title 38 U.S.C. once and for all.

CONTRACT CARE COORDINATION

I would like to address a trend that we believe could have a substantial negative impact on the VA health care system. We have serious concerns about the contract care coordination pilot program authorized in P.L. 109-114, the ?Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act of 2006.? The conference report accompanying this law requires the VA to establish a comprehensive managed care demonstration project in at least three Veterans Integrated Service Networks (VISNs). We oppose the VA's planned approach to this new requirement to establish additional, parallel contract programs on a broad scale.

VA's approach to this requirement seeks to contract health care services provided by non-VA providers on a broad basis. This only serves to dilute the quality and quantity of VA services for new as well as existing veteran patients. Ultimately, contract care is not more cost-effective or cost-efficient than care provided by the VA, and we certainly do not believe that the VA will find the same level of high-quality care in the private sector. There is no reason for VA to move into this arena on a broad basis.

The Secretary of Veterans Affairs Jim Nicholson recently testified to the remarkable success of the VA health care system and the positive media that it has recently received as a result of this success. He explained that it is a model for the rest of the country and private industry. In fact, Secretary Nicholson stated before the House Committee on Veterans' Affairs at a hearing on February 8, 2006 that ?for the sixth consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey.? This is true because the VA health care system operates as a fully integrated, government managed health care system.

BENEFITS RECOMMENDATIONS

PVA would like to offer a few improvements to benefits provided by the VA. PVA members are the number one beneficiary of the Special Adaptive Housing (SAH) grant and the adaptive automobile grant. Unfortunately, periodic increases in these grants have not kept pace with inflation. For both the SAH grant and the adaptive automobile grant, we believe that an automatic annual adjustment indexed to the rising cost-of-living should be applied. Furthermore, in accordance with the recommendation of The Independent Budget, the adaptive automobile grant should be increased to 80 percent of the average cost of a new vehicle to meet the original intent of Congress.

PVA would also like to recommend a change in the compensation provisions outlined in Title 38, Section 5111. Under current law, the effective date for a veteran's finding of service connection is the day after his or her date of military discharge. However, the effective date for his or her VA compensation payments is the first day of the month following the month when that service connection was granted. Because the veteran's compensation payment for a given month is not made until the end of the month, he or she could lose up to an entire months worth of pay under this current provision.

As an example, if SGT John Smith is medically retired on 01/31/06 from the Army for a C4 spinal cord injury from a sniper bullet, then his effective date for benefits is 02/01/06. However, his effective date for compensation payment is 03/01/06, and he would not receive his first payment until 03/31/06. Current law does not allow him to be compensated for the month of February in this case. We believe the law should be changed to make the veteran's effective date of service connection and effective date for compensation payment the same.

PVA appreciates the opportunity to present our legislative priorities and concerns for the second session of the 109th Congress. We look forward to working with the Committee to ensure that adequate 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 this Committee will take the opportunity to make meaningful improvements to the benefits that veterans rely on.

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