H.R. 2792, THE DISABLED VETERANS SERVICE DOGS AND HEALTH CARE IMPROVEMENT ACT OF 2001 AND RELATED LEGISLATIVE MATTERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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H.R. 2792, THE DISABLED VETERANS SERVICE DOGS AND HEALTH CARE IMPROVEMENT ACT OF 2001 AND RELATED LEGISLATIVE MATTERS

THURSDAY, SEPTEMBER 6, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Stearns, Simmons, Filner, Rodriguez, and Snyder.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Good afternoon, everyone. Great to have you in attendance and to join us. I anticipate we will have other members of Congress here shortly, just concluded with a vote on the House floor. And I look forward to having my other colleagues here to hear what you all have to say to me.

We are here to take testimony on a bill introduced on August the 2nd, one that I introduced, H.R. 2792. It is the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001. And I am pleased to hear comments, including some concerns about the legislation.

We are very honored today to have the Secretary of Veterans' Affairs with us, Secretary Principi. And it is an honor for me as the subcommittee chairman to have you here in front of our subcommittee. And we look forward to receiving your advice on this legislation.

We will be hearing remarks in our second panel from three members of Congress—the gentlewoman from California, Ms. Capps; the gentleman from Mississippi, Mr. Wicker; and the gentleman from Florida, Dr. Weldon—concerning proposals they wish to have this subcommittee deal with regarding veterans' health care.

First, I would like to take the opportunity to welcome some special guests, Ms. Beth Barkley and Moira Shea. Ms. Shea, along with her special assistants, Rin Tin Tin #8, Fearghas, Gustav, and Bo, respectively.

I understand that you each will have a short statement, and then Ms. Barkley and her service dogs will demonstrate to the audience why service dogs are assets to vets who suffer from disabilities, and

why this subcommittee should authorize more use by the VA health care system.

When Mr. Filner arrives, I will be happy to have any opening statement or comments from the distinguished gentleman from California.

Most of us remember that remarkable dog, Rin Tin Tin, the loyal companion and trusted partner, and I do from my days of watching TV and the movies. And we have the eighth, seventh or eighth generation with us today, lineal descendants.

I was a state legislator before becoming a member of Congress, and the first piece of legislation that I introduced as a member of the State senate in Kansas was authorizing support dogs to be used in public facilities. And that bill became law, and I have seen demonstrations of how important support dogs can be in providing a greater quality of life for those who are their companions.

And it is a great opportunity to highlight that again today here in Washington, DC. So let's begin our testimony. Ms. Barkley, Ms. Shea, is there a preference between the two of you who goes first?

Mr. BARKLEY. Let her go first.

Mr. MORAN. Ms. Shea.

STATEMENT OF BETH BARKLEY, VICE PRESIDENT, A RINTY FOR KIDS, INC.; ACCOMPANIED BY MOIRA SHEA; "RIN TIN TIN #8"; "FEARGHAS"; AND "GUSTAV"

STATEMENT OF MOIRA SHEA

Ms. SHEA. Okay, thank you. My name is Moira Shea, and though I work as a senior policy advisor for Congresswoman Connie Morella, I am here today as a private citizen.

I thank you, Chairman Moran, for your invitation to testify today on H.R. 2793, The Disabled Veterans Services Dogs and Health Care Improvement Act of 2001. My comments will apply only to Section II of this bill.

With my testimony, I hope to be eloquent enough to communicate the great services that both working dogs can provide to people with disabilities. I have Usher's Syndrome, the leading cause of deaf-blindness in the United States. When I was a baby, my parents noted that I was not responding to the phone, and learned that I was hearing impaired. And when I was 15, I was tripping over things in broad daylight, and my parents learned that I was going blind. I have a progressive vision loss. Every year I see less and less. I am now losing my reading vision.

In 1993, I thought I had MS. My legs would not move when I would go to cross the streets. In reality I was paralyzed with fear, too scared to move, for fearing that I would be hit by either a car or bike. I could no longer trust my vision, and I could not bring myself to use a white cane.

About that time, I learned that one did not have to be totally blind to use a guide dog. So I applied to the Leader School for the Blind in Rochester, Michigan. It was the toughest decision but the best decision I have ever made in my life. I was totally unprepared for the great benefits that I would receive.

I found that with my dog that I could in essence see better. For example, when I would go to the airport, I could see where the gate

was, and he could get me through the crowd without bumping into people or tripping over luggage. He does escalators, revolving doors. He knows his left from his right. And I no longer had to hold on to someone's arm to get around. He is a marker to others that I cannot see well.

I gained so much independence with my dog, I had more energy when I got to work in the morning because I wasn't so stressed out just getting there. I never thought that the dog would become my companion, but he did, and with that he took away my fear of going blind, and gave me peace.

I have this horrific fear of going blind. There is no fear like slowly losing your vision. Simply put, it is torture. You lose a little, you learn to accommodate, and then you lose some more. You are in a constant state of grieving.

I found soon after getting my dog that I no longer had that fear. I know that no matter what, I will always, until a cure is found, I will always be safe with a remarkable, loyal, and steadfast guide dog by my side.

Mr. Chairman, it is my hope that with enactment of this legislation, that there will be a rigorous evaluation and strong certification process put in place for these dogs. Today one can get a dog and claim that they have trained it to be a working dog. Often times these individuals have no qualifications to be a trainer, and the dogs are often, too often, poorly trained. This does a disservice to those of us who depend on well-trained working dogs and work hard for access for all working dogs.

It is my hope that the Veterans' Administration will set a standard, raise the bar, and ensure that all working dogs are well-trained and pass a certification process, which will ensure that the working dogs are performing the needed services. Working dogs are not pets; they have an enormous responsibility for the personal safety of their handlers. With a rigorous certification process in place for working dogs, American veterans will be assured that they are getting the best—a well-trained dog with an ideal disposition for working.

Mr. Chairman, I commend you and your subcommittee staff for being proactive and expanding the service of providing guide dogs to veterans who are blind to include service dogs for all American veterans with disabilities. I am sure that many of America's veterans will derive benefits that cannot be measured.

Thank you.

[The prepared statement of Ms. Shea appears on p. 72.]

Mr. MORAN. Let me say thank you very much. It is my understanding that Senate rules did not allow the use of dogs on the Senate floor, and because of your efforts, those rules have been changed. And I congratulate you on your success, and again, I think this is an awfully important issue. We are also checking to make sure our House rules are cooperative in that regard as well, too.

So, thank you very much for your testimony, thank you for being here, and please express my appreciation to your boss for allowing you the time off this afternoon.

Ms. SHEA. Okay.

Mr. MORAN. Ms. Barkley.

STATEMENT OF BETH BARKLEY

Ms. BARKLEY. Thank you. Honorable ladies and gentleman, Ms. Shea, I want to thank you for the opportunity to speak to the important issue of service assistance dogs for veterans. Your excellent work and vision, as represented by your bill, provides opportunities for our veterans to improve and normalize their lives.

Humans and canines have worked together for a very long time. There are many proposed eras for the beginning of this partnership, but we know that among the earliest relics found, dogs and humans were together. In some parts of the world, the written word has indicated that dogs became scavengers and they are not considered good companions at the time urbanization began. However, we have found that over the thousands of years that dogs worked well with humans in a variety of tasks.

In the beginning of the 20th century in the United States, people became used to seeing guide dogs for people with visual impairments. Hearing dogs, for people with hearing disabilities, have gained acceptance. And increasingly, we read about, or see on television, reports of service or assistance dogs who help people with physical disabilities. An emerging discipline is the psychiatric service dog.

Dogs have, compared to humans, a huge capacity to identify, sort, and retain scents. Dogs' primary means of communication is body language, which we humans don't read too well. Because certain dogs can predict an imminent seizure in their partner, there is research being done into the ability of dogs to recognize the changes in the human brain experience—it could be chemical, it could be electrical; we don't know—prior to the onset of seizures.

Dogs are also routinely trained to detect minute amounts of drugs, accelerants, explosives, as well as meat and vegetable material. From that training, we produce drug dogs, fire dogs, and bomb dogs for law enforcement agencies, and the Beagle Brigade for the Department of Agriculture.

Dogs have also been trained to indicate human skin cancer, and research is underway to expand to other types. Dairy herd owners use dogs to detect the proper time to artificially inseminate a cow. Search and rescue dogs find people who are lost or trapped, bodies of disaster and homicide victims, and body fluid evidence for law enforcement. It is a great capacity, for dogs to be our partners.

Guide dogs help their human partners negotiate through the environment. Hearing dogs alert their human partners to particular sounds in the environment. Assistance dogs help their human partners overcome and mitigate the condition that disables the human. All of these dogs that work with humans are using their highly developed sense of smell, their acute power of observation, and other abilities, as well as their genetic predisposition to partner to us.

In general, assistance dogs do obvious tasks. They retrieve objects. A larger dog can provide pulling power for wheelchairs. Opening doors. Taking objects from their human partner to another place or person. Reacting to a medical process in a specified way. Physically assisting persons in or out of a wheelchair, or a bed, or a bathroom facility.

In addition, and most importantly, assistance dogs can be trained to the individual needs of their human partner, such as providing

assistance in balance or pulling the bedclothes on or off for their partner. I have included in my written report to you an appendix, which lists a great variety of the tasks that these dogs can do.

I was very interested to hear Ms. Shea speak to dogs being well-trained to a certain standard. And I will expand upon that—I agree with it, and expand upon it to say that there should be a certain repertoire of basic things that a dog should be able to do, in order to be certified as an assistance dog.

The end result of all of the tasks that I have listed or could talk about or enumerate is to increase the independence of the human and provide for their safety. The overall improvement to the quality of life for the human partnered with an assistance dog cannot be overemphasized.

The number and types of disabilities where an assistance dog can be used is as varied as the number of individuals who might qualify for one. And while there is a basic level that they should attain, each dog should be trained to work with the specific problems that that person has. And this can be done.

The dog cannot only help with everyday tasks. They can help prevent injury. A lot of people who have injuries or diseases are in a condition where they will get worse physically over time, particularly if they are overusing, let's say, shoulder and arm joints to push a wheelchair—overusing in the sense that as they mature and get older, those joints, muscles, ligaments will degenerate. Providing an assistance dog helps forestall any further degeneration.

There is a serious, lifelong commitment by the partner, the human partner, for the assistance dog. Dogs are living beings; they are an alien species that has chosen us to live with—unlike cats, who sort of let us live with them, the dogs have chosen us. They cannot be deactivated like a toy and put on a shelf. They must go forward with their everyday functions, just as if they were working, even when they are not. So it is a serious and lifelong commitment, and I feel very strongly about this, because there are far too many dogs on this earth that are just thrown away, literally, put down, because there is not a role for them in the world. It is a serious proposition to have a service dog and use them.

The conclusion is clear: there are standard tasks identified as the basis for assistance dog training. There is consensus that specific tasks must be developed and taught to each individual partner and team. There are large and small organizations sponsoring assistance dog training, most of which are non-profit. The benefits provided by assistance dogs are many, and range from help with mobility, balance, preservation of strength, and object retrieval and placement, to seizure detection, partner safety, and securing help for the partner.

The actual cost of training a service dog has been estimated to range between $15,000 and $25,000 to $35,000, which seems like a lot of money. But this is a non-technical way of approaching a problem, and a way that it can be solved with relative ease.

While it may sound like a lot of money for the training of a dog, you must understand that it is one of the reasons that Gustav is here. These puppies have to be worked with and trained from the time that they are weaned, all the way through until they meet their partner and go home with them.

The benefits provided by service dogs are supported by the appropriate ADA laws. There are, however, State variations, which—no two are actually alike. Many States have defined the access of where a service dog will go, and also where a service dog in training may go. And that can be somewhat limited.

Regardless of that, the bottom line for all of this is that it is time for our disabled veterans to routinely have the opportunity to benefit from assistance dog use. Our veterans should be authorized to receive assistance dogs, and enabled to do so. Thank you.

[The prepared statement of Ms. Barkley, with attachments, appear on p. 74.]

Mr. MORAN. Thank you very much. If you didn't, you might introduce those three who have joined you. Ms. Shea, I am not sure whether you introduced your colleague or not.

Ms. BARKLEY. Both of them are asleep on the floor.

Ms. SHEA. Could you repeat the question?

Mr. MORAN. My question was, did you want to introduce your dog?

Ms. SHEA. Oh.

Mr. MORAN. Don't wake him or her up.

Ms. SHEA. Actually, at times I call him American Express, because I can't leave home without him, and he is accepted everywhere. (Laughter.)

Ms. SHEA. I hope American Express uses that for a commercial, and that I get some dividends off of that one.

Mr. MORAN. Mr. Filner, do you have opening remarks or questions of our witnesses?

Mr. FILNER. Welcome to the committee. On behalf of UPS, I would like to——

(Laughter.)

Mr. FILNER. I will have some statements, if I may reserve time, when we get to the other panels. I do want to thank our first panel.

Ms. Shea, you said in your testimony, "I hope to be eloquent enough to communicate the great services that working dogs can provide to people with disabilities." You and Ms. Barkley have exhibited such eloquence, and we thank you. We have learned from it, and we will act on your testimony. So thank you very much.

Ms. SHEA. You are welcome.

Mr. MORAN. I thank the gentleman from California. Mr. Simmons.

OPENING STATEMENT OF HON. ROB SIMMONS

Mr. SIMMONS. Thank you, Mr. Chairman. Very briefly, I went to college with a classmate and fellow student who had a seeing-eye dog. And I realize that a seeing-eye dog is somewhat different from an assistance dog, but over 4 years I began to realize and appreciate what extraordinary value the relationship between the dog and James Pugh—which was his name, a Philadelphia family—what great value that relationship had, and how important a role the dog played in the success of my schoolmate's time in college.

Just recently, as my wife went back to teaching in New London in Connecticut, one of the students, a new student, arrived with an assistance dog. And because of the particular condition that the student had, she had been using the assistance dog for a period of

over a year. And it was the first time that the school had been confronted with the situation, but they learned quickly what it was all about, and we have, as a family, come to appreciate how important this is.

There is a saying here in Washington that if you want a friend in Washington, you need to buy a dog. I guess that tells us something about this city, but it also tells us something about dogs: that the relationship between dogs and humans, which is longstanding over thousands of years, is one of trust and affection and assistance, and survival, in some cases.

So the idea that we would be applying these principles to assist our veterans, I think, is a good idea. And that is why I support the concept, and that is why I am a co-sponsor of the bill.

Thank you.

Mr. MORAN. Thank you very much. The gentleman from Arkansas, Mr. Snyder.

[No response.]

Mr. MORAN. Mr. Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Mr. Chairman. I didn't get here to hear, Ms. Shea, your entire testimony. But there is one section of your opening statement where you say, "I lost this horrific fear of going blind. There is no fear like losing your vision. Simply put, it is torture." I don't think anyone on the committee, probably, fully understands that.

"You lose a little," you say, "you learn to accommodate, and then you lose more. You are in a constant state of grieving." And I think you make the case that having this dog—you no longer have the fear, is what you said. And I think that statement in itself is the most clear indication that veterans who are in similar situations, who are in need of this type of service, should have it.

So I commend you for your personal experience, and your graphic way of explaining it. I think when we go from day to day, we forget. But you, again, bring to our attention how important it is to see, and that the fear that you had is being mitigated through the company of this dog. So I commend you for it.

Ms. SHEA. I can't really explain why that happens. It wasn't an expectation. But I can tell you, I can't walk from this table to the door without bumping into something. I can't see well enough to get to the door. I can get up and tell my dog to find the door, and I get out. And that in itself, I think, really eliminates my fear.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. MORAN. Thank you, Mr. Stearns. Mr. Rodriguez.

[No response.]

Mr. MORAN. I did have a couple of questions. I want to make sure that if service dogs are authorized for veterans—and I suppose this is a question for you, Ms. Barkley—the adequate supply. Is there a sufficient number of dogs to meet the needs of those who are using, who could use a support dog today?

Ms. BARKLEY. I believe that there is. There are people, for certain types of assistance dogs, that actually retrieve them from public pounds, private pounds. And there are some like the Our Kids Foundation, which deals mainly with children, that get them from

a breeding program. But I believe that the dogs are there. I think at this point it is a matter of standardizing the training, putting the bar high for expectations, and getting the recipient, the partner of the dog, together with the dog for one-on-one training to make it work.

Mr. MORAN. I think that's all the questions I have. Thank you both very much for being here. I am very grateful for your participation in the hearing. Thank you.

Ms. SHEA. Thank you.

Mr. MORAN. We now have the pleasure of three of our colleagues. Ms. Capps, Dr. Weldon, and Mr. Wicker, if you would join us?

Committee, these are members of Congress, among others, who have interest in health care issues affecting veterans. And so it is an opportunity to hear some of our colleagues, and suggestions they have of how we can address health care issues on behalf of veterans.

Dr. Weldon has been here before, and in fact provisions of his proposal are included in the legislation that is before us. In fact, it is legislation the House of Representatives has previously passed. So Dr. Weldon, we will begin with you, and thank you for joining us.

STATEMENTS OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. DAVE WELDON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; AND HON. ROGER WICKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

STATEMENT OF HON. DAVE WELDON

Dr. WELDON. I want to thank you as well, Chairman Moran, for including in your veterans health care legislation the provisions from that bill, which was introduced last year by myself and my colleague, Lois Capps. Representative Capps and I not only represent the Nation's premier space launch facilities, but we also represent thousands of veterans who live a great distance from a VA hospital.

We also want to thank Congressman Cliff Stearns of Florida, who as chairman of this subcommittee last year worked very hard to help us move this provision through committee and through the House. I am also very appreciative of the support that we have received from the former chairman of the full committee, Mr. Stump of Arizona, and as well the ranking members, Lane Evans and Luis Gutierrez, for the support they have provided to the Weldon-Capps language.

I will be very brief. As most of you know, I am a physician. I still practice medicine, seeing patients on a monthly basis at the VA clinic in Brevard County in my congressional district. I also received a portion of my medical training at the VA Medical Center in Buffalo, NY. I want us to give all that we can to see that our veterans receive the best quality medical care available.

Before being elected to Congress, I cannot recall how many times I sat across the desk from a veteran in my medical office and told them that they needed to be hospitalized. Many would respond that

they only option would be to travel across the State to receive their inpatient care in a VA hospital. They did not want to make that long drive, away from friends and family for weeks at a time. Having friends and family nearby, I believe, is a key factor in a patient's speedy recovery from an illness.

Veterans want access to quality health care, close to home. They don't want their doctor to tell them to pick up their suitcase and travel across the State. They want choices as well. They would like the option of a local hospital or a VA hospital.

Many of you know about the successful VA inpatient program we have had operating in Brevard County, FL, in my congressional district for several years now. Under the program, thousands of veterans have been given a choice in going to a VA hospital across the State or to a local hospital with which the VA has entered into a contract with, to provide inpatient care.

Over 98 percent of the veterans who have used the local inpatient option have said that they would recommend it to a friend. The veterans, in short, love it.

Has the VA saved money under this program? The VA's own report said that the care received by veterans under this program is provided at a savings in the range of 15 to 20 percent.

Recently, the VA chose to limit coverage in this program to service-connected disabilities. I soon discovered that under the current law, if the VA pays one dollar of care, they have to foot the entire bill. There is a prohibition on coordination of benefits under Section 5 of the bill.

The bill before you, under Section 5, seeks to allow a test in which veterans would be permitted to coordinate their various health care benefits—in other words, VA, Medicare, or private insurance. Section 5 of this bill builds on the pilot program that continues to operate in Brevard County. This plan would allow veterans from four different locations in the United States to coordinate their health care benefits for treatment of non-service connected ailments.

It would say to the seniors in my district, who have been excluded from the current program, you can coordinate your VA and Medicare benefits. It would say to those who are not yet 65, you can coordinate your VA and private health insurance benefits.

This proposal would guarantee to a veteran in communities with no local VA hospital the same access that the VA gives to those who live down the street from a VA hospital. Today, a veteran who needs care for a non-service connected illness can walk into a VA hospital and receive care. Unfortunately, many veterans do not live near a VA inpatient facility, and they do not have the same option.

In conclusion, Section 5 of this bill is about one thing: serving veterans. I commend the committee and the chairman for moving this bill forward, and for including this provision in its legislative language. Let's do what is right for all veterans. Let's help veterans who need access to health care locally. That is what this bill does, and I appreciate the chairman's support for this initiative.

Mr. MORAN. Thank you very much. Ms. Capps, welcome to our subcommittee.

STATEMENT OF HON. LOIS CAPPS

Mrs. CAPPS. Thank you. Thank you, Mr. Chairman. I am submitting a lengthier statement, written statement, for the record, which I will summarize for you now.

I am very grateful to you, Chairman Moran, and Ranking Member Filner and the subcommittee for the opportunity to comment on two very important bills before you today: The Veterans Emergency Telephone Act and The Disabled Veterans Service Dog and Health Care Improvement Act. As the author of the first bill and original co-sponsor in the last Congress for a key provision in the second bill, I am pleased the subcommittee is considering these important pro-vet measures.

H.R. 1435, The Veterans Emergency Telephone Service Act, sets up a toll-free national veterans' hotline service that can be accessed by veterans in all 50 States, 24 hours a day, 7 days a week. This service will combine the aspects of the 911 emergency line with a 411 information line. The bill currently has 71 co-sponsors.

I first want to commend the full committee on a Subcommittee on Benefits for their leadership in the recent establishment of the pilot program to expand access to the VA's benefits counselors. As part of H.R. 2540, the VA will no operate its information lines no less than 12 hours a day Monday through Friday, and no less than 6 hours on Saturday. This expansion of access will be an important step in the effort to provide the quality and breadth of service that we owe our veterans.

However, I submit that we can and should go further. H.R. 1435 will provide better, immediate, and constant access to counseling and crisis intervention services, including suicide prevention, substance abuse rehabilitation programs, and mental health services. It would provide vital information to destitute veterans in need of emergency food and shelter services. Some calls may be so desperate that immediate crisis intervention is essential to save a life.

For routine inquiries that are normally and capably handled by existing toll-free numbers at the VA, the "911-411" operators may simply give general guidance and refer the caller to the appropriate VA resource. But this much-needed hotline has a bargain basement cost of only $2 million per year. This is a small price to pay for a critical, urgent assistance, that it will provide for our benefits.

By virtue of their service and sacrifice on behalf of this Nation, our veterans deserve the very best support services that we can provide them, especially in their moments of greatest need. Sadly, such moments don't always occur during business hours, 6 days a week.

And now, another important bill before you today is H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001. And of particular interest to me, in Section 5, which creates a pilot program, and not one in four remote geographic areas, to allow veterans to receive inpatient care at local hospitals. This provision is very similar to H.R. 4575, which Dr. Weldon and I introduced in the last Congress, and which he has described. It is also very similar to language included in H.R. 5109, that the Department of Veterans Affairs Health Care Personnel Act of 2000, which passed the committee and passed the House unanimously last year. Unfortunately, the Senate did not act on this measure.

I want to commend the subcommittee for its past support of this important legislation. I would also like to commend Dr. Weldon for his ongoing leadership on this issue.

Mr. Chairman, the need for this provision is as great, if not greater, today as it was last year. For example, today vets in my district on the central coast of California must ride to Los Angeles or to Fresno for hospital care in a VA facility. This means a trip of 2½ to 5 hours to check into a hospital. It puts an unnecessary burden on people who served this Nation so bravely. Many of them are getting older, and this is a very precarious situation for their family and loved ones as well.

If a veteran is so sick that he or she needs inpatient hospital care, he shouldn't be forced to drive hundreds of miles for treatment. This inconvenience means that vets are often in hospitals far away from family and friends, and for many the hardship is enough to make the hospitals inaccessible for all practical purposes.

This pilot project would allow the VA to contract with local non-VA medical facilities to care for veterans who live a significant distance from a VA hospital. Veterans could check in with their local VA clinic, and then get referred to a nearby hospital. This would allow vets to receive care close by to their friends and family. This provision gives vets more health care choices.

Mr. Chairman, this is a pilot project, and its results should be carefully studied. It is not intended to undermine the Veterans' Administration's specialized hospital care in any way. Rather, it would augment it.

In fact, I have a hunch—and this is now what I hope the pilot project might bear out—that it would result in more hospital care, more medical care for veterans, because anecdotally, they are now telling me in my district that they avoid meeting their medical needs, they take care of themselves over the counter or do various things, whereas if they establish trust with their local hospital, I believe the referrals will be made for that specialized care that their local hospital can't provide.

So I sincerely hope the subcommittee will approve this measure as expeditiously as possible. And again, I thank you for the opportunity to testify on these important matters.

[The prepared statement of Congresswoman Capps appears on p. 86.]

Mr. MORAN. Thank you, Mrs. Capps. Mr. Wicker.

STATEMENT OF HON. ROGER WICKER

Mr. WICKER. Thank you very much, Mr. Chairman. And I, too, have a statement which has been submitted for the record, and I ask that it be received in its entirety.

Mr. MORAN. Without objection, so ordered.

Mr. WICKER. I am delighted to be here, and appreciate the attention of the members of the subcommittee this afternoon. I know the constraints on everyone's time. It is also an honor to be here with Representative Weldon and Representative Capps.

You will find that my legislation addresses a problem that both of them mentioned, and that is the fact that many eligible veterans have to drive sometimes hours and hours one way, simply to get

the veterans care that they are entitled to. My bill is H.R. 1136, and it deals with the issue of prescription drugs for eligible veterans.

Let me just tell you, members of the subcommittee, how this came to me. A physician from the town I grew up in, Pontotoc, MS, called me up. I had known him for years and years. And he said, Roger, I don't know if you are aware, I see countless veterans, who are eligible to have their prescriptions filled by a VA medical center. I want to write the prescription for them. Instead, the veteran has to go 2, sometimes 3 hours away, see another physician, have the same test run, and then get the same prescription that the general practitioner would have given them in the first place.

Well, it seemed like something that Congress should be able to address. But before I authored the bill, ladies and gentlemen, I wanted to see if I was really on to something that was worthwhile. And it so happened that I found out that the Inspector General was at that very moment in the process of issuing a report dealing with this very issue. That report came out in December of last year, and the Inspector General's report says it so much better than I do. Let me just read a couple of sentences from the IG report.

The report says this: "We believe that the process VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility or private insurance coverage who choose to be treated by a private, not a VA, health care provider, must frequently, as a result of these processes, submit to duplicate exams, tests, and procedures by VHA, simply in order to receive their prescriptions. As a result, VA Medical Centers frequently end up spending more on scarce clinical resources to rewrite prescriptions than the prescriptions themselves cost."

So based on the information provided to me by my own constituent, as well as the IG report, I have submitted this legislation, H.R. 1136, which simply gives the veteran the option of obtaining a written prescription from a physician outside the VA bureaucracy if he or she so chooses. Then that prescription would follow them to the VA, and the prescription would be filled.

Now, of course whenever you are looking at doing something different, Mr. Chairman, there are always questions. Is it going to cost money? Is it going to work for the veteran? So I would simply submit for the attention of the members of the subcommittee, the fact that the Inspector General determined that the Department of Veterans Affairs could save over $1 billion a year by allowing the VA to fill subscriptions written by private physicians. This is money that could be spent for other veterans' health care.

Not only will it save money, it will reduce the backlog. You have certainly heard from our veterans about backlogs at our VA facilities. It would free up medical staff so that they could attend to other patients who are willing to drive that distance.

This is not a new concept, Mr. Chairman. The VA treats 3.7 million veterans in this manner already. These are veterans who are "permanently housebound, or in need of regular aid and attendance." In those instances, the primary physician can submit the prescription. It is filled by the VA and that has worked very well.

I would also submit to the members of the subcommittee that this is a concept which works quite well also with the Department of Defense, which has for years allowed private physicians, as I am suggesting, to write prescriptions for those retirees who are eligible for military health services. The Department of Defense currently fills approximately 30 million prescriptions per year in this manner, over one-half of the total prescriptions filled by DOD.

So I would suggest to you that there is evidence that the bill will save money, that it will work for the veteran. And I think this is a good way to do what the other two witnesses have said, and that is take care of the veterans and provide better care, more options, for those who have served our country.

And I would thank you, Mr. Chairman.

[The prepared statement of Mr. Wicker appears on p. 89.]

Mr. MORAN. You are very welcome, thank you, Mr. Wicker, Mrs. Capps, and Dr. Weldon. I very much appreciate your testimony, your interest in our country's veterans. And I certainly share your concern about geographic distances. I have no VA hospital in my district, and these issues of geography, the nature of many places in the country, was an important one to make. So we treat these issues, I would treat these issues very seriously.

Mr. Filner, questions of our witnesses?

Mr. FILNER. Yes, let me add my thanks to your colleagues and your interest in making sure our veterans are well-served. I do want to say before I get into substance, I am more than a little disappointed at the structure of our hearing today, Mr. Chairman. As the Ranking Member, when I agreed to the schedule of dates, I assumed that I would have some input into the legislation and into the hearing and the witness list. As far as I know, our side of the aisle has had no input into this hearing whatsoever. I almost recommended to my colleagues, why bother attending if we are not going to have any input into the situation?

I hope that there will be changes between the time this bill leaves this subcommittee and goes further. But I will tell you, by giving the title of a bill like H.R. 2792, Disabled Veterans Service Dogs it gives the impression of a Christmas tree. To call it the Service Dogs act, and then fill up much of the rest of the bill with a turkey is not really the way we ought to be going.

So I really want to object. I had tried to call you earlier to say that to you in private. Not only do we have some reservations on what is in this bill; we would have liked to make some recommendations on what would be in the bill, also. My colleagues have had, and I have had, some legislation that we would have liked to have seen included.

On this bill itself, Dr. Weldon, opening up access to your constituents and others is something we all agree to. And we did pass the bill last year.

Now, I think we have different circumstances this year. I know that the VA has already been telling its field people that we have an $800 million shortfall, perhaps, in current services. And to implement the Millennium Health Care Act, which many of this committee were very proud of, Mr. Stearns, this was his baby—to implement that, and we have been slow in doing that, would cost another $400 million.

We all know we need long-term care and mental health improvements in the VA given the increasingly scarce resources in other priorities, I'm not sure that we would want to look at this in the same way as we did last year.

It seems to me now, what we will be doing is setting up an eligibility category for veterans, not on status or need, but on location—but more important, the veteran's own health insurance will be a key factor here. Therefore, we create a disparity between health care available to veterans who choose to use the health care system of the VA and those who have their own insurance and have previously chosen not to use facilities; now we are going to have to subsidize that situation. That sets a precedent for sending veterans to non-VA providers for inpatient service that are paid by the veteran's own insurance. We would now subsidize care outside of the system, losing both the direct and appropriated dollars, and any third party reimbursements.

I am looking at Mr. Principi. I have read your testimony. I think we have agreement on this. If this precedent is set and expanded, our own health care facilities would become merely local referral centers, without the resources to sustain the full range of care, including the specialized services such as spinal cord injury care and substance abuse treatment, for which the VA is well known.

And the VA would not only *not* have any control to manage the care once it is referred, but it would be the secondary payer, and paying without being the provider of care.

So we need to increase the access, but I am not sure we need to do that at the cost of unraveling our whole health care system. Veterans deserve and need a unique health care system devoted and dedicated to treating their unique needs. Picking up the co-payments for veterans who have insurance will ultimately transform the VA from a health care system designed and focused on veterans' medical care into an insurance company. And while we are trying to give access, we will do so at the cost of maintaining a fully staffed and functioning veterans health care system.

So I am thinking we ought to re-look at that bill. Dr. Weldon, what is your reaction to what I said? Again, I do appreciate you have been an advocate for increasing access, and we must find a way to do that.

Dr. WELDON. Well, certainly you would have to agree that we have a two-tiered system, American system, that is enjoyed by all those veterans who live near their facilities, and a system that denies care to all those who live far away. It is plain and simple. Rural America suffers badly from this, and in high-growth States like California and Florida, there have been large geographic regions—my region, and Lois Capps' region—where the veterans are simply told, tough, we will pack your bags and you go.

I think the response for the VA needs to be to either build hospitals in these regions, or to implement a program like this.

Now, I would like to address the issue that you brought up, which is that somehow by implementing this pilot program in a handful of regions, that it will somehow destroy specialized programs for veterans with certain disabilities, and could someday ultimately lead to the veterans health care system just being reduced to a health insurance plan. I heard comments like that last year,

and I think, you know, most people agree that those were rather extreme presumptions. And certainly, as a physician myself, I would never expect to see the quality of our health care program decline because of implementing something like this.

I think the critical issue is we need to be trying our best to provide health care that is good quality, that is close to home for veterans. And I think we have a reasonable proposal on the table to test that hypothesis. And as I said, if the Veterans' Administration is going to refuse to implement something like this for the areas that are underserved and have a lot of veterans, then I believe their only other option is to start getting out their blueprints and drawing up plans to put hospitals in those locations, because you have a tremendous disparity. There are regions in this country that have far fewer veterans than the number that are in Lois' district and mine that have veterans' health care facilities, that have hospitals. And so that is what this debate is really about.

Mr. FILNER. I hope you or someone from your staff might stay for the later panels, because Secretary Principi and the VSOs, I think, almost uniformly are in opposition. I——

Dr. WELDON. If, if——

Mr. FILNER (continuing). I think they will try to answer your question.

Dr. WELDON. Last year, all the VSOs supported my bill except four of them.

Mr. FILNER. Well, maybe the situation changed. So, stay around or have someone stay around, because you raise some very interesting questions.

And I would say to you also that many of us tried to get additional resources into the VA during the budget process, and during the appropriations process. And I think it is a little bit—I will say hypocritical—I don't mean it that strongly, I can't find a weaker word—that we vote against those attempts to increase the resources, and then say the VA is not fulfilling the needs that you claim.

We know there are needs out there. And the Secretary is nodding; the VA has been experimenting with outpatient clinics and all kinds of other ways to outreach. And yet, people who want these things then vote against the amendments to increase the resources.

So I would have to say let's find a way to do it. If it takes more resources, we need your vote to do that, too.

Mr. MORAN. Ms. Capps.

Ms. CAPPS. I know you addressed this to my colleague here, but if I could respond to my colleague, Mr. Filner?

Just on a couple of the things that you mentioned. One, to keep in mind, we won't know if this would work, or how costly it would be, unless we try it. And that is, to me, the point of the pilot study. It is not meant to disrupt the system at all.

And there is an assumption that was made that insurance policies wouldn't be used. I think there could be stipulations made to insure that onerous burdens on the VA would not be incurred by this. And also stringent guidelines as to the boundaries of where, that these really only target those hard-to-reach populations. I would submit that that would be one way to control some of the

concerns, but also to measure, and to give us something to measure.

Mr. MORAN. Mr. Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. First of all, it is my understanding that these are pilot tests, and that in the case of the veterans traveling, we are only dealing with four sites and tests to be determined. I will say, as somebody who has a lot of veterans in my veterans' hospitals, my veterans have to travel. And in trying to address this problem in the Rhode Island veterans' hospital, which is out-of-State but serves the northern tier of my district, they said, well, we can help you with that. We will send a taxicab out. Well, but to bring the cab out, we need to put four people in the cab just to make it cost-effective.

Yes, I don't know why we all talk about the greatest generation, and why we all talk about the Korea vets, and why we are all concerned about these monuments on the Mall, if we don't give a damn enough to provide medical services to veterans. We stick four of them in a cab, not less, to transport them for an hour and a half on an appointment it has taken them 6 months to get. And yet right in their own home community, there are medical facilities available. I don't understand that.

I don't understand why we can't get some service off the military Navy base in Rhode Island. I don't understand why the capacity at the Coast Guard Academy is limited. We have got LNM Hospital, we have got Bacchus Hospital, we have got a whole series of medical facilities throughout Eastern Connecticut, which has no VA system. But we make those poor guys sit there and wait 5 or 6 months, and then crowd into a cab to go someplace, when in fact they could go down the road.

That is point one, I guess. It is a kind of a question, right?

(Laughter.)

Mr. SIMMONS. Point two, on the 800 number. It is great. And Rhode Island, to their credit, has extended the Rhode Island 800 number into eastern Connecticut, to the 860 area code. That is fabulous, because half of the veterans in eastern Connecticut go to the Rhode Island hospital, when they can get there and if they can get there. So that is great. I think that is super, and that is a step in the right direction.

I commend the VA and the Secretary for appointing people in these facilities who have the foresight to look across a State border to serve veterans. Because I think we need to look a lot more over borders—bureaucratic borders, State borders. We have got to look over a lot of borders to serve veterans. That is our fundamental purpose.

And then thirdly, on the pharmacy benefits. I have been to the VA hospital in New Haven, and to Rhode Island, on pharmacy benefits. I think it is absolutely correct. We have backlogs on procedures, we have doctors and nurses who are tied up. We have patients waiting 6 months to be seen. And yet folks that have scrips from decent doctors throughout the State can't get their prescriptions filled. It is ludicrous. The whole system is bogged down on this.

And, you know, there are simple ways—I mean, if the doctors aren't trusted, then have a list of recommended doctors. But let's,

again, help the veterans. Isn't that what we are here to do? Not to preserve and protect some bricks and mortar and some bureaucracy, and some antiquated system. You know, we are supposed to break through that, so the service gets to the veteran and it gets there cheap. And so the Veterans' Administration itself is now burdened with duplicating all of this work.

You know, when I go to my doctor, I can take the prescription to CVS, or to the Super A&P, or to several different places. You go in, they look at it, they figure out what the doctor is trying to say, and they fill the prescription. Nobody at CVS says, well, I have to talk to the CVS doctor. Right? "Oh, I am sorry, you are going to have to talk to the CVS doctor to double-check your doctor."

So I mean, I think these are great ideas. I am not sure I know what the problem is. Maybe the panel can tell me what the problem is. Maybe there is no problem.

Mr. MORAN. My suggestion to the panel is they let Mr. Simmons' testimony stand, without responding. (Laughter.)

Ms. CAPPS. Happy to do it.

Mr. SIMMONS. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Simmons, thank you very much. Mr. Snyder?

Mr. SNYDER. I am trying to figure out what questions, and you may have to go over to someone else. I think the Secretary is here and maybe we'll hear next from him.

Mr. MORAN. Mr. Rodriguez?

Mr. RODRIGUEZ. I would say one of the problems was the tax cut. But one of the realities is that——

Mr. SIMMONS. But we don't want to get political, right? Not with the veterans. Right?

Mr. RODRIGUEZ. Unfortunately, that was a political decision that was made.

But let me be straightforward. Based on this piece of legislation, it is my understanding that close to 85 percent of participants would have health insurance coverage. And so what would you say to the statement that this would just be subsidizing the insurance companies and the hospitals, versus actually meeting the needs of our veterans?

Dr. WELDON. Well, regarding the specific legislative language, my language was changed slightly by the committee. But I believe I can answer your question. The way it currently works right now in my congressional district, if a veteran is under 65 and he has a service-connected disability, he goes to the local community hospital and the Veterans' Administration pays his entire bill.

What we are trying to do is open the program up to veterans over the age of 65. Now, right now the Veterans' Administration currently absorbs a huge amount of work that should be paid for by Medicare. There are many veterans over the age of 65 who are hospitalized at VA hospitals all over America on an annual basis, and the Veterans' Administration is paying for the hospital care for these patients.

What we propose for the conduit of this contracting is that veterans over the age of 65, Medicare would pay the bulk of the bill, and the VA would simply pay the co-pays and the deductibles so there would be no out-of-pocket expenses for the veteran. To me, this is a very reasonable, rational use of what I call coordinating the

health care benefits for the American people. And I think it makes a tremendous amount of sense.

Now, I think there are some legitimate cost issues worth debating globally for the VA, and some legitimate long-term policy issues worth debating. But we are not talking about implementing this across the United States in all 50 states. We are talking about four pilot programs——

Mr. RODRIGUEZ. Well, but how long is the drive for a veteran in your district to the nearest hospital?

Dr. WELDON. For me?

Mr. RODRIGUEZ. Yes, to the VA hospital.

Dr. WELDON. It probably averages 3 hours in my congressional district.

Mr. RODRIGUEZ. One hundred fifty miles?

Dr. WELDON. Yes, in that range, about that. And it is not so much an issue for the veterans themselves who are being hospitalized. It is for their families——

Mr. RODRIGUEZ. Where are you suggesting the pilot programs be at?

Dr. WELDON. Well, the language in my bill last year, which is similar, is that the Veterans' Administration is provided the latitude of selecting the four locations. I would certainly encourage them to make two of them——

Mr. RODRIGUEZ. And what are the parameters that you have given in terms of that selection?

Dr. WELDON. Well, we essentially gave them parameters that would allow our districts to qualify. But I will admit to you that more than four locations——

Mr. RODRIGUEZ. There are veterans who live 300 miles away from the nearest VA hospital in South Texas.

Dr. WELDON. Well, actually, our hope is that yours would be one of those included. (Laughter.)

Dr. WELDON. I am serious. I was hoping it would be, preferably two Democrats and two Republicans. And I looked at yours, and I said they would have to include yours.

Mr. RODRIGUEZ. When I said 300 I wasn't referring to my district. In my district, some veterans live 200 miles from the nearest VA hospital. But in the Valley, in Solomon Ortiz's and Ruben Hinojosa's districts veterans travel up to 300 miles.

Dr. WELDON. Right.

Mr. RODRIGUEZ. To the nearest VA hospital.

Dr. WELDON. Well, I think you—last year, weren't you one of the co-sponsors over there, and Mr. Hinojosa was a co-sponsor?

Mr. RODRIGUEZ. No, it was probably one of the others, not me, because I do have some problems with your proposal. I want to reach out and do whatever I can for veterans who need help. We need to move forward in that direction. But we also have to be willing to bite the bullet and put up the necessary resources. That is also important.

Dr. WELDON. Well, I certainly want to put up sufficient resources, but I would also like to apply the resources in a very efficient manner that provides quality care close to home.

Mrs. CAPPS. Could I——

Mr. MORAN. Mrs. Capps?

Mrs. CAPPS (continuing). Just make a point to Mr. Rodriguez's concern? And that is that the difference between this bill and the one last year that did pass, is that because of cost concerns, a cap has been put on the total amount that can be allocated. So this is not going to be some wild, harebrained idea.

Mr. RODRIGUEZ. What is the cap on this particular bill?

Mr. MORAN. $50 million. I appreciate the panel's testimony. Thank you for taking your time today to see us.

Dr. WELDON. Thank you.

Mr. MORAN. And we look forward to working with you on these health care issues.

As I said earlier, we are very delighted to have the Secretary before our subcommittee. We are very honored, humbled, that he would take his time to appear before this committee looking at health care issues. And Mr. Principi, we have appreciated your candor and approach to veterans' issues, and welcome your comments and statement today.

STATEMENT OF ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY FRANCES MURPHY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH

STATEMENT OF SECRETARY PRINCIPI

Secretary PRINCIPI. Thank you, Mr. Chairman. It is an honor to be here, Ranking Democratic Member Filner, members of the committee. I am with Dr. Fran Murphy, the Deputy Under Secretary of Health. Dr. Garthwaite, unfortunately, was hospitalized yesterday. And I am very, very pleased to report he is doing well and is out of the hospital, but he did give us a scare. I have his able deputy with me today.

Thank you for inviting me to provide comments on H.R. 2792. The first provision, of course, relates to the service dogs available to disabled veterans. I might say that we received open testimony from the first panelists this afternoon on the value that the guide dogs and service dogs will bring to veterans who are hearing impaired and who have spinal cord injuries or other chronic impairments. And we certainly support expanding the current authority to allow these disabled veterans to have access to the service dogs, and also to pay certain costs associated with adjusting to the dogs.

We do believe, however, that the provision for guide dogs and service dogs should continue to be limited to the veterans, the 2.1-plus million veterans who are entitled to service-connected disability compensation. If the provision becomes law, we will develop stringent criteria and guidelines to ensure that we provide dogs to those veterans who certainly can benefit most by them.

Section 3 of the bill addresses VA's statutory obligation to maintain capacity for the specialized treatment and rehabilitative needs of disabled veterans. VA shares the committee's commitment to maintaining capacity to meet the needs of patients with these special needs. And I can assure this committee, members of the committee, that I believe the specialized programs of VA to care for the spinal-cord injured veterans, blind rehabilitation, caring for the seriously mentally ill, and certainly geriatric care, are of utmost im-

portance to me. We will continue to provide a leadership role in those areas.

We believe that the evaluation of access to specialized care should be based on the relevant patient population, and that there should be appropriate access across the country. For that reason, we support the requirement to maintain capacity for each geographic area. However, using dollar expenditures for the 1996 level of infrastructure may not be the best way to achieve our shared goal of maintaining capacity and caring for these veterans who need the specialized programs. We believe that the VA health care system should stay focused on assessing the evolving needs for specialized services of the population that we are serving in each network, measuring the care we provide, measuring the quality of that care, and the health outcomes, and assessing our patients' access to that care, including waiting times for appointments.

We believe veterans will be best served if we can adjust our capacity measures as the population of veterans with special disabilities change, and as medical science and technology improve. I think we have seen what we can do with atypical antipsychotics in allowing patients who have serious mental illness not be institutionalized, but that they can lead productive and useful lives in the private sector.

So we urge you to give us some flexibility, to work with us in revising the requirements in ways that would ensure we can achieve the best outcomes possible for our patients.

Section 4 of your bill would establish new geographically based income thresholds for determining a non-service connected veteran's priority for care and co-payment requirements. We are interested in and are exploring geographically based income thresholds for enrollment priority decisions. However, at this time we do not support the specific methodology adjustment in your bill.

The bill uses a poverty index developed by the Department of Housing and Urban Development to establish alternative income thresholds. There are many poverty indices, using different methodologies and criteria, and there are serious questions about what these indices really measure. For example, the HUD index is based on the income, rather than on the cost of living. And it incorporates policy decisions that may be relevant to housing, and who should be in housing and get housing grants, and not health care.

So we are currently reviewing the various poverty indices to identify the best way to proceed. And hopefully we can work with the committee in developing an index that would meet our respective needs.

There are some policy implications here that I think the members of the committee need to focus on as we move forward. For example, adoption of an income threshold that would move a substantial number of veterans from priority 7 to priority 5 would reduce the veterans health care resources that we derive from co-payments. And we use those resources, obviously, to expand the reach of health care.

There could be dramatic effects on resource allocation amongst the various networks, since care for priority 5 veterans is included in our allocation model, and priority 7s are not in that model. So with a finitely budgeted health care system, money could be coming

out of one network and going to another network. We need to assess those implications.

But there are other implications, as we look at geographic income. For example, would adjustment of the threshold for health care decisions based on regional income create a precedent for regionalized variation in how we compute disability compensation, who becomes eligible for pension? Because, if you live in a certain area of the country, perhaps the pension doesn't go as far, and in other areas it goes too far. So I think it might have some implication for the benefits side of the house, and I think we should discuss those implications and the possible precedents set by the geographic variation.

Section 5, to establish the pilot program authorizing special benefits for some veterans receiving care in a VA outpatient clinic who need hospital care, as addressed by the previous panel. I almost wish I could have testified before that panel. I feel I am on the hot seat now, but that is fine, and I certainly appreciate Congressman Weldon and the others who testified earlier about their motivation and intent of this proposal.

However, I must strongly oppose this proposed pilot program. There are, with this proposal, very serious policy implications that again I would hope that our respective bodies—the committee and I and my staff—can work through. And I would like to talk about some of those.

My concern is that the pilot project would not answer some very, very fundamental policy questions implied by the proposal. Again, I truly respect what they are trying to do here. But my concern is, is the question should VA be transformed into a payer for care rather than a provider for care? If so, what criteria would Congress use to define who qualified for what would be, in effect, VA health insurance?

Does the Congress want us at VA to follow DOD's footsteps toward Tricare? And I think there are serious questions about that, because I believe—and I am speaking personally now, and not as part of the administration—that a lot of funds have been taken out of the DOD direct health care system in order to pay for Tricare. And I think it possibly has had a degradation on the direct health care system of DOD, because of the sheer magnitude of the costs for Tricare. I think it is something that we need to look at as we move forward.

One of the justifications for rolling the priority 7 veterans into our health care system is our need for enough patients to sustain VA's capacity to provide a full spectrum of comprehensive care—what we have talked about earlier: spinal cord injury, blind rehabilitation, mental health, and geriatric care. Would not diversion of patients from VA facilities to community hospitals work to the detriment of our shared goal of maintaining capacity, and at the same time weaken one argument of continued enrollment of priority 7 veterans? I think we need to look at that.

If the policy implied by the proposed pilot were widely implemented, without a guarantee of additional funds that we talked about earlier, what would be the effect on the entire VA health care system of increased enrollments motivated by a more attrac-

tive benefit that you can get the health care in a private hospital right across the street from your home?

Again, I am not saying that I don't want to achieve uniform and equity of access. I think those are important issues. But at the same time, I am concerned about the impact on the VA health care system, the health of our health care system.

I think we are a national resource. And I can also say, I have been in about 30 States now, in many, many VA hospitals. And I have talked to patients, and families of patients, who have traveled very long distances to those VA medical centers. Of course it is inconvenient, and it is troublesome. But they want to be in that VA medical center. They don't want to go to the community hospital, because they are getting compassionate, high-quality care.

I have learned of many wives who slept in a chair in a VA hospital room next to their elderly, World War II veteran spouse, and tell me that this was the best care they have received anywhere. And they were in private hospitals before. So I say to you, members of the committee, we are providing a high quality of care. And yet I know it is inconvenient to have to drive 1 or 2 or 3 hours.

I also agree that we need to look at constructing new hospitals in some areas. I think Dr. Weldon is correct: We need to look at Brevard County, Florida and we need to look at other sections of the country where we have a growth in the veteran population. I am certainly willing to do so, and I believe we have to look at our infrastructure to make adjustments, and build new inpatient bed towers where we need to. And perhaps, in some cities where we might have three or four, look at closing one down, so that the dollars saved can be used to build facilities in other parts of the country. Those are tough political questions, but I think we need to address them.

And finally, I think the other section, 6, of the bill, to create a 3-year pilot program in which veterans receive fee-basis and contract hospitalization, would receive care through a contractor acting as a managed care coordinator—I think that is a good provision. We are interested in establishing such a pilot program. There are some restrictive requirements to this provision in your bill which we would like to work with the staff on, to see if we can modify them somehow. But we believe that the cost of the pilot program is worthwhile. We would just like to see some changes to some of those requirements.

I will conclude at that. I know I have exceeded my time limit; I apologize, Mr. Chairman.

[The prepared statement of Secretary Principi appears on p. 93.]

Mr. MORAN. We are very happy to receive your testimony. And Mr. Filner, I would ask you if you have questions of the Secretary.

Mr. FILNER. Thank you, Mr. Principi, and again, thank you for your aggressive advocacy for veterans in the time you have been Secretary, and we appreciate that very much.

Secretary PRINCIPI. Thank you, sir.

Mr. FILNER. I think you had many of the same questions I did on Section 5. Let me turn to Section 6 for a second, you were somewhat rushed on that one.

I know as I look at it, what we are doing—at a time when this Congress is faced with incredible problems with HMOs—we are de-

bating a patients' bill of rights. We had testimony about some of the problems—the VA, under this legislation, is being instructed to run a managed care program at several locations. And a managed care contractor would be in charge of this.

A class-action suit has been instituted on behalf of Medicaid recipients in Connecticut against this very provider. So I just want you to be aware of this, I will get the exact reference for you, Mr. Secretary.

Secretary PRINCIPI. I would appreciate that.

Mr. FILNER. I think we have to be very careful of moving here. As you have stated so eloquently, Mr. Principi, the care of veterans is an inherent responsibility that you are managing. It is not the private sector's responsibility. And you have focused your medical staff and resources exclusively on treatment and research on veterans' illnesses and disabilities. We can't find that in the private sector.

So your undivided focus on veterans has developed expertise, *world-class* expertise, in spinal cord injury, blindness, traumatic brain injury, amputation, serious mental illness, post-traumatic stress disorder. So you are playing a key role in this country.

If we go to this pilot program, where we rely on fee-based care and contract hospitalization, we are, I think, getting into a serious, serious problem. Right now, because of lack of resources, you may have to send veterans out in some of these areas. And you would not like to do that, I take it; you would like to have the resources to do it yourself.

So this bill would make a bad situation worse, in my opinion. It adds a managed care review by one contractor over another one, and reduces your ability to care for veterans. So I think—we are dealing with this managed care operator here, and we have seen this all across the country. Their job is to make a profit. Your job is to treat the veteran.

But they are going to try to cut the cost, dramatically. I am not sure that they will not do that at the expense of the veteran, in which case we are paying and we are saving money, supposedly, but we are reducing the care that the veteran receives.

So I am not sure that we are ready to move in this area. We have tremendous problems with managed care operators all across the country. To put the VA into that situation, when the current HMOs are having difficulties, as I understand it is questionable. And I don't understand giving HealthNet 15 percent of the cost just to look at something that we ought to be doing anyway.

I would just ask your response to that.

Secretary PRINCIPI. Well, I agree with you. My understanding of the provision would be in areas where we do have veterans receiving contract care. And let's assume that maybe—not HealthNet, I don't know about them. But let's say there is a good Tricare provider in a certain region of the country that either has a uniform set of policy guidelines for military retirees and dependents, that, as a pilot project, look in that area, whether it be the West or the South, to enroll our patients with that Tricare provider, and to measure the quality of the care, the cost that we are providing, relative to what we were providing prior to that.

So no, I am not in any way advocating sending more patients out to be enrolled in HMOs. But for those who are currently out there receiving contract care, it would be to say, you know, I can support a pilot project that says let's enroll the 25 or 50 or 100 veterans who are on a contract in that Tricare region. That was where I was coming from on that, Mr. Filner.

Mr. FILNER. All right. Well, I hope, again, before we end up passing this bill—I hope we don't—but give us a look at the whole operation. I am not sure we all fully understand it.

Secretary PRINCIPI. I agree with you. I just want to emphasize, I agree with you that I do not support sending these veterans out into HMOs. I would like to see those who are under contract, to the best we can, bring them back in the system.

Mr. FILNER. Mr. Chairman, just one minute or under ten seconds. The company in Connecticut is being sued as a class-action suit by the Medicaid patients, claiming that there was a routine denial of low-income patients for the medical care they need.

Mr. SIMMONS. Can I respond to that, Mr. Chairman?

Mr. FILNER. I am just saying that there is this charge out there.

Mr. MORAN. Mr. Simmons, it is your time for questions, and you may use your 5 minutes as you choose.

Mr. SIMMONS. I don't recall in my discussion that I recommended that these veterans be referred to an HMO. HMOs have had problems all over the country, and that is not what I was suggesting.

Mr. Secretary, thanks very much for coming. Thanks for your visits to the great State of Connecticut. And I believe you have some planned in the future, and we are very appreciative of that.

You made the comment that you are stuck between a choice of being a payer for care and a provider for care, and you are a provider for care. And that is where you want to be and that is where you are. But I would suggest that you don't have to be one or the other, and that in actual fact, in some circumstances, you should be both.

And that is what this pilot test is designed to establish, because you see, for some veterans, you are not providing, because it is not convenient to provide, and therefore they are not accessing those benefits, if you will, that would otherwise be available to them. Because of transportation, because of distance, and because of strangeness of the system, they tend to rely, and they want to rely, more on their local doctors.

I am a beneficiary of the GI Bill, and I very much enjoyed having the benefit of the GI Bill. But you know, they didn't tell me what school to go to. They told me to apply to a school within a certain program limit, and then the check would come. And I guess in a way, I would like to establish that as an analogy. They didn't tell me I had to go to West Point, or to Annapolis, or a military school. They said, you pick the school, and if the program is right, we will pay the bill. And it worked very well.

And what I guess I am saying to you is for those areas where you provide care, where veterans can take advantage of that, or in those cases where they really want it and they are willing to go 3 or 4 hours, or even move to that city for that care, that is great. That is terrific. And I agree with you, you provide services that are extraordinary.

But there is an unserved population of veterans out there that cannot easily be provided for. And wouldn't it be nice if you could pay for them? You be the HMO, not some private entity of profit-making, but you care for them. And all this test, all this pilot program does is try to test that idea. If the idea fails, great. We have tested it, and it doesn't work.

But in my district, this is what I hear from my veterans: why can't we try something like this? And I think that Mr. Rodriguez and Dr. Weldon and others have encountered the same thing. If I lived and represented New Haven, I can tell you, we wouldn't have a problem, because the New Haven VA hospital is one of the best in the country. It is awesome, it is terrific, we love what they do down there.

But I guess what I would be appealing to you for is the willingness to understand that very discrete population that we are talking about, and to give some consideration to supporting a test, a pilot program, a test of this idea.

Secretary PRINCIPI. Sir, I don't——

Mr. SIMMONS. You don't have to call me sir. I work for a living, just like you.

Secretary PRINCIPI. I would venture to guess that this would be a very, very successful pilot program. And I think that is not the issue.

The issue is one of cost. We are a finitely budgeted health care system, unlike Medicare or Medicaid, where you get the billing—you pay Medicare part B, and the doctor submits the bill, and you get paid Medicaid charges. We don't get any Medicare subvention. Every year we have to come and fight. We all know that. It is not a partisan issue—Republican, Democrat, the issues are always tough when you are a discretionary budgeted activity.

And if I could be guaranteed—which I know we cannot—that Tony Principi and VA will have all the money it needs to be a payer and a provider, I would say this is great. But unfortunately, I don't think that is the case.

And look at DOD. Are they going to talk to the Surgeon Generals—and maybe I am a little out of turn here. But I think if you talk to the Surgeon Generals, they will tell you that the direct health care system has suffered somewhat because they have had to be a payer and a provider.

And that is my concern. We don't have philosophical differences. I want to make it as convenient as possible for the veterans to access the VA health care system. I think the community-based outpatient clinics have done a wonderful job, almost too good. I think we are a victim of our own success.

But now the question becomes, and the one we are intensely discussing today, is the 2002 budget, how much are we going to get when the Appropriations Committee reaches agreement? What do I do about category 7s? Our pharmacy budget has gone from $720 million the last time I was here as Deputy Secretary, to now we are at $2.5 billion and another $600 million to administer that program. Health care costs are rising precipitously.

That is my challenge, and our challenge, is how do we pay for it?

Mr. MORAN. Mr. Snyder? Incidentally, committee, we have a vote in approximately 20 minutes, which I believe is the last vote of the day. And so I am going to do my best to keep us on time, and hopefully at least hear the testimony from the last panel.

Mr. Snyder?

Mr. SNYDER. Thank you, Mr. Chairman. If I just may add my own comment to your comment about cost, I think as you look at the budget numbers, I mean, unless there is some magic out there, I don't see any big influxes of new money coming anytime soon in the next years, as you are trying to solve the problems you have.

Mr. Secretary, do you have any comments on Congressman Wicker's bill on prescription drugs?

Secretary PRINCIPI. I would like nothing better than to be able to provide prescriptions for all of our veterans. And I very, very seldom disagree with my IG about cost.

There is no question that the IG is right that we would save money if we did not have to do the medical evaluation, like Mr. Simmons said earlier. Then we could just provide the prescription. But if you pick up some of the senior citizen magazines today, you will see an ad or something that says, go down to the VA to get your prescriptions filled if you are a veteran, because you don't have to pay all this money, just pay your two dollars' co-pay, or seven dollars, and it has increased.

I think the doors would come tumbling down by 25 million veterans—or whatever percentage are on prescriptions, seeking to get their prescriptions filled at the VA. So I think yes, on the one hand we would save money. But how do you control the workload increase?

If you just increase by 25 percent the number of veterans who are coming to us for prescriptions—and that is not a large number—the bill would be $9.2 billion. Fifty percent, it would be $15.9 billion. Again, where do we get the money?

So, yes, we would like to do that. But somehow, I don't know who should receive the benefit——do we just do it for the service-connected? Do we do it for the non-service connected? Whom do we provide it to?

Mr. SNYDER. It would be for all drugs. The language of the bill seems to be pretty inclusive that you would have to provide all medicines.

Secretary PRINCIPI. Yes. Again, I just think that there would be such a rush to come to VA, and rightfully so, because the cost of pharmaceuticals is so darn expensive in this country. For example, my mother is paying $400 a month. And so I would love to see that.

But I don't know how, again—it is a budgetary issue.

Mr. SNYDER. I wanted to ask just a clarification on your comments on those service dogs, on the dogs, that you wanted them to be service-connected. I don't know what current policy is. I assume that if the dog would not have to necessarily be assigned only to a veteran that had a disability—the dog doesn't have to be related to the service-connected disability, is that correct? It would just be enough that the veteran was service-connected, for whatever reasons?

Secretary PRINCIPI. Today, it is—Dr. Murphy, correct me if I am wrong—we provide guide dogs to blinded veterans who are service-connected disabled only. We do not provide the guide dogs to non-service connected.

Mr. SNYDER. Service-connected for the blindness?

Secretary PRINCIPI. Yes, correct.

Mr. SNYDER. Okay.

Secretary PRINCIPI. And again, I think we looked at the potential cost. The cost to train the dog is $15,000 to $25,000, as was stated earlier today. If we opened it up to non-service connected——

Mr. SNYDER. I understand.

Secretary PRINCIPI (continuing). The cost. But I do believe, we do support it for service-connected, and maybe we could take a look at it in a year or two, and assess whether we can expand it to non-service connected.

Mr. SNYDER. Do you have any comments on the bill, the hotline bill that could pass—we had a hearing on this, I think, in the last few months. But I thought the opinion, your opinion at the time was that you are working to improve your telephone hotline, and that you weren't all that excited about bringing in a private group to do that. Is that still your position?

Dr. MURPHY. We have spent a lot of time and resources improving our own helpline and hotline system. In fact, we have established a requirement for every network and every facility to have 24/7 telephone triage coverage. This provision would appear to be a duplication of VHA's efforts, and likewise of VBA's efforts.

Mr. SNYDER. With regard to this section 5 provision, I want to get a sense of specifically where the problem is for the veterans. I understand the geography. I think one of our members made a comment that this was as much for the families as for the veteran.

On the other hand, families make decisions. I mean, I am from a rural State, I am from a rural area. You know, a lot of my constituents, you start moving in next to them, and they will move further away. I mean, they choose to live in rural areas for reasons. They don't want to be near metropolitan areas.

But we now have language, do we not, that for medical emergencies veterans—clearly, I mean, we expect them to go to the nearest private hospital, and you are now required to reimburse for that; is not that correct?

Secretary PRINCIPI. That is correct. And we have implemented the regulations. They can go to a private hospital for emergent care. And of course, we did not receive any additional in funding for that, and we expect in that steady-state it is going to cost us close to $400 million a year.

I guess that part of the issue is the unfunded mandates that we are trying to provide. But every year, the budget doesn't reflect the new programs. But we have implemented those regulations; July 12 we started that.

Mr. SNYDER. So that, in terms of our folks in the rural areas that would have to drive some distance to a VA hospital——

Secretary PRINCIPI. Right, that is correct.

Mr. SNYDER (continuing). In emergency situations, it's taken care of. It will be a cost and a benefit for all veterans. We don't get into

this business of whether or not insurance or not insurance. I mean, veterans eligible for care.

Dr. MURPHY. Either their private insurance, if they have private insurance, or Medicare coverage would cover that. Or if there is no other payer, then VA under the Millenium Health Care bill can pay for emergency care. And that is the real issue.

Eighty-five percent of the population in the pilot would already have other health care insurance. And VA will be paying for their co-payments and co-insurance.

Is that really what Congress intends as a good use of the taxpayers' dollars? Do we need to be duplicating benefits that already exist?

Mr. SNYDER. Thank you, Mr. Secretary, and Dr. Murphy, for your service.

Mr. MORAN. Mr. Snyder, thank you. Mr. Secretary, I am as usual impressed by your testimony and your forthrightness. And I will reserve my questions; I will have an opportunity, I think, to present those to you in writing and talk to you about them later, in the interests of hearing from our fourth panel.

Secretary PRINCIPI. Thank you so much, Mr. Moran. Mr. Chairman.

Mr. MORAN. Thank you so much, Mr. Secretary. And I would call upon that fourth panel, which consists of Richard Fuller, National Legislative Director of the Paralyzed Veterans of America; Ms. Joy Ilem, Assistant National Legislative Director, Disabled American Veterans; Mr. Thomas H. Miller, Executive Director, Blinded Veterans Association; and Ms. Jacqueline Garrick, Deputy Director for Health Care of the American Legion; and Mr. Richard Jones, the National Legislative Director of AMVETS. We welcome all of you.

Mr. Fuller, you look the most ready. Is that true?

Mr. FULLER. Mr. Chairman, we have got a lot to talk about.

Mr. MORAN. All right, let's get to work.

STATEMENTS OF RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; THOMAS H. MILLER, EXECUTIVE DIRECTOR, BLINDED VETERANS ASSOCIATION; JACQUELINE GARRICK, DEPUTY DIRECTOR, THE AMERICAN LEGION; AND RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

STATEMENT OF RICHARD FULLER

Mr. FULLER. And I will try to be brief. This is a complicated bill.

First of all, on behalf of Paralyzed Veterans of America, I want to thank you for the opportunity of being here to listen and express our views on H.R. 2792 and the other bills. In particular, Mr. Chairman, PVA would like to thank you for including many of PVA's legislative priorities as part of the bill. We certainly do appreciate that.

There are several provisions, as I said, in the bill that we support. There are others that we will oppose, and I will try to comment on each of these provisions as briefly as possible.

The Department of Veterans Affairs is currently authorized to provide guide dogs to blinded veterans with service-connected disabilities only. However, there are many veterans, both service-connected and non-service connected, who suffer from certain disabilities who would greatly benefit from having a service or guide dog. The *Journal of the American Medical Association* published a study in 1996 that assessed the value of service dogs for people with ambulatory disabilities. And the study demonstrated dramatic economic benefits of service dogs. After one year, the study found a decrease of 68 percent in paid assistance hours and a 64 percent decrease in unpaid assistance hours. And I request, Mr. Chairman, that a copy of the April 3, 1998, JAMA study be included as part of the record if possible.

[The attachment appears on p. 118.]

Mr. FULLER. We strongly object to the language that was introduced in the Senate version of this bill, and it was just testified to by the VA that it would restrict service dogs to only those veterans in receipt of disability compensation. With health care eligibility reform passed in 1996, we have moved to a uniform benefits package for all veterans enrolled for VA care. And as such, all veterans enrolled in the VA health care system, as provided for in H.R. 2792, your bill, should have the opportunity to receive the benefit of service and guide dogs where appropriate.

I might add for the record that the provision of guide dogs is no cost to the VA whatsoever. They are provided free, as is all the training. There are providers of service dogs who do charge for those, but there are also others who do not, that are also non-profit organizations. One, I think, in Kansas is called Aim High, and it uses inmates at Fort Leavenworth to train dogs for disabled veterans.

Section 3 of the bill addresses the maintenance of capacity, and we have testified on this issue before, Mr. Chairman. We greatly appreciate your bringing this to the fore as we reauthorize for 3 years the reporting criteria. PVA believes that we have developed a standard with the VA, or have been battling with the Department for years to determine, how do you define capacity? And finally last year we agreed to find a definition which was based on staffed beds and staff. We count them every month; it seems to work for us. We are concerned that the language which is included in the version of the bill that you have introduced only addresses resources, and we looked at that very early on. Only addressing resources is sort of fraught with mischief, because it doesn't really get a handle on what is going on.

We also would strongly suggest that the bill be amended to require that the maintenance of capacity should be part of the performance plans of both the medical center directors and the VISN directors. There needs to be accountability in there as well.

I would like to address section 4, which is the means-test threshold. PVA has argued in favor of a change in the means-test used by VA to determine whether veterans will be placed in enrollment categories 5 or 7 for a long time. These category placements are important because veterans enrolled in lower categories, such as 6 or 7, whose incomes are above current means-test levels are required to make co-payments for most of their care. Most importantly, vet-

erans placed in category 7 are at greater risk of losing access to VA health care due to upcoming potential budgetary constraints.

Congress, in establishing category 5, demonstrated its intention to provide health care without co-payment to veterans with lower incomes, intending to assess a veteran's ability to defray the cost of health care by a means test. Unfortunately, the current national "one-size-fits-all" means test fails to take into account the higher costs of living faced by certain veterans in different geographic locations.

As the attached white paper to my testimony discusses, we have identified an established formula implemented by the Department of Housing and Urban Development to set income limits for eligibility for low-income housing benefits. The HUD formula makes adjustments in means test eligibility based on the cost-of-living experience in almost every locality in the United States—north, east, south, and west. This proposal keeps the existing VA means-test threshold, meaning no veteran in any part of the country would lose existing enrollment status under the current floor.

However, thousands of veterans in every part of the country would have an improved cost-of-living adjusted standard to judge their ability or inability to defray the cost of their care. And that was the intention when the means test was enacted back in 1986.

Briefly, I would like to address the pilot program for coordination of ambulatory community hospital care, which is a larger name than this proposal had last year. PVA opposes this section very vociferously, which would allow non-service connected veterans in underserved areas to go to private health care inpatient facilities using their private health insurance.

The VA, as we said, would only pay for the co-payments associated with these health care visits. PVA is not opposed to contracting for medical services when there is a demonstrable lack of availability of certain services within the VA, but we do oppose efforts that would turn the VA into an insurer of health care rather than a provider of health care. And passage of this provision would not only represent a major departure from the usual delivery of VA health care services, but would provide disparate treatment of veterans depending on whether or not they have their own private health insurance.

It would also undermine the VA's ability to maintain specialized programs, as we have heard, by eroding the VA's patient and resource base. And I think what we need to underscore here, which was mentioned before, with a current inadequate health care appropriation, VA is finding it difficult to care for existing enrolled veterans, let alone subsidize an expansion of non-VA benefits and services to new beneficiaries.

Section 6 would force veterans currently using fee-based services in four geographic areas to receive their health care from a managed care provider. We oppose this section as well. People with disabilities are most at risk under a managed care regime. By its nature, a managed care plan is designed to limit and ration health care services. Forcing disabled veterans into a managed care plan would severely limit health care choice.

And as well, on H.R. 1136 very briefly, PVA does not support H.R. 1136, a bill that requires VA pharmacies to dispense medica-

tions on demand to veterans for prescriptions written by private practitioners. The VA, again, is a provider of health care. It has neither the resources nor the ability to be turned into a drugstore.

Thank you, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement of Mr. Fuller, with attachments, appear on p. 104.]

Mr. MORAN. Mr. Fuller, thank you very much. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you. Mr. Chairman, members of the subcommittee, I am pleased to present the views of the Disabled American Veterans on several pieces of legislation before the subcommittee.

I will begin with H.R. 2792. DAV is not opposed to favorable consideration of section 2 of this bill, which would authorize VA to provide service dogs to certain hearing-impaired veterans and veterans with spinal cord injury or dysfunction. Likewise, we do not object to favorable consideration of section 4 of H.R. 2792, concerning any change in the means test used by VA in determining enrollment priority.

We also have no objection to favorable consideration of section 7 of this bill, which would authorize bereavement counseling and mental health services for immediate family members of certain veterans.

We support section 3 of the bill, which would amend requirements for evaluating capacity levels for VA's specialized programs. We would, however, like to see this section of the bill further clarify VA's obligation to maintain its capacity in each network, and include a provision to hold VISN and medical directors accountable for maintaining capacity levels as directed by law.

We need specific information to appropriately assess if capacity is being met in each service area. For example, the types of programs available in each location, the number of patients treated in dedicated programs, the dollars expended on that care, the number of inpatient beds available when appropriate, and the number of full-time employees that support these specialized programs.

DAV is opposed to section 5 of this bill, which would allow certain veterans in underserved areas to seek inpatient services in private sector hospitals utilizing their own health insurance, with VA becoming a secondary payer of any out-of-pocket expenses. This initiative would encourage VA to refer patients, and the dollars used to subsidize their care, outside the VA system. We are deeply concerned that it would lose the appropriated dollars and third-party reimbursements that veterans bring to help underwrite the provision of care for all veterans using the facility, and endangering VA's ability to maintain its full range of specialized inpatient services.

DAV also is concerned about section 6 of H.R. 2792, which would establish a managed care pilot program for contract hospitalization and fee basis users. We believe this initiative may create a barrier for these veterans in getting the care they need. Managed care programs frequently limit care and do not offer the kinds of specialized services available from VA to disabled veterans. Additionally, this initiative may prevent these veterans from receiving care from

a physician with whom they have a positive, longstanding clinical relationship.

DAV is opposed to the final provision of H.R. 2792, section 8, which pertains to an extension of expiring collections authorities. Congress authorized VA to collect co-payments for treatment of non-service connected conditions as a temporary measure to achieve savings for deficit reductions. The delegates to our most recent National Convention passed a resolution opposing any legislation that would require VA to increase or extend the congressional authority for collection of co-payments.

We have also been requested to comment on H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001, and H.R. 1136. As written, DAV is opposed to H.R. 1435. As stated in our July 10 testimony before the Subcommittee on Benefits, this measure attempts to take away an intrinsic part of VA's mission of service to veterans and their families.

Based on an informal study conducted by DAV, we believe the VA telephone number is working. We do not believe that a private, non-profit organization would be better able to handle this function. As an amended version of this bill is incorporated in H.R. 2540 as a pilot program for VA to expand its current service hours, we support the language of that section 407 in H.R. 2540.

DAV has concerns about the final measure under consideration in H.R. 1136, which would require VA pharmacies to dispense medications to veterans with prescriptions written by private practitioners. We recognize that VA is experiencing a large influx of veterans seeking care, apparently to obtain low-cost medications through VA, and perhaps this legislation would result in a net savings to VA.

However, we foresee that if veterans were authorized to access prescription drug benefits only, a significant number of veterans who are not currently using the system would likely choose this option and thereby cause a significant increase in the rise of pharmaceutical costs to VA. Of great concern to the DAV is that if this measure were passed and not appropriately funded to meet the presumed increased cost in pharmaceuticals, it would be extremely detrimental to the VA health care system and to currently enrolled veterans.

That concludes my testimony. Thank you.

[The prepared statement of Ms. Ilem appears on p. 124.]

Mr. MORAN. Congratulations, Ms. Ilem, you read very quickly. Mr. Miller.

STATEMENT OF THOMAS H. MILLER

Mr. MILLER. Thank you very much. Mr. Chairman, members of the subcommittee, on behalf of the Blinded Veterans Association, I want to express our appreciation for the invitation to express our views this afternoon on H.R. 2792. Unfortunately, I can't read as fast as Joy and Richard, so I will be brief and concentrate my comments on H.R. 2792, The Disabled Veterans Service Dog and Health Care Improvement Act of 2001.

Mr. Chairman, I want to commend you especially for the introduction of this very, very important piece of legislation, and your staff for crafting the language in the bill. BVA strongly supports

section 2 of this bill, which would expand VA's authority to provide service dogs, hearing dogs, and guide dogs to certain disabled veterans. As has been previously testified to by my esteemed colleague Mr. Fuller and by your first panel, the benefits of utilization of service dogs or guide dogs by people who are blind has been well-documented, most recently, I guess, by the article in JAMA, which outlines in great detail the benefits derived from the utilization of service dogs by certain disabled people.

The use of guide dogs has a much longer and richer history. Everyone is familiar with guide dogs and the benefit they afford to people with severe visual impairment and blindness, enhancing their quality of life, their independence, and their ability to travel safely, efficiently, and independently. We are confident that service dogs will provide similar benefits to our disabled colleagues with ambulatory or hearing impairments.

I strongly disagree, however, with the Secretary in his testimony that these animals, these service dogs, guide dogs, hearing dogs, should be limited only to those veterans with service-connected disabilities. We believe that is inconsistent with the intent of the Eligibility Reform Act of 1996, and we would hope that these dogs could be provided to eligible veterans with the disabilities outlined in the legislation. As Mr. Fuller testified, there are no costs involved in the training or the provision of guide dogs for people who are blind. The only cost the VA may occur with regard to the provision of guide dogs would be veterinary bills that might be incurred during the life of the dog.

Additionally, a very, very small percentage of the blind community as a whole take advantage of using guide dogs. Less than four percent, and it is probably closer to two percent of people who are blind use guide dogs. And that is probably accurately reflective of the veteran population as well. Expanding the eligibility for receiving guide dogs is not going to cause a rush on the VA of blinded veterans seeking to get a guide dog. We expect that there will probably be very little change, but for those veterans who have a demonstrated need for and a demonstrated ability to benefit from a guide dog, we believe ought to have that opportunity and access to that dog. And similarly for those veterans with physical disabilities that can truly benefit from an assistive dog.

Section 3 of the bill, which would extend VA's requirement to maintain capacity to provide specialized rehabilitative services to disabled veterans and continue their reporting requirement for an additional 3 years, we strongly support. However, we would like to see this provision strengthened.

One of the weaknesses of the Eligibility Reform Act, from our perspective, particularly the provision requiring VA to maintain capacity, was that it allowed VA too much flexibility in terms of defining capacity and how it would be measured.

Another provision in that Eligibility Reform Act required the VA to review, have their capacity report annually reviewed by the Federal Advisory Committee on Prosthetics and Special Disabilities Programs. I have served on that advisory committee since its inception, and for the past several years have had the honor of chairing that committee. And throughout this process of VA reporting its maintenance of capacity, our committee has indeed reviewed that

report. It has been forwarded to the Hill for their review, and in each instance the committee has failed to endorse VA's assertion that they have indeed maintained capacity.

Many of the problems the committee has identified regarding concerns about capacity issues relate to the VA information management system, the lack of national standards and guidelines regarding how data will be captured, what data will be captured, how it will be rolled up, and have recommended in numerous reports the need for such national standards and guidelines, and accountability to ensure that networks across the system, as well as facilities, are adhering to these guidelines. There needs to be standard coding and costing procedures, so that everybody is coding workload in the same way, using the same system, and all the facilities and networks are costing services provided using the same software and the same methodology, so that national data can be rolled up and accurately reflect what the workload is and what the true costs of providing those services are.

I would also disagree with the Secretary regarding his request for flexibility to adjust the definition depending on new models of service delivery. We certainly are not opposed to innovative and new approaches to service delivery, but we are opposed to not funding and protecting the existing, proven services until new and innovative services have been adequately tested, evaluated, and functional outcome data supports that they will provide service at the same level as previously existing and maybe more costly programs that VA has operated for many, many years.

And I would agree with both Mr. Fuller and Ms. Ilem, with the need to have performance included in the performance measures that facility and network directors—maintenance of capacity is a very important measure. Accountability is critical across the board, throughout the networks and the facilities. And until we have had national standards against which all of these managers can be measured, we are going to have serious concerns about whether or not capacity is truly being maintained in the special disabilities programs.

Very briefly, we would also support section 4, the means test approach utilized by HUD, which reflects cost-of-living variances across the country. It would, we believe, provide greater access for certain veterans—greater equity of access for veterans for VA health care.

We would oppose, for all the reasons stated, section 5 and section 6. We have grave concerns about the availability of services to disabled veterans and specialized services, and we are concerned about the drain of resources from the MCCF fund in order to pay co-pays and deductibles for veterans receiving care in non-VA facilities.

Similarly, as has been previously testified by others, we have concerns about forcing veterans into managed care programs. As Mr. Filner indicated, there are horror stories in the news all the time about HMOs and managed care providers. And by virtue of their being for-profit organizations, they tend to want to enroll young, healthy individuals who don't require a lot of health care. As you look at the demographics of our veteran populations, we

have very few young, healthy veterans who are going to be seeking health care.

They are older. They are multiply medically involved, and they require many specialized services that may or may not be available to them through a managed care program or a non-VA facility. I agree strongly with Secretary Principi that philosophically we would agree that veterans should have easy access to care. But our concern is that the care that they have access to is high-quality care that will be capable of addressing the needs of those veterans that would be seeking that care and again, we would support section 7, the bereavement counseling—and that concludes my comments, Mr. Chairman. And again, thank you very much for allowing us to participate this afternoon.

[The prepared statement of Mr. Miller appears on p. 130.]

Mr. MORAN. Mr. Miller, thank you very much for your testimony. Ms. Garrick.

STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Mr. Chairman and members of the committee, good afternoon. The American Legion appreciates the opportunity to comment on the draft legislation under consideration here today. The American Legion has reviewed these issues and offers the following comments.

On H.R. 2792, section 2, the American Legion is aware of the vital services these animals offer in assisting persons with disabilities. The companionship and aid service dogs offer is well documented in the private sector, and eloquently spoken of today by Moira Shea and Beth Barkley. VA should make every effort to assess and provide all eligible veterans requesting service dogs with that option.

Section 3—the strength of the VA health care system is the experience it has in handling the unique health care concerns of the service-connected and catastrophically ill veteran. Spinal cord injury, blindness, amputation, traumatic brain injury, and mental illness are more prevalent in veterans than in the general population because of the dangerous nature of military service.

The American Legion does not believe that this legislation will ensure that the maintenance of capacity for disabled veterans will be protected. VA has been measuring capacity using this formula since eligibility reform passed, and each year the American Legion and her sister VSOs have testified on the lack of capacity for the special emphasis programs. This provision seems to be an attempt to circumvent the need for VA to return to its previous level of capacity. Therefore, the American Legion believes VA should not be allowed to reduce its capacity below the 1996 level.

Section 4—in its written statement, the American Legion fully supported section 4. However, in light of Secretary Principi's testimony here today, the American Legion now has reservations, since disenrolling priority 7 veterans would be in direct opposition to the American Legion position, and we will need to re-look at this provision.

Section 5—In the past, the American Legion has supported VA's use of contracts to expand access into rural communities where no VA care exists. However, the American Legion, through its national

field service site visit process, has known that in some cases contracts were poorly written and resulted in additional expenses and lack of control over the quality of patient care.

The American Legion passed a resolution to ensure that VA contracts were written to include precertification, utilization review, concurrent screening, repatriation of patients, and be negotiated by the VISN office. N addition, the community hospital must be accredited for the level of care it is contracted to perform, and must meet the same benchmarks for performance by which VA facilities would be held accountable.

Under these circumstances, the American Legion would support the proposed pilot program. Furthermore, there is no clear delineation for psychiatric services under this pilot, and if VA could contract as outlined by the American Legion, then patients with psychiatric diagnoses should not be discriminated against and should be offered the same type of access to inpatient care.

Section 6—under this program, the Secretary would provide, through a managed care coordinator contractor, contract hospitalization and fee basis for veterans already receiving care. The American Legion views this provision with trepidation. VA oversight of contracting process has not been stellar, as previously noted. The American Legion believes each contract proposal should meet the same criteria just outlined. Finally, the American Legion believes that severing the longstanding relationships between the veterans and their VA care provider, if the providers are not part of the managed care network, will ultimately result in the dissatisfaction of the veteran, and place a new added burden on VA nursing. The managed care network is too reminiscent of DOD's Tricare, which has left too many retirees and their families frustrated, dissatisfied, and disconnected.

Section 7—the American Legion has long been a proponent of allowing veterans' dependents access to VA health care, and includes this very concept in its GI Bill of Health. The expansion of services to bereaved spouses and families coping with mental illness is a step in the right direction.

In regard to H.R. 1435, this act would give VA authority to award a private entity the purposes of establishing a toll-free number. The VA currently has such a number. Given the complex nature of veterans' benefits and administration, the American Legion is skeptical that the establishment of such services by a private entity would not result in chaos, especially if there were two different numbers in place.

In regard to H.R. 1136, the American Legion has carefully weighed both sides of this issue as presented by VA leadership and the IG. VA has expressed serious concerns over patient safety and accountability if it were to act as a drug store. The IG did not support the concerns for quality or safety VA leadership has purported. The IG did find evidence that filling outside prescriptions would not result in poorer quality of care as long as safety provisions were in place. DOD does operate its formulary in this manner, and there have been no known documented cases whereby retirees suffered because DOD filled a wrongly written prescription or there was a drug interact.

The American Legion has received numerous contacts from veterans in favor of having their non-VA-provided prescription filled at a VA pharmacy. In a recent VA local user evaluation, or VALUE, survey, the American Legion documented that 88 percent of veterans use VA because of the prescription drug benefit. And many veterans commented on expanding this access.

The American Legion at this time feels there is enough evidence to support expanding the VA pharmacy benefit to include outside prescriptions. This mandate would have to be funded to take into account the increase in workload this would generate for VA.

Mr. Chairman and members of the committee, that concludes this statement. Thank you.

[The prepared statement of Ms. Garrick appears on p. 134.]

Mr. MORAN. Thank you very much. And Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Mr. Chairman and members of the subcommittee, I am pleased to be here today to present the views of AMVETS regarding proposed legislation before the panel.

Regarding H.R. 2792, the section on service dogs is welcomed, compassionate legislation. AMVETS began some time ago a donor partnership with a non-profit group called Paws With a Cause. Paws With a Cause trains service dogs, and matches them with disabled people.

AMVETS has seen firsthand how highly trained dogs can make a valuable contribution toward the miracle of independence. And, like everyone else, disabled veterans want to manage their lives with as much independence as humanly possible.

While we support the bill, the provision on dogs, AMVETS would like to make certain that it specifically authorizes payment for the cost of training service dogs. We were dismayed to hear this morning that the training of service dogs doesn't cost anything. We did hear, however, Secretary Principi say the costs ranged from $15,000 to $25,000. We do recognize that training service dogs does cost money. It also costs time. And these dogs need to be trained specifically for the needs of the client veterans they serve.

If the Secretary is to provide a service dog, as outlined in new subsection (c), he is also granted, we presume, the authority to pay for the trained dogs, the same as he is granted authority under subsection (d) to pay travel and incidental expenses incurred by the client-veteran.

It should be understood that not every assistance organization requires veterans to travel to a training center. Some organizations work in close quarters with the veteran, in the home and in the community, to develop a working team. Therefore, there is no travel involved on the part of these veterans.

AMVETS would note another potential benefit of service dogs, and that is cost-effectiveness. In a study published by the *Journal of the American Medical Association*, the value of the service dogs is measured in economic terms. The study finds that one service dog saves an average of $16,000 a year in costs that would otherwise go to pay for direct attendant care. Extrapolated over a 10-year lifespan of a dog's active assistance, the value of these service dogs helps make this legislation economically sound, too.

With regard to other sections of this legislation, AMVETS supports section 3, to maintain VA capacity for specialized treatment and rehabilitation of disabled veterans. AMVETS strongly believes that the core focus of the VA health system should be on assistance to, and treatment of, disabled veterans. We hear, however, that there may be some fine-tuning necessary to this section, and we would support that fine-tuning, as the other witnesses have described.

AMVETS supports section 4, regarding the use of an index among geographic localities as a way to determine who is, in fact, unable to defray the expenses of medical care. Clearly, the current use of a single national means test to determine the priority classification of veterans for VA health care fails to account for variations in the cost of living in the area where veterans reside.

Our preference, of course, is to eliminate the means test for veterans who served their country during periods of national emergency or war. A veteran is a veteran. We do not apply a means test when we send him or her in harm's way. Why, then, should we impose a service test after they have paid the price?

AMVETS supports the goals of section 5 and 6. We, too, want every veteran who has an injury or illness incurred in the defense of America to receive appropriate, world-class health care. We want their access to the system improved. Our bottom line is access to care for veterans, especially those who need specialized service, or who, because of their circumstances, rely on VA as their health provider. Our veterans deserve no less.

AMVETS remains concerned, however, about the resources currently available to the VA health care system. The challenges faced by VA and the veterans it serves are not easy. Clearly, the health care system is in dire need of additional funding caused by years of inadequate budget proposals. With next year's appropriations likely to fall short of meeting the challenges that face the system, it is difficult to see a positive effect on the quality, timeliness, and accessibility of health care received by our veterans, including those veterans who reside in your districts.

AMVETS supports section 7 to expand counseling services for families of veterans receiving VA treatment. This sort of benefit is what the Department of Veterans Affairs is all about—to help not only those who gave so much on behalf of the Nation, but also their families, who in turn help our heroes do what they do so the rest of us can live in freedom.

AMVETS supports H.R. 1435, a bill to establish a national toll-free telephone hotline for veterans and their dependents. AMVETS believes, however, that the opportunity to provide these services should not be limited solely to America's private non-profit community, as outlined in this bill. The bill should be amended to allow free, open, American competition, thereby giving the secretary the opportunity to choose the best provider for the job. We feel such a service would complement a series of 800 services already available to veterans and their dependents.

AMVETS has no position on H.R. 1136, a bill to require Department of Veterans Affairs pharmacies to dispense medication to veterans for prescriptions written by private practitioners without providing them primary care. We recognize that pharmaceutical costs

are rising within VHA as a proportion of overall medical care expenses. In some respects, the rising costs make it difficult for VA to carry out its other priority, health care services.

AMVETS is aware of estimates that suggest the open filling of prescriptions would require resources equal to as much as one-third of VA's current health care budget. That is a level of funding equivalent to providing VA medical care to more than 1 million veterans.

Clearly, if we are to come to grips with our honor and obligation to those who have worn the Nation's uniform, we must understand that freedom is not free. Its costs are measured in terms of lives lost; citizen soldiers who, together with their families, bear the scars, the injuries, of their service throughout the remainder of their adult lives.

Mr. Chairman, our veterans are indeed special. They are a unique national resource to whom we owe an enormous debt of gratitude. In sum, AMVETS firmly believes, as stated in The Independent Budget, that adequate funding remains the central issue of VA's health care system.

This concludes my testimony. Thank you for extending AMVETS the opportunity to appear before you today, and thank you for your support for veterans.

[The prepared statement of Mr. Jones appears on p. 138.]

Mr. MORAN. Mr. Jones, thank you very much. I thank the panel. And Mr. Filner, questions or comments?

Mr. FILNER. Thank you, Mr. Chairman. I thank the panel. I am glad to see we are all for the dogs and we are all against the turkeys. That is mainly as I heard it.

Mr. Chairman, had I been asked, I would have recommended that the American Federation of Government Employees, which represents, I think, almost 70 percent of the VA employees, be allowed to testify. Since they weren't asked, I would like to submit for the record a letter addressed to Chairman Smith, Chairman Moran, Ranking Member Evans, and myself, dated August 27, on the subjects of this hearing, if I may submit it.

Mr. MORAN. For the record, I have that letter, and it will be entered in the record without objection.

[The letter appears on p. 144.]

Mr. FILNER. Thank you, Mr. Chairman.

Let me say, Mr. Chairman, again, I hope that as we proceed on this subcommittee, we will have true input and dialogue on both sides of the aisle.

Let me just tell you very briefly two items which I would have recommended be on this hearing today. As you know, Mr. Chairman, I have long sought support for Filipino veterans that fought bravely alongside our GIs in the Philippines during World War II. Apparently because of conditions that exist today, Filipino veterans are dying at a higher rate than their U.S. counterparts. I think it is time, as the world's one true superpower, that we live up to the promises we made back in 1946 to these brave heroes. Veterans of the Commonwealth Army, for example, now have access to Medicare and Social Security, but not to the VA health system. I think we have to redress this grievance. And also, since Marcos no longer reigns in the Philippines, I think we can restore the grant we once

made routinely to the Philippines, to allow them to bolster their care for aging veterans there. So I would have recommended that we look at that issue.

And then secondly, I think we have to carefully consider additional recruitment and retention tools to offer the VA as it begins to confront the problem of severe shortages of certain types of health care personnel. For example, nurses comprise about 60 percent of the workforce. They are the lifeblood of medical centers. We need to proactively address the crisis of vacancies there, and do whatever it takes to ensure that the VA is able to compete as effectively as possible for scarce health personnel.

It is these kinds of issues, Mr. Chairman, that I think we should look at also. I look forward to working with you to address these issues, and to take a closer look at some of the problems that were brought up in the testimony today to H.R. 2792 as we move forward.

Thank you, Mr. Chairman.

Mr. MORAN. Mr. Filner, thank you very much. As you and I have previously discussed, I look forward to having a hearing concerning the issue of Filipinos and their medical benefits. And I also agree with you the serious issues we face in regard to health care professional recruitment and retention within the VA and within the health care system of our country. And I do welcome input and your suggestions as to how we can best address those needs.

And I appreciate one of the witnesses here at this table, the indication about draft legislation, because I see what is before us as that, an opportunity for us to take some ideas that we heard in testimony earlier this year, put them before the subcommittee, and flesh out those things which make sense and eliminate those which don't.

And so I look forward to working not only with Secretary Principi and Dr. Murphy, but certainly the folks at this panel and other VSOs as we try to find the right answers to the questions that are presented, not only by the legislation that we had the hearing on today, but also by the comments by our colleagues, Ms. Capps and Mr. Wicker, in regard to legislation that they would like to see the subcommittee address.

And in regard to concluding our hearing, I would without objection put into the record the testimony of Michael Sapp, the CEO of Paws With a Cause.

[The attachment appears on p. 147.]

Mr. MORAN. And also the testimony of Philip Litteer of Vietnam Veterans of America.

[The attachment appears on p. 154.]

Mr. MORAN. And without objection, those items are entered into the record, along with the letter of August the 27th from AFGE. We will hold the record open for 5 days.

And with that, the committee is adjourned.

[Whereupon, at 4:20 p.m., the subcommittee was adjourned.]

APPENDIX

I

107TH CONGRESS
1ST SESSION

H. R. 2792

To amend title 38 United States Code, to authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other improvements in health care benefits provided by the Department of Veterans Affairs, and for other purposes

IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 2001

Mr MORAN of Kansas (for himself, Mr SMITH of New Jersey, and Mr SIMMONS) introduced the following bill, which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other improvements in health care benefits provided by the Department of Veterans Affairs, and for other purposes

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Disabled Veterans
5 Service Dog and Health Care Improvement Act of 2001 ".

1 **SEC. 2. AUTHORIZATION FOR SECRETARY OF VETERANS**
2 **AFFAIRS TO PROVIDE SERVICE DOGS FOR**
3 **DISABLED VETERANS.**

4 (a) AUTHORITY.—Section 1714 of title 38, United
5 States Code, is amended—

6 (1) in subsection (b)—

7 (A) by striking "seeing-eye or" the first
8 place it appears;

9 (B) by striking "who are entitled to dis-
10 ability compensation" and inserting "who are
11 enrolled under section 1705 of this title";

12 (C) by striking ", and may pay" and all
13 that follows through "such seeing-eye or guide
14 dogs"; and

15 (D) by striking "handicap" and inserting
16 "disability"; and

17 (2) by adding at the end the following new sub-
18 sections:

19 "(c) The Secretary may provide—

20 "(1) service dogs trained for the aid of the
21 hearing impaired to veterans who are hearing im-
22 paired and are enrolled under section 1705 of this
23 title; and

24 "(2) service dogs trained for the aid of persons
25 with spinal cord injury or dysfunction or other
26 chronic impairment that substantially limits mobility

1 to veterans with such injury, dysfunction, or impair-
2 ment who are enrolled under section 1705 of this
3 title.
4 "(d) In the case of a veteran provided a dog under
5 subsection (b) or (c), the Secretary may pay travel and
6 incidental expenses for that veteran under the terms and
7 conditions set forth in section 111 of this title to and from
8 the veteran's home for expenses incurred in becoming ad-
9 justed to the dog.".
10 (b) CLERICAL AMENDMENTS.—
11 (1) The heading for such section is amended to
12 read as follows:
13 **"§ 1714. Fitting and training in use of prosthetic ap-**
14 **pliances; guide dogs; service dogs".**
15 (2) The item relating to such section in the
16 table of sections at the beginning of chapter 17 of
17 such title is amended to read as follows:

"1714 Fitting and training in use of prosthetic appliances, guide dogs, service dogs."

18 **SEC. 3. MAINTENANCE OF CAPACITY FOR SPECIALIZED**
19 **TREATMENT AND REHABILITATIVE NEEDS OF**
20 **DISABLED VETERANS.**
21 (a) MAINTENANCE OF CAPACITY ON A SERVICE-NET-
22 WORK BASIS.—Paragraph (1) of section 1706(b) of title
23 38, United States Code, is amended—

1 (1) in the first sentence, by inserting "(and
2 each geographic service area of the Veterans Health
3 Administration)" after "ensure that the Depart-
4 ment";
5 (2) in clause (B), by inserting "(and each geo-
6 graphic service area of the Veterans Health Admin-
7 istration)" after "overall capacity of the Depart-
8 ment"; and
9 (3) by inserting after the first sentence the fol-
10 lowing new sentence: "The capacity of the Depart-
11 ment (and each geographic service area of the Vet-
12 erans Health Administration) to provide for the spe-
13 cialized treatment and rehabilitative needs of dis-
14 abled veterans (including veterans with spinal cord
15 dysfunction, blindness, amputations, and mental ill-
16 ness) within distinct programs or facilities shall be
17 measured by the annual amount (adjusted for infla-
18 tion) expended for care of such veterans in dedicated
19 programs which provide such specialized treatment
20 and rehabilitative services through specialized
21 staff.".
22 (b) EXTENSION OF ANNUAL REPORT REQUIRE-
23 MENT.—Paragraph (2) of such section is amended by
24 striking "April 1, 1999, April 1, 2000, and April 1, 2001"
25 and inserting "April 1 of each year through 2004".

1 **SEC. 4. THRESHOLD FOR VETERANS HEALTH CARE ELIGI-**
2 **BILITY MEANS TEST TO REFLECT LOCALITY**
3 **COST-OF-LIVING VARIATIONS.**

4 (a) REVISED THRESHOLD.—Subsection (b) of section
5 1722 is amended to read as follows:

6 "(b) For purposes of subsection (a)(3), the income
7 threshold applicable to a veteran is the greater of the fol-
8 lowing:

9 "(1) For any calendar year after 2000—

10 "(A) in the case of a veteran with no de-
11 pendents, $23,688, as adjusted pursuant to
12 subsection (c); or

13 "(B) in the case of a veteran with one or
14 more dependents, $28,429, as so adjusted, plus
15 $1,586, as so adjusted, for each dependent in
16 excess of one.

17 "(2) The amount in effect under the HUD Low
18 Income Index that is applicable in the area in which
19 the veteran resides.".

20 (b) HUD LOW INCOME INDEX.—Subsection (b) of
21 such section is further amended by adding at the end the
22 following new paragraph:

23 "(3) For purposes of paragraph (1)(B), the term
24 'HUD Low Income Index' means the family income ceiling
25 amounts determined by the Secretary of Housing and
26 Urban Development under section 3(b)(2) of the United

1 States Housing Act of 1937 (42 U.S.C. 1437a(b)(2)) for
2 purposes of the determination of 'low-income families'
3 under that section.".

4 (c) CONFORMING AMENDMENTS.—Such section is
5 further amended—

6 (1) in subsection (b)(2), by striking "December
7 31, 1990" and inserting "December 31, 2001"; and

8 (2) in subsection (c), by striking "subsection
9 (b)" and inserting "subsection (b)(1)".

10 (d) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on April 1, 2002.

12 **SEC. 5. PILOT PROGRAM FOR COORDINATION OF AMBULA-**
13 **TORY COMMUNITY HOSPITAL CARE.**

14 (a) IN GENERAL.—Chapter 17 of title 38, United
15 States Code, is amended by inserting after section 1725
16 the following new section:

17 **"§ 1725A. Coordination of hospital benefits: pilot pro-**
18 **gram**

19 "(a) PILOT PROGRAM.—Subject to the availability of
20 funds specified in subsection (g), the Secretary shall carry
21 out a pilot program in not more than four geographic
22 areas of the United States to improve access to, and co-
23 ordination of, inpatient care of eligible veterans. Under the
24 pilot program, the Secretary, subject to subsection (b),
25 shall pay certain costs described in subsection (b) for

1 which an eligible veteran would otherwise be personally lia-
2 ble. The authority to carry out the pilot program shall ex-
3 pire on September 30, 2006.

4 "(b) PAYMENT OF COSTS.—In carrying out the pro-
5 gram described in subsection (a), the Secretary may pay
6 the costs authorized under this section for hospital care
7 and medical services furnished on an inpatient basis in
8 a non-Department hospital to an eligible veteran partici-
9 pating in the program. Such payment may cover the costs
10 for applicable plan deductibles and coinsurance and the
11 reasonable costs of such inpatient care and medical serv-
12 ices not covered by any applicable health-care plan of the
13 veteran, but only to the extent such care and services are
14 of the kind authorized under this chapter. The Secretary
15 shall limit the care and services for which payment may
16 be made under the program to general medical and sur-
17 gical services and shall require that such services may be
18 provided only upon preauthorization by the Secretary.

19 "(c) ELIGIBLE VETERANS.—(1) A veteran described
20 in paragraph (1) or (2) of section 1710(a) of this title
21 is eligible to participate in the pilot program if the
22 veteran—

23 "(A) is enrolled to receive medical services from
24 an outpatient clinic operated by the Secretary which
25 is (i) within reasonable proximity to the principal

1 residence of the veteran, and (ii) located within the
2 geographic area in which the Secretary is carrying
3 out the program described in subsection (a);
4 "(B) has received care under this chapter with-
5 in the 24-month period preceding the veteran's ap-
6 plication for enrollment in the pilot program;
7 "(C) as determined by the Secretary before the
8 hospitalization of the veteran (i) requires such hos-
9 pital care and services for a non-service-connected
10 condition, and (ii) could not receive such services
11 from a clinic operated by the Secretary; and
12 "(D) elects to receive such care under a health-
13 care plan (other than under this title) under which
14 the veteran is entitled to receive such care.
15 "(2) Nothing in this section shall be construed to re-
16 duce the authority of the Secretary to contract with non-
17 Department facilities for care of a service-connected dis-
18 ability of a veteran.
19 "(3) Notwithstanding subparagraph (D) of para-
20 graph (1), the Secretary shall ensure that not less than
21 15 percent of the veterans participating in the program
22 are veterans who do not have a health-care plan.
23 "(d) CASE MANAGEMENT.—As part of the program
24 under this section, the Secretary shall, through provision
25 of case-management, coordinate the care being furnished

1 directly by the Secretary and care furnished under the
2 program in non-Department hospitals to veterans partici-
3 pating in the program.

4 "(e) DESIGNATION OF PARTICIPATING SITES.—(1)
5 In designating geographic areas in which to establish the
6 program under subsection (a), the Secretary shall ensure
7 that—

8 "(A) the areas designated are geographically
9 dispersed;

10 "(B) at least 70 percent of the veterans who re-
11 side in a designated area reside at least two hours
12 driving distance from the closest medical center op-
13 erated by the Secretary which provides medical and
14 surgical hospital care; and

15 "(C) the establishment of the program in any
16 such area would not result in jeopardizing the crit-
17 ical mass of patients needed to maintain a Depart-
18 ment medical center that serves that area.

19 "(2) Notwithstanding paragraph (1)(B), the Sec-
20 retary may designate for participation in the program at
21 least one area which is in proximity to a Department med-
22 ical center which, as a result of a change in mission of
23 that center, does not provide hospital care.

24 "(f) REPORTS.—(1) Not later than September 30,
25 2003, the Secretary shall submit to the Committees on

1 Veterans' Affairs of the Senate and House of Representa-
2 tives a report on the experience in implementing the pilot
3 program under subsection (a).

4 "(2) Not later than September 30, 2005, the Sec-
5 retary shall submit to those committees a report on the
6 experience in operating the pilot program during the first
7 two full fiscal years during which the pilot program is con-
8 ducted. That report shall include—

9 "(A) a comparison of the costs incurred by the
10 Secretary under the program and the cost experience
11 for the calendar year preceding establishment of the
12 program at each site at which the program is oper-
13 ated;

14 "(B) an assessment of the satisfaction of the
15 participants in the program; and

16 "(C) an analysis of the effect of the program on
17 access and quality of care for veterans.

18 "(g) FUNDING LIMITATIONS.—(1) The total amount
19 expended for the pilot program in any fiscal year (includ-
20 ing amounts for administrative costs) may not exceed
21 $50,000,000.

22 "(2) Any expenditure of funds for the pilot program
23 shall be made from amounts in the Medical Care Collec-
24 tions Fund attributable to collections under section 1729
25 of this title. No funds may be expended to support the

1 purposes of this section from any other funds available
2 to the Secretary for the delivery of health care services
3 to veterans, including funds appropriated or otherwise
4 available for the care and treatment of veterans who re-
5 quire specialized care and resources.

6 "(h) HEALTH-CARE PLAN DEFINED.—For purposes
7 of this section, the term 'health-care plan' has the mean-
8 ing given that term in section 1725(f)(3) of this title.".

9 (b) CLERICAL AMENDMENT.—The table of sections
10 at the beginning of such chapter is amended by inserting
11 after the item relating to section 1725 the following new
12 item

"1725A. Coordination of hospital benefits pilot program."

13 **SEC. 6. PILOT PROGRAM FOR CONTRACT HOSPITALIZA-**
14 **TION AND FEE BASIS AMBULATORY CARE.**

15 (a) ESTABLISHMENT OF PROGRAM.—The Secretary
16 of Veterans Affairs shall conduct a pilot program under
17 which veterans receiving fee basis and contract hos-
18 pitalization under sections 1703 and 1728 of title 38,
19 United States Code, in selected service areas of the Vet-
20 erans Health Administration shall be provided such hos-
21 pitalization through a contractor that is a managed care
22 coordinator. The program shall be conducted during the
23 three-year period beginning on July 1, 2002.

24 (b) SITES FOR PROGRAM.—The Secretary shall con-
25 duct the pilot program in not less than four geographic

1 service areas of the Veterans Health Administration that
2 are selected by the Secretary for participation in the pro-
3 gram from among such service areas that are located in
4 areas that the Secretary determines exhibit mature man-
5 aged care markets. Under the program, to the extent prac-
6 ticable all fee basis and contract hospitalization provided
7 by the Secretary in a selected geographic service area shall
8 be provided through a managed care coordinator con-
9 tractor.

10 (c) SELECTION OF CONTRACTOR.—The Secretary
11 shall select a contractor for the pilot program not later
12 than six months after the date of the enactment of this
13 Act. The contractor shall be an experienced managed care
14 coordinator with an in-place network of credentialed pro-
15 viders.

16 (d) AUTOMATIC ENROLLMENT.—Each veteran who is
17 enrolled under section 1705 of title 38, United States
18 Code, who resides in a geographic service area selected for
19 participation in the pilot program, and who as of the com-
20 mencement of the pilot program is authorized use of non-
21 VA care services through fee basis programs of the De-
22 partment, or who is eligible for contract hospitalization
23 under section 1703 or 1728 of title 38, United States
24 Code, shall be automatically enrolled for participation in
25 the pilot program. Each such veteran shall be provided

1 a directory of credentialed health care providers from
2 which to choose when approved by the Secretary to receive
3 non-VA care or to use in health emergencies in the case
4 of contract hospitalization.

5 (e) PROGRAM FEATURES.—As part of the program,
6 the Secretary shall provide for the following:

7 (1) Use of commercial-industry standards (or in
8 their absence, Department standards) for access,
9 timeliness, patient satisfaction measures, and utiliza-
10 tion management.

11 (2) Assignment of a primary care manager at
12 each department medical center participating in the
13 program.

14 (3) Establishment by the contractor of a toll-
15 free telephone system staffed by registered nurses to
16 provide advice and health care referral information
17 to veterans enrolled in the pilot program on a 24-
18 hour a day, seven-day a week basis.

19 (4) Establishment by the contractor of a vet-
20 erans service telephone line for the provision of in-
21 formation on eligibility, enrollment, and provider lo-
22 cations.

23 (5) Concurrent review.

24 (6) Demand management.

25 (7) Disease management.

1 (8) Health and wellness programs.

2 (f) PRIMARY CARE MANAGER FUNCTIONS.—Each
3 primary care manager provided for pursuant to subsection
4 (e)(2) shall have responsibility for the coordination and
5 case management of each veteran enrolled under section
6 1705 of title 38, United States Code, through that medical
7 center who is enrolled in the pilot program pursuant to
8 subsection (d), to ensure that such veterans receive the
9 appropriate care, and that the veteran is brought back into
10 the VA system for followup whenever possible and appro-
11 priate.

12 (g) REPORTS.—(1) Not later than October 1, 2003,
13 the Secretary shall submit to Congress a report on the
14 operation of the pilot program through June 30, 2003.
15 That report shall include the Secretary's assessment of—

16 (A) the adequacy of the managed care net-
17 works;

18 (B) patient satisfaction surveys completed by
19 veterans participating in the program;

20 (C) cost savings to the Department as a result
21 of care provided through the program; and

22 (D) proposed uses for savings if the pilot pro-
23 gram were implemented on a permanent basis
24 throughout the Department for the management of
25 non-VA care.

1 (2) Not later than October 1, 2004, the Secretary
2 shall submit a report to Congress on the program through
3 June 30, 2004. The Secretary shall include in that report
4 the matters specified in paragraph (1) and the Secretary's
5 recommendation for implementing on a nationwide basis
6 the management system tested in the pilot program.

7 (h) GAO REVIEW.—Not later than June 30, 2005,
8 the Comptroller General of the United States shall con-
9 duct a review of the pilot program and shall provide to
10 Congress the Comptroller General's findings and rec-
11 ommendations concerning the program.

12 (i) NON-VA CARE DEFINED.—For purposes of this
13 section, the term "non-VA care" means care provided in
14 a facility other than a facility of the Veterans Health Ad-
15 ministration or by a health care provider who is not an
16 employee of the Veterans Health Administration.

17 **SEC. 7. RECODIFICATION OF BEREAVEMENT COUNSELING**
18 **AUTHORITY AND CERTAIN OTHER HEALTH-**
19 **RELATED AUTHORITIES.**

20 (a) STATUTORY REORGANIZATION.—Subchapter I of
21 chapter 17 of title 38, United States Code, is amended—

22 (1) in section 1701(6)—

23 (A) by striking subparagraph (B) and the
24 sentence following that subparagraph;

1 (B) by striking "services—" in the matter
2 preceding subparagraph (A) and inserting
3 "services, the following:"; and
4 (C) by striking subparagraph (A) and in-
5 serting the following:
6 "(A) Surgical services.
7 "(B) Dental services and appliances as de-
8 scribed in sections 1710 and 1712 of this title.
9 "(C) Optometric and podiatric services.
10 "(D) Preventive health services.
11 "(E) In the case of a person otherwise receiving
12 care or services under this chapter—
13 "(i) wheelchairs, artificial limbs, trusses,
14 and similar appliances;
15 "(ii) special clothing made necessary by
16 the wearing of prosthetic appliances; and
17 "(iii) such other supplies or services as the
18 Secretary determines to be reasonable and nec-
19 essary.
20 "(F) Travel and incidental expenses pursuant
21 to section 111 of this title."; and
22 (2) in section 1707—
23 (A) by inserting "(a)" at the beginning of
24 the text of the section; and
25 (B) by adding at the end the following:

1 "(b) The Secretary may furnish sensori-neural aids
2 only in accordance with guidelines prescribed by the Sec-
3 retary.".

4 (b) CONSOLIDATION OF PROVISIONS RELATING TO
5 PERSONS OTHER THAN VETERANS.—Such chapter is fur-
6 ther amended by adding at the end the following new sub-
7 chapter:

8 "SUBCHAPTER VIII—HEALTH CARE OF
9 PERSONS OTHER THAN VETERANS

10 **"§ 1782. Counseling, training, and mental health serv-**
11 **ices for immediate family members**

12 "(a) COUNSELING FOR FAMILY MEMBERS OF VET-
13 ERANS RECEIVING SERVICE-CONNECTED TREATMENT.—
14 In the case of a veteran who is receiving treatment for
15 a service-connected disability pursuant to paragraph (1)
16 or (2) of section 1710(a) of this title, the Secretary shall
17 provide to individuals described in subsection (c) such con-
18 sultation, professional counseling, training, and mental
19 health services as are necessary in connection with that
20 treatment.

21 "(b) COUNSELING FOR FAMILY MEMBERS OF VET-
22 ERANS RECEIVING NON-SERVICE-CONNECTED TREAT-
23 MENT.—In the case of a veteran who is eligible to receive
24 treatment for a non-service-connected disability under the
25 conditions described in paragraph (1), (2), or (3) of sec-

1 tion 1710(a) of this title, the Secretary may, in the discre-
2 tion of the Secretary, provide to individuals described in
3 subsection (c) such consultation, professional counseling,
4 training, and mental health services as are necessary in
5 connection with that treatment if—

6 "(1) those services were initiated during the
7 veteran's hospitalization; and

8 "(2) the continued provision of those services
9 on an outpatient basis is essential to permit the dis-
10 charge of the veteran from the hospital.

11 "(c) ELIGIBLE INDIVIDUALS.—Individuals who may
12 be provided services under this subsection are—

13 "(1) the members of the immediate family or
14 the legal guardian of a veteran; or

15 "(2) the individual in whose household such vet-
16 eran certifies an intention to live.

17 "(d) TRAVEL AND TRANSPORTATION AUTHOR-
18 IZED.—Services provided under subsections (a) and (b)
19 may include, under the terms and conditions set forth in
20 section 111 of this title, travel and incidental expenses of
21 individuals described in subsection (c) in the case of—

22 "(1) a veteran who is receiving care for a serv-
23 ice-connected disability; and

1 "(2) a dependent or survivor receiving care
2 under the last sentence of section 1783(b) of this
3 title.

4 **"§ 1783. Bereavement counseling**

5 "(a) DEATHS OF VETERANS.—In the case of an indi-
6 vidual who was a recipient of services under section 1782
7 of this title at the time of the death of the veteran, the
8 Secretary may provide bereavement counseling to that in-
9 dividual in the case of a death—

10 "(1) that was unexpected; or

11 "(2) that occurred while the veteran was par-
12 ticipating in a hospice program (or a similar pro-
13 gram) conducted by the Secretary.

14 "(b) DEATHS IN ACTIVE SERVICE.—The Secretary
15 may provide bereavement counseling to an individual who
16 is a member of the immediate family of a member of the
17 Armed Forces who dies in the active military, naval, or
18 air service in the line of duty and under circumstances
19 not due to the person's own misconduct.

20 "(c) BEREAVEMENT COUNSELING DEFINED.—For
21 purposes of this section, the term 'bereavement counseling'
22 means such counseling services, for a limited period, as
23 the Secretary determines to be reasonable and necessary
24 to assist an individual with the emotional and psycho-

1 logical stress accompanying the death of another indi-
2 vidual.

3 **"§ 1784. Humanitarian care**

4 "The Secretary may furnish hospital care or medical
5 services as a humanitarian service in emergency cases, but
6 the Secretary shall charge for such care and services at
7 rates prescribed by the Secretary.".

8 (c) TRANSFER OF CHAMPVA SECTION.—Section
9 1713 of such title is—

10 (1) transferred to subchapter VIII of chapter
11 17 of such title, as added by subsection (b), and in-
12 serted after the subchapter heading;

13 (2) redesignated as section 1781; and

14 (3) amended by adding at the end of subsection
15 (b) the following new sentence: "A dependent or sur-
16 vivor receiving care under the preceding sentence
17 shall be eligible for the same medical services as a
18 veteran, including services under sections 1782 and
19 1783 of this title.".

20 (d) REPEAL OF RECODIFIED AUTHORITY.—Section
21 1711 of such title is amended by striking subsection (b).

22 (e) CROSS REFERENCE AMENDMENTS.—Such title is
23 further amended as follows:

24 (1) Section 103(d)(5)(B) is amended by strik-
25 ing "1713" and inserting "1781".

(2) Sections 1701(5) is amended by striking "1713(b)" in subparagraphs (B) and (C)(i) and inserting "1781(b)".

(3) Section 1712A(b) is amended—

(A) in the last sentence of paragraph (1), by striking "section 1711(b)" and inserting "section 1784"; and

(A) in paragraph (2), by striking "section 1701(6)(B)" and inserting "sections 1782 and 1783".

(4) Section 1729(f) is amended by striking "section 1711(b)" and inserting "section 1784".

(5) Section 1729A(b) is amended—

(A) by redesignating paragraph (7) as paragraph (8), and

(B) by inserting after paragraph (6) the following new paragraph (7):

"(7) Section 1784 of this title.".

(6) Section 8111(g) is amended—

(A) in paragraph (4), by inserting "services under sections 1782 and 1783 of this title" after "of this title,"; and

(B) in paragraph (5), by striking "section 1711(b) or 1713" and inserting "section 1782, 1783, or 1784".

1 (7) Section 8111A(a)(2) is amended by insert-
2 ing ", and the term 'medical services' includes serv-
3 ices under sections 1782 and 1783 of this title" be-
4 fore the period at the end.
5 (8) Section 8152(3) is amended by inserting
6 "services under sections 1782 and 1783 of this title"
7 after "of this title),".
8 (9) Sections 8502(b), 8520(a), and 8521 are
9 amended by striking "the last sentence of section
10 1713(b)" and inserting "the penultimate sentence of
11 section 1781(b)".
12 (f) CLERICAL AMENDMENTS.—
13 (1) The table of sections at the beginning of
14 such chapter is amended—
15 (A) by striking the item relating to section
16 1707 and inserting the following:

"1707. Limitations.";

17 (B) by striking the item relating to section
18 1713; and
19 (C) by adding at the end the following:

"SUBCHAPTER VIII—HEALTH CARE OF PERSONS OTHER THAN VETERANS

"1781. Medical care for survivors and dependents of certain veterans
"1782. Counseling, training, and mental health services for immediate family members
"1783. Bereavement counseling
"1784. Humanitarian care."

20 (2) The heading for section 1707 is amended to
21 read as follows:

1 **"§ 1707. Limitations".**

2 **SEC. 8. EXTENSION OF EXPIRING COLLECTIONS AUTHORI-**

3 **TIES.**

4 Sections 1710(f)(2)(B) and 1729(a)(2)(E) of title 38,

5 United States Code, are each amended by striking "Sep-

6 tember 30, 2002" and inserting "September 30, 2007".

○

107TH CONGRESS
1ST SESSION

H. R. 1435

To authorize the Secretary of Veterans Affairs to award grants to provide for a national toll-free hotline to provide information and assistance to veterans.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2001

Mrs. CAPPS (for herself, Mr. EVANS, Mr. TOWNS, Ms. JACKSON-LEE of Texas, Mr. LUTHER, Ms. NORTON, Mr. MOORE, Mr. KILDEE, Mr. ROSS, Mr. OWENS, Ms. WOOLSEY, Mr. DOYLE, Mr. LANTOS, Mr. GONZALEZ, Ms. MCKINNEY, Mr. BLUMENAUER, Mr. SANDERS, Mr. HOLDEN, Ms. WATERS, Mr. HONDA, Mr. PASCRELL, Mrs. MALONEY of New York, Mrs. CHRISTENSEN, Mr. STRICKLAND, Mr. MEEHAN, Mrs. NAPOLITANO, Mr. MASCARA, Mr. NEAL of Massachusetts, Mr. HINOJOSA, Mr. BOUCHER, Mr. SHERMAN, Ms. DELAURO, Mr. WYNN, Ms. KILPATRICK, Mr. MOLLOHAN, Mr. UDALL of New Mexico, Mr. FILNER, Mr. FALEOMAVAEGA, Mr. COYNE, Ms. HOOLEY of Oregon, Mr. FROST, Mr. LEWIS of Georgia, Mr. RAHALL, Mr. MORAN of Virginia, Mr. OBERSTAR, Mr. WEXLER, Mr. BECERRA, Mr. RODRIGUEZ, Mr. KIND, Ms. SLAUGHTER, Mr. UNDERWOOD, Mr. BERMAN, Ms. BALDWIN, Ms. CARSON of Indiana, Mrs. TAUSCHER, Mr. STUPAK, Mr. EHRLICH, and Mr. ENGLISH) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To authorize the Secretary of Veterans Affairs to award grants to provide for a national toll-free hotline to provide information and assistance to veterans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Veterans' Emergency
3 Telephone Service Act of 2001".

4 **SEC. 2. NATIONAL VETERANS ASSISTANCE HOTLINE**
5 **GRANT.**

6 (a) AUTHORITY TO AWARD GRANTS.—The Secretary
7 of Veterans Affairs may award a grant to a private, non-
8 profit entity to provide for the operation of a national, toll-
9 free telephone hotline to provide information and assist-
10 ance to veterans and their families, including crisis inter-
11 vention counseling, general information with respect to
12 veterans benefits under title 38, United States Code, refer-
13 rals to appropriate individuals with expertise in such vet-
14 erans benefits, and information with respect to the provi-
15 sion of emergency shelter and food, substance abuse reha-
16 bilitation, employment training and opportunities, and
17 small business assistance programs.

18 (b) DURATION.—A grant under this section may ex-
19 tend over a period of not more than two years.

20 (c) ANNUAL APPROVAL.—The provision of payments
21 under a grant under this section shall be subject to annual
22 approval by the Secretary and subject to the availability
23 of appropriations for each fiscal year to make the pay-
24 ments.

25 (d) ACTIVITIES.—Funds received by an entity under
26 this section shall be used to establish and operate a na-

1 tional, toll-free telephone hotline to provide information
2 and assistance to veterans. In establishing and operating
3 the hotline, a private, nonprofit entity shall—
4 (1) contract with a carrier for the use of a toll-
5 free telephone line;
6 (2) employ, train, and supervise personnel to
7 answer incoming calls and provide counseling and
8 referral services to callers on a 24-hour-a-day basis;
9 (3) assemble and maintain a current database
10 of information relating to services for veterans to
11 which callers may be referred throughout the United
12 States; and
13 (4) publicize the hotline to potential users
14 throughout the United States.
15 (e) APPLICATION.—A grant may not be made under
16 this section unless an application for such grant has been
17 approved by the Secretary. To be approved by the Sec-
18 retary under this subsection an application shall—
19 (1) contain such agreements, assurances, and
20 information, be in such form and be submitted in
21 such manner as the Secretary shall prescribe
22 through notice in the Federal Register;
23 (2) include a complete description of the appli-
24 cant's plan for the operation of a national veterans
25 assistance hotline grant, including descriptions of—

1 (A) the training program for hotline per-
2 sonnel;
3 (B) the hiring criteria for hotline per-
4 sonnel;
5 (C) the methods for the creation, mainte-
6 nance and updating of a resource database;
7 (D) a plan for publicizing the availability
8 of the hotline;
9 (E) a plan for providing service to non-
10 English speaking callers, including hotline per-
11 sonnel who speak Spanish; and
12 (F) a plan for facilitating access to the
13 hotline by persons with hearing impairments;
14 (3) demonstrate that the applicant has nation-
15 ally recognized expertise in the area of furnishing
16 assistance to veterans and a record of high quality
17 service in furnishing such assistance, including a
18 demonstration of support from advocacy groups,
19 such as Veterans Service Organizations; and
20 (4) contain such other information as the Sec-
21 retary may require.
22 (f) AUTHORIZATION OF APPROPRIATIONS.—
23 (1) IN GENERAL.—There are authorized to be
24 appropriated to carry out this section $2,000,000 for
25 each of fiscal years 2002 and 2003.

1 (2) AVAILABILITY.—Funds authorized to be ap-
2 propriated under paragraph (1) shall remain avail-
3 able until expended.

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107TH CONGRESS
1ST SESSION

H. R. 1136

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 2001

Mr WICKER (for himself, Mr PICKERING, Ms. MCKINNEY, Mr. BOUCHER, Mrs. MEEK of Florida, Mr. SHOWS, Mrs. MINK of Hawaii, Mr. SCHAFFER, Mr NORWOOD, Mr STUPAK, Mr. PAUL, Ms. HART, and Mr CRAMER) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. AUTHORITY OF DEPARTMENT OF VETERANS**
2 **AFFAIRS PHARMACIES TO DISPENSE MEDICA-**
3 **TIONS TO VETERANS ON PRESCRIPTIONS**
4 **WRITTEN BY PRIVATE PRACTITIONERS.**

5 (a) AUTHORITY.—Section 1712(d) of title 38, United
6 States Code, is amended to read as follows:

7 "(d) Subject to section 1722A of this title, the Sec-
8 retary shall furnish to a veteran such drugs and medicines
9 as may be ordered on prescription of a duly licensed physi-
10 cian in the treatment of any illness or injury of the vet-
11 eran.".

12 (b) CLERICAL AMENDMENTS.—(1) The heading of
13 section 1712 of such title is amended by striking the sixth
14 through ninth words.

15 (2) The item relating to section 1712 in the table of
16 sections at the beginning of chapter 17 of such title is
17 amended by striking the sixth through ninth words.

○

Statement of Lane Evans
Ranking Member, Committee on Veterans' Affairs
Hearing on Health Legislation
September 6, 2001

Good afternoon. I am pleased to have an opportunity to speak to H.R. 2792, the legislation Chairman Moran has introduced for our consideration. I know that we will be working together to perfect this proposal and I look forward to being involved in that process.

I am pleased to support the provision for which the bill is named that would authorize VA to provide service dogs for disabled veterans. We have all seen the benefits these dogs can provide in helping veterans with serious disabilities lead more productive lives. I am also pleased that this bill attempts to tackle the difficulties that remain in assessing VA's specialized programs for its most seriously disabled veterans. I hope to offer some additional comments about applying a standard that will achieve what I believe is a common goal—assuring the integrity of these programs developed on behalf of our most vulnerable veterans.

However, I am concerned about some of the provisions in H.R. 2792. We have long struggled with the redistribution effects that the Veterans Equitable Resource Allocation system has had in many areas of this country, including in the network that serves many of the veterans in my district. I believe that applying a means test to the health care eligibility threshold is well intended, but would have an enormously disruptive effect on the system. Like the Secretary, I am happy to assess alternatives that may work toward some shared goals.

I also have concerns about embracing Section 5 of this bill, which I understand is the same provision we supported as part of H.R. 5109. What has changed my support is the number of additional priorities VA has for the extremely limited resources it will have available in FY 2002.

I know that we have many expert witnesses to hear from this afternoon so I will close here. Mr. Chairman, I certainly look forward to working with you in supporting a bill that can receive the support of both Democrats and Republicans. Thank you.

House Committee on Veterans' Affairs
Subcommittee on Health
September 6, 2001
Testimony of Moira M. Shea

My name is Moira Shea, although I work as a Senior Policy Advisor for Congresswoman Morella, I am here today as a private citizen.

I thank you Chairman Moran for your invitation to testify here today on H.R. 2793, "The Disabled Veterans Service Dogs and Health Care Improvement Act of 2001" my comments will apply to only Section II of this bill.

With my testimony, I hope to be eloquent enough to communicate the great services that both working dogs can provide to people with disabilities.

I have Usher's Syndrome, the leading cause of deaf-blindness in the United States. When I was a baby and not responding to the ring of the phone my parents learned that I was hearing impaired. When I was 15 and tripping over things in broad day light, my parents learned that I was going blind. I have a progressive vision loss. Every year I see less and less. I am now losing my reading vision.

In 1993, I thought I had MS, my legs would not move when I would try to cross the streets, in reality I was paralyzed with fear, too scared to move, fearing that I would be hit by a bike or a car.

I could no longer trust my vision, and I just could not bring myself to use a white cane.

About that time, I learned that one did not need to be totally blind to use a guide dog. I applied to the Leader Dogs for the Blind school in Rochester Michigan.

It was the toughest decision but the best decision I have ever made in my life. I was totally unprepared for the great benefits I would receive.

I found with my dog, that I could in essence "see" better. For example when I would go to the airport. I could see just enough to give my dog directions to the gate, and he would guide me there without bumping into people or tripping over luggage.

He does escalators, revolving doors, he knows his left from right. I no longer had to hold on to someone to get around.

He is a marker to others that I cannot see well.

I gained so much independence with my dog, I had more energy when I got to the office in the morning because I was no longer stressed getting there. I never thought the dog

would become my companion, but he did, and with that, he took away a life long fear of going blind, and gave me peace.

I have lost this horrific fear of going blind. There is no fear like slowly losing your vision. Simply put, it is torture. You lose a little, you learn to accommodate and then you lose more, you are in a constant state of grieving.

I found soon after getting my dog, that I no longer had that fear. I know that no matter what, I will always, until a cure is found, be safe with a remarkable, loyal, steadfast guide dog by my side.

I am a very independent, self sufficient person, With my guide dog, I was able to keep my job, I was able to keep my dignity.

Mr. Chairman, it is my hope that with enactment of this legislation, that there will be a rigorous evaluation and strong certification process for these dogs put in place. Today one can get a dog, and claim that they have trained the dog to be either their guide dog or a service dog. Too often these individuals have no qualifications to train a dog, and all too often the dogs are very poorly trained.

This does a great disservice to those of us who depend on well trained working dogs and work hard for access for all working dogs.

It is my hope that the Veterans Administration will set a standard, raise the bar, and ensure that all working dogs are well trained and pass a certification process, which will ensure that they are performing the needed services. Working dogs are not pets, they have an enormous responsibility for the personal safety of their handlers.

With a rigorous certification process in place for working dogs, American veterans will be assured that they are getting the best, a well trained dog with an ideal disposition for working.

Mr. Chairman, I commend you and the Subcommittee staff for being proactive and expanding the service of providing guide dogs to the veterans who are blind to include service dogs for in those in need.

I am sure that many of America's veterans will derive benefits that cannot be measured.

Thank you

1

The Veterans Subcommittee on Health
Hearing regarding H.R. 2792, Disabled Veterans Service Dogs and Health Care Improvement Act of 2001

Views of Ms. Beth Barkley, Vice President, A Rinty of Kids™, Inc., on HR 2792's provision to authorize Veterans to receive Service Dogs

Honorable Ladies and Gentlemen,

Thank you for the opportunity to speak to the important issue of Service Assistance Dogs for Veterans. Your excellent work and vision, as represented by H. R. 2792, provides opportunities for our Veterans to improve and normalize their lives.

Humans and canines have worked together for a long time. There are many proposed eras for the beginning of that association, and lengthy arguments to support each time period. It is sufficient to say that our partnership with dogs is ancient. Unfortunately some of the earliest "civilized" writings about dogs come from the early urbanization of humans, and those writings portray an animal that has gone from hunting partner to city scavenger in a particular area of the world. The written word is powerful to humans, so those early writings have given undue weight to the view of dogs as "unclean" and of little value. Far more evidence exists of the enhancements dogs bring to human life! Whether guarding, herding, leading, searching, hearing, assisting, or being a companion, the role of dogs as human partners is ever expanding.

In the beginning of the twentieth century in the United States, the general public became used to Guide Dogs for people with visual impairments. Hearing Dogs, for people with hearing disabilities have gained acceptance. Increasingly we read about, or see on television, reports on Assistance Dogs who help people with physical disabilities. An emerging discipline is the Psychiatric Service Dog.

Dogs have, compared to humans, a huge capacity to identify, sort, and retain scents. Dogs' primary means of communication is body language – which we humans don't read too well. Because certain dogs can predict an imminent seizure in their partner, there is research being done into the ability of dogs to recognize the changes in that the human brain experiences (chemical? electrical? We don't know yet) prior to the onset of seizures. Dogs are routinely trained to detect minute amounts of drugs, acellerants, explosives, as well as meat and vegetable material. From that training we produce Drug Dogs, Fire Dogs, and Bomb Dogs for law enforcement agencies, and the Beagle Brigade for the Department of

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Agriculture. Dogs have also been trained to indicate human skin cancer, and research in training is underway to expand to other types of cancer. Dairy herd owners use dogs to detect the proper time to artificially inseminate a cow. Search and Rescue Dogs find people who are lost or trapped, bodies of disaster and homicide victims, and body fluid evidence for law enforcement.

Guide Dogs help their human partners negotiate through the environment. Hearing Dogs alert their human partners to particular sounds in the environment. Assistance Dogs help their human partners overcome and mitigate the condition that disables the human. All of these dogs that work with humans are using their highly developed sense of smell, their acute power of observation, and other abilities, as well as their genetic predisposition to partner with us.

Assistance Dogs do the obvious tasks: retrieving objects, providing pulling power for wheelchairs, opening doors, taking objects from the partner to another place or person, reacting to a medical crisis in a specified way, physically assisting the person into or out of the wheelchair or bed or bathroom facility. In addition, **and most importantly,** Assistance Dogs can be trained to meet the **individual needs** of their human partner such as providing assistance in balance or pulling the bed clothes off or onto their partner. Appendix One is a list of common tasks for Assistance Dogs that I compiled from experience and from research on the Internet. **The end result of all these tasks is to increase the independence of the human and provide for their safety. The overall improvement to the quality of life for the human partnered with an Assistance Dog cannot be overemphasized.**

We often see programs about the athlete with a disability. The athlete who participates in wheelchair races develops strong arm, shoulder, and back muscles to propel themselves along. Others find special equipment, or develop it themselves, to participate in sporting activities. Some people, however, have disabilities that require them to husband their strength rather than strive to develop it. They may not seem disabled at first glance. Their hidden disability can be degenerative. An Assistance Dog that opens doors (handle, lever, "panic push bar"), or retrieves the dropped object, or reaches up to bring or place or activate something, helps their partner conserve the energy and reduces the "wear and tear" on joints and reduces the likelihood of injury. It is as if these folks were given a set amount of movements to "spend." Every movement (task) that the Service Dog performs for them avoids a withdrawal from their movement bank! People who suffer from chronic pain as a result of their disability can be helped in similar fashion.

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Psychiatric Service Dog training was developed and brought to public light in 1997 by Joan Froling of Sterling Heights, Michigan. A mobility impaired Service Dog trainer, Ms. Froling has done extensive research into developing Service Dog tasks for those suffering from Panic Disorder, Post Traumatic Stress Disorder (PTSD), and disabling Depression. In Appendix Two I have included her list of tasks for this type of Service Dog.

I will speak only briefly regarding the Americans with Disabilities Act. Since 1990 the numbers of Service Dogs has increased dramatically. Acceptance of these dogs in public places, in compliance with the ADA, has also increased, but not in parallel with the numbers of Service Dogs. There are still too many incidences of ignorance of the law or outright rejection of the rights of persons with Assistance Dogs. I can only imagine the distress of a person partnered with a Service Dog as they approach yet another public facility and wonder what attitude and situation they will be confronted with *this time*. Part of the problem is, of course, the varying State Laws that exist to regulate Service Dogs. As an example, imagine being a partner with an Assistance Dog in the Washington, D. C., area, and how much paperwork you would need to keep with you to address concerns by restaurant managers in Virginia, Maryland, and DC! The ADA and compliance is fruitful ground for another subcommittee, so I will leave it alone.

There is a serious life-long commitment on the part of the Assistance Dog provider, trainer, and disabled recipient. Dogs are living beings. They are the alien species that chose to live with us (unlike cats that let us live with them!). They do not have removable batteries or off switches. They cannot be deactivated like a toy and put on the shelf until further need. Many, many people do not believe that a dog is a life-long commitment. Look at the number of public and private shelters in the United States and how many dogs are killed because they do not have a home. An estimate by the ASPCA in 1998 reported 15 dogs were alive for every adult in the USA. I don't know the accuracy of that estimate or what the number might be today, but I know that there are too many dogs being killed for frivolous reasons. Taking a dog into your home is a life-long responsibility – the life of the dog (and I don't think dogs live long enough!). The recipient of a Service Dog must understand the commitment. If they have a family, the family must understand the commitment.

A human must have regular medical treatment, eat well, exercise appropriately, pick up their trash, behave well, and be loved. All those things are true for the Assistance Dog, too! The dog must be healthy and have regular veterinary care. This assures a dog that remains in good

health for service, and assures the public that zoonotic diseases are not a concern. The dog must have time off from work, time when they can exercise and be a dog. The dog must be well trained, behave well, and know the tasks that their partner requires. And the dog must be loved – unloved dogs do not thrive and they do not maintain a high level of working ability. Call it the mammal baseline for life, what is necessary for the human is necessary for the dog!

Service Dogs require basic training and specific training. Basic training, which includes all types of socialization from weaning forward, is most often done in a foster home. Strict guidelines and tasks to be learned are provided to the approved foster home. The dog must be non-aggressive to humans and other animals (dogs, cats, squirrels, birds) that might be encountered during a days activities. They learn to be non-disruptive (meaning no inappropriate vocalizations), they must be most thoroughly house broken, and must be clean (as odor free and free of loose hair as possible).

When the young dog emerges from the foster home they are ready to learn specific tasks. While there are some common tasks for Service Dogs, bringing an object is an example, most of the tasks will be specific to the recipient. It is common for a Service Dog and partner to have the trainer go to them, observe the life needs of the partner, and do the specific task training on-site. Trainers often go to the home of the Assistance Dog and partner after the initial training to "fine tune" tasks, or develop new tasks based on need.

This level of individual training is a must, both for dog and recipient partner, and there are costs associated with this training. Estimates range from $15,000 to $25,000 per dog, and that includes volunteer help. Foster homes usually receive money only for dog food and veterinary care. The organizations sponsoring Assistance Dogs are most often non-profit, relying on donations for operating expenses (Appendix Three lists some Web pages of Assistance Dog organizations and links). Some trainers are paid, but not usually enough to provide a living income (they sell other types of training to exist). Expenses would include, among others, trainers time, facilities, food and veterinary care, dog transportation, training equipment, harnesses, jackets, identification cards, recipient transportation and time. While donations have sustained the training and placement of most existing Assistance Dogs, you need only hear about the extensive waiting lists for these dogs to know that donations are not meeting the need and many deserving partners do not yet have their Assistance Dogs.

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It is reassuring to note that the tasks (or training criteria) listed by the organizations providing Assistance Dogs are relatively standard across the world. This is a unique and precious circumstance as there seems to be little to no fighting between organizations on what an Assistance Dog needs to know. This is not often the case in emerging disciplines and speaks to the understanding and research done by Assistance Dog organizations.

The conclusions are clear: there is an extensive need for Assistance Dogs. There are standard tasks identified as a basis for Assistance Dog training. There is consensus that specific tasks must be developed and taught for each dog/partner team. There are large and small organizations sponsoring Assistance Dog training, most of which are non-profit The benefits provided by Assistance Dogs are many and range from help with mobility, balance, preservation of strength, and object retrieval and placement, to seizure detection, partner safety, and securing help for the partner. The appropriate law exists on the Federal level to allow access for Assistance Dogs and partners. Many states have laws that further define Assistance Dog access (such as where dogs in training are allowed). It is time our disabled veterans are routinely provided the opportunity to benefit from Assistance Dog use. Our veterans should be authorized to receive Assistance Dogs per H.R. 2792.

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APPENDIX ONE

What are the tasks that an Assistance Dog can do?

- Pull wheelchair
- Open doors, close doors
- Pick up objects
- Place objects (putting money on a tall counter)
- Repeatedly bring objects (newspaper every day from door)
- Carry objects (eg. notes) to designated person (by learned name or from hand indication)
- Bring telephone
- Replace telephone
- Carry or drag bags (books, groceries)
- Bring own food bowl
- Bring named clothing (coat, gloves, boots, shoes)
- Place items in clothes washer
- Pull items from clothes dryer
- Drag wheelchair to bedside
- Seek and find named person
- Go out on command, touch objects until correct one is indicated, bring back (or by laser indication)
- Carry items between partner and others
- Place items in trash can
- Bring bag with medication from usual place
- Bring liquid drink (in can or container)
- Open closets, cupboards
- Turn off or on lights
- Bring TV or radio remote control on command (or even find it!)
- Open refrigerator door
- Open and close bathroom stall door
- Pull off shoes, socks, trousers, etc.
- Pull covers on or off of partner in bed
- Bring leash, collar, harness to partner
- Bring duffel bag with "dog equipment" to partner, from vehicle, off of hook on wheelchair, etc.
- Knock receiver off of large button telephone and push "911" pre-programmed button with nose or paw
- Carry appropriate weight of objects (papers, laptop PC, cell telephone, etc.) in back pack
- Bark, and continue barking, for help
- Brace and assist partner in and out of wheelchair, bed, toilet, bath, vehicle, etc.
- Brace on command
- Wake up partner at sound of smoke alarm

APPENDIX TWO

What are the tasks that a Psychiatric Assistance Dog can do?

- Mobility tasks as listed in APPENDIX ONE
- Fetch medication bag, purse, etc., from normal place
- Lead partner to designated exit from office
- Use appropriate telephone to dial (pre-programmed button) 911 on hearing smoke alarm
- Nudge partner during "freezing" episode (panic attack, Parkinson's Disease suffer) to enable further movement
- Go to specified family member and bark for emergency help
- Leave house/office and go to specified neighbor and bark for emergency help
- Remove photo ID card and/or explanation card from back pack or pocket on wheelchair for speech impaired partner and hand it to designated person
- Notify partner at specific, repetitive times of day to take medication
- Alert partner and assist them out of room or building at sound of smoke alarm
- Place themselves between partner and anyone else on command for partners with Reflex Sympathy Dystrophy, other painful condition, or traumatic claustrophobic syndrome
- Vocalize on hand signal in order to provide "excuse" for partner to leave area when panic attack is imminent
- Search vehicle or home for intruders before partner enters

While the public is not encouraged to think of the Assistance Dog as a defensive device and they are not trained to attack, training the dog to look around and/or bark on a hand signal can provide the partner with added security in isolated situations (at the ATM) or when suspicions are aroused.

APPENDIX THREE

Various Web sites for Assistance Dog organizations, many containing further links. The sheer number of sites on the Web devoted to Assistance Dog training organizations is testament to the validity of these dogs and the great need for them.

The Delta Society

Independence Dogs Inc.

International Association of Assistance Dog Partners

Assistance Dogs International Inc.

Canine Companions for Independence

Assistance Dogs of America Inc

A Rinty For Kids (ARF Kids) Inc.

Another informative site:

Dr. P's Assistance Dogs

A. E. (BETH) BARKLEY
2334 Great Falls Street
Falls Church, Virginia 22046-2311
703 532-3848

DOG TRAINING AND HANDLING EXPERIENCE

Cadaver Dog Handling Experience:

- Search and Rescue Dog Handler 1980-1990, D.O.G.S. East, Inc Searches throughout the mid-Atlantic region and overseas
- Search and Rescue Dog Handler 1986-1999, United States Disaster Team (OFDA) Searches in El Salvador and Armenia.
- Search and Rescue Dog and Cadaver Dog Handler 1988-1999. FEMA Search and Rescue, Virginia Task Force #1 Searches throughout the United States
- Cadaver Dog Handler and Search and Rescue Dog Handler 1990-present, Northern Virginia Search and Rescue Dogs of Search Services America (NOVASARD). Searches throughout the United States and Canada.

Deployment Highlights:

- 1985 West Virginia floods, three recoveries
- 1986 San Salvador, El Salvador earthquake, eight live finds, numerous recoveries
- 1988 Armenia earthquake, numerous recoveries
- 1992 Virginia homicides, two recoveries
- 1992 Virginia lost, one recovery
- 1993 Virginia homicide, evidence recovery
- 1993 Virginia suicide, one recovery
- 1994 Virginia lost, one recovery
- 1994 Manitoba, Canada lost, one recovery
- 1995 Oklahoma City, Oklahoma, numerous recoveries, evidence recovery
- 1995 Virginia floods, one recovery
- 1996 Virginia lost, evidence recovery
- 1997 Virginia suicides, three recoveries
- 1998 Massachusetts/New Hampshire suicide, one recovery
- 1998 Ontario, Canada lost, one recovery
- 1999 Virginia homicide, evidence recovery
- 2000 North Carolina abduction, evidence recovery
- 2001 North Carolina homicide, evidence recovery

Cadaver Dog classes and tests taken:

- 1990 – Virginia Department of Emergency Services Cadaver Dog Clinic, Richmond, VA Instructor Andy Rehmann. 20 hour class, attended with Canine Sirius
- 1992 – K-9 Specialty Search School, North Franklin, CT: Instructor Andy Rehmann Two week class, attended with Canine SAR Czar.
- 1992 – Passed K-9 Specialty Search School Cadaver Dog Certification with Canine SAR Czar instructor Andy Rehmann
- 1999 – Passed NOVASARD Cadaver Dog Certification, Basic, with Canine YoYo.
- 2001 – Re-certified NOVASARD Cadaver Dog Certification, Advanced, with Canine SAR Czar
- 2001 – Passed NOVASARD Cadaver Dog Certification, Basic and Advanced, with Canine Fearghas.

Presentation and Demonstration Highlights include National Association for Search and Rescue (three national seminar presentations); Virginia Department of Emergency Management (twenty-one presentations and demonstrations); Federal Bureau of Investigation (two demonstrations and one presentation); Fairfax County Police Department (multiple presentations and demonstrations), Congressional Subcommittee on Urban Collapse (presentation and demonstration), Loudon County Sheriffs Department (presentation and demonstration); Quantico Marine Corps Range Control Officers (three presentations and demonstrations).

SAR, Cadaver Dog, and Handler Training experience

- Instructor for Virginia Department of Emergency Management 1986, at more than thirty-five Ground Search and Rescue Colleges
- Training Director for D.O.G.S. East, Inc., 1985-1990
- Training Director for NOVASARD, 1990-present
- Owner and Lead Trainer for Find 'Em K9 Training, 1996-present, seminars given.
  - ✓ 1996 – Volunteer and Law Enforcement Handlers, Virginia
  - ✓ 1997 – Volunteer Handlers, Manitoba, Canada
  - ✓ 1998 - Volunteer and Law Enforcement Handlers, Virginia
  - ✓ 1998 - Volunteer and Law Enforcement Handlers, Houston, Texas
  - ✓ 1999 - Volunteer and Law Enforcement Handlers, Virginia
  - ✓ 2001 - Volunteer and Law Enforcement Handlers, Virginia

Committee and Developmental Activities:

- Member of the Congressional Subcommittee on Urban Collapse, 1990
- Member of the FEMA Developmental Committee on Standards for Disaster Search and Rescue Dogs, 1991
- Founding Trainer for the FEMA Disaster Search and Rescue Dog School, Camp Atterbury, Indiana

Assistance Dog Training:

- Re-training of Seizure Detection Dog for 16 year old
- Training of Basic and Specific Tasks for Assistance Dog for 12 year old quadraplegic
- Training of Specific Tasks for Assistance Dog for 9 year old paraplegic
- Training of Basic Tasks for Hearing Dog for 31 year old hearing impared person (2nd dog)

Personal Canines used for search

- Panda 1980-1989
- SAR Czar 1990-2001
- Jadzia 1996-1997
- YoYo 1999-2000
- Fearghus 2000-present
- Gustav 2001 - in training

September 6, 2001

I have not received any Federal Grant or contract for any Assistance Dog at any time.

ARF Kids (A Rinty for Kids), Inc., has not received any Federal Grant or contract for any Assistance Dog at any time.

Beth Barkley
Vice President
ARF Kids, Inc.

Testimony of
The Honorable Lois Capps
Committee on Veterans' Affairs
Subcommittee on Health
September 6, 2001

I am grateful to Chairman Moran, Ranking Member Filner, and the Subcommittee for the opportunity to comment on two very important bills before you today The Veterans Emergency Telephone Act and The Disabled Veterans Service Dog and Health Care Improvement Act. As the author of the first bill and an original co-sponsor in the last Congress for a key provision in the second bill, I am pleased the Subcommittee is considering these important pro-vet measures

H.R 1435, The Veterans Emergency Telephone Service Act, sets up a toll free national veterans' hotline service that can be accessed 24-hours, 7 days a week. This combination "911-411" number for veterans would provide a one-stop, toll free number that veterans can call at any time of day or night for assistance The bill is based on a similar, very successful program that is operated on a smaller scale by the National Veterans Foundation in Los Angeles My bill currently has 71 cosponsors.

In the past, toll free information lines for vets have typically dumped them into a frustrating automated system of repeated transfers and long waiting periods Despite the wide array of services offered by the Department of Veterans Affairs, many veterans assistance programs are unknown to the constituency they intend to support

I would like to commend the full Committee and the Subcommittee on Benefits, for their leadership in the recent establishment of a pilot program to expand access to the Department of Veterans Affairs' benefits counselors. As part of H.R. 2540, the VA will operate its information lines no less than 12 hours a day, Monday through Friday and no less than six hours on Saturday. This expansion of access will be an important step forward in the effort to provide the quality and breadth of service that we owe to our veterans. However, I submit that we can and should go farther.

Lately, I have heard that the VA has made improvements in the operation of their information lines. If that is the case, and I hope it is, I commend the VA for their progress However, recently one of my staff called the information line operated by the VA and was forced to wait on hold for 31 minutes.

Even if the information lines have improved, their availability and scope continues to be limited by design. And crisis intervention is not a service that is currently provided to veterans over the information line.

Sadly, there is a critical need for veterans and their loved ones to have 24-hour/ 7 day a week access to information and crisis intervention services. Should this bill become law, veterans in need of assistance would be able to call from anywhere in the

country, free of charge, to receive immediate help or referral to services close to their homes

This service would provide immediate and constant access to counseling and crisis intervention services, including suicide prevention, substance abuse rehabilitation programs, and mental health services. It would provide vital information to destitute veterans in need of emergency food and shelter services. Some calls may be so desperate, immediate crisis intervention is essential to save a life.

This hotline would also provide information on medical treatment, employment training and opportunities, and small business assistance programs.

For routine inquiries that are normally and capably handled by existing toll-free numbers at the VA, the "911-411" operators may simply give general guidance and refer the caller to the appropriate VA resource

The "911-411" hotline has a bargain basement cost when compared to its far-reaching and much-needed benefits. I have seen a business plan that shows costs of only $2 million per year for a hotline that would be available to veterans at any time of the day or night in all 50 states. This is a small price to pay for the critical, urgent assistance that it provides for our veterans.

By virtue of their service and sacrifice on behalf of this nation, our veterans deserve the very best support services we can provide them, especially in their moments of greatest need. Sadly, such moments don't always occur during business hours, six days a week

Another important bill before you today is H.R 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001 As you know, language very similar to Section 5 of this bill was passed by this Committee and the House last year as part of H.R. 5109, Department of Veterans Affairs Health Care Personnel Act of 2000. I would like to commend the Subcommittee for its bipartisan support of this important legislation last year. I would also like to thank Dr. Weldon for his outstanding ongoing leadership on this issue It was gratifying to see the House pass this bill unanimously although I was disappointed that it was not successful in the Senate.

The need for this provision is as great today as it was last year. Section 5 would create a pilot program in not more than four remote geographic areas to allow veterans to receive inpatient care at local hospitals. It would allow the Veterans Administration to contract with local non-VA medical facilities to care for veterans who live a significant distance from a VA hospital.

Today, the veterans in my district on the central coast of California must drive to Los Angeles or to Fresno for hospital care under the VA That means a trip of 2 ½ to 5 hours to check into a hospital. This puts an unnecessary burden on people who served this nation so bravely. If a veteran is so sick that he or she needs inpatient hospital care,

they should not be forced to drive hundreds of miles for treatment This is very inconvenient, and it means that veterans are often in hospitals far away from family and friends For many, the hardship is enough to make the hospitals inaccessible for all practical purposes.

This provision gives veterans more health care choices and provides more viable options for their care. This is a pilot project, the results of which should be carefully studied It is not intended to undermine the Veterans' Administration specialized hospital care in any way Rather, it would augment it. I sincerely hope the Subcommittee will approve this measure as expeditiously as possible.

Again, I thank the Subcommittee for this opportunity to testify on these two important issues.

Testimony by Representative Roger Wicker
House Veterans Affairs Health Subcommittee
September 6, 2001

I appreciate the opportunity to testify on behalf of H.R. 1136, legislation which has bipartisan support and is cosponsored by 43 of our colleagues, including the Ranking Member of this Subcommittee, Mr. Filner I am pleased this panel is considering this change in law because it will save tax dollars and enable the VA to be more responsive to our nation's veterans

For veterans in Mississippi and other states, it is often difficult and expensive to drive to a VA facility for a prescription. I have discussed this issue with veterans from across my state, and they share similar experiences. The comments of one North Mississippi man are typical. He makes the point that no one knows his medical history better than his family doctor, whom he has seen for more than 40 years. He questions the need to travel 25 miles to a VA clinic or sometimes 100 miles to the VA hospital in Memphis when the same service could be provided closer to home. Veterans often see their local doctors and have prescriptions written, but the medication cannot be filled by the VA until they are examined by a VA physician.

H.R. 1136 will provide veterans the option of obtaining their prescriptions from a physician outside the VA bureaucracy. The Veterans Prescription Access Improvement Act will offer an alternative approach to thousands of veterans who would prefer to absorb the costs associated with a visit to a private physician instead of utilizing VA facilities.

Although this problem may be felt most acutely in rural areas, this bill will improve access to health care for all veterans. As the ranking member of the full Committee correctly pointed out in a recent Dear Colleague, our nation's veterans face unreasonable delays when they seek care. If a veteran in the first district of Mississippi called today to the Memphis, Tennessee, VA hospital to get an appointment with a doctor, they would be lucky to get on the schedule by November.

There are several possible solutions to this problem. As a member of the Appropriations Committee, and a former member of the VA/HUD Subcommittee, I have supported increased funding for veterans medical care. Congress has increased funding for veterans health care by 23% in the past three years, including the $1 billion increase in

the FY 02 VA/HUD bill But in addition to this increased funding, we should also consider new approaches to improve access and quality of care for our veterans at a reduced cost.

In a December 2000 report, the Inspector General of the Department of Veterans Affairs stated that many veterans use the VA solely for the purpose of filling prescriptions originally written by private physicians. In order to acquire the less expensive drugs provided by the VA, a veteran will undergo exams by both a VA doctor and a private physician.

The Inspector General's report stated:

"We believe that the processes VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility and/or private insurance coverage who choose to be treated by private non-VA health care providers must frequently, as a result of these processes, submit to duplicate exams, tests, and procedures by VHA simply in order to receive their prescriptions. As a result, VA medical centers frequently end up spending more on scarce clinical resources to "re-write" prescriptions than the prescriptions themselves cost "

The Inspector General determined that the Department of Veterans Affairs could save over $1 billion a year by allowing the VA to fill prescriptions written by private physicians -- money which could be spent on needed care for our veterans

Not only will the enactment of this proposal save money, it will reduce the backlog at crowded VA facilities by allowing some patients to choose an alternative method of care, closer to home, while freeing up VA medical staff so that they can attend to other patients

Critics of this proposal have said that it could result in added demand for prescriptions which the Treasury could not afford. However, easier access to medication should be a goal for which we strive. Veterans should not have to go without necessary medical care because of the inefficiencies in the current system. Further, as the IG report stated, the waste in the current system significantly exceeds the added cost of prescription drugs under a system proposed by HR 1136. In addition, it is reasonable to expect that

the VA's drug purchasing power will increase, thereby making the cost of drugs even less

Other concerns have been raised that quality of care will be diminished if this legislation is enacted. I suggest that the opposite will occur. If access to prescription medication is increased, more veterans will have the benefits of affordable prescription drugs.

As the IG's report found, most "priority group 7" veterans use the VA only for prescriptions since they prefer to use their private physicians. This could be attributed to the high rate of turnover of VA medical staff, the difficulty in getting an appointment with the same doctor time after time, or the lack of coordination of care in the current system

The veterans in the First district of Mississippi most often utilize either the VA hospital in Jackson, Mississippi, or Memphis, Tennessee Both of these medical centers are teaching facilities which depend on relatively short-term staff, a problem which is compounded by the high turnover of full time VA medical staff. This creates a lack of continuity of care in these facilities as compared to what is offered by a hometown doctor.

This is not a new concept. The VA already has a system in place to provide prescription drugs to veterans whose prescriptions are written by a private physician. However, under current law, only veterans who are "permanently housebound or in need of regular aid and attendance" may obtain their prescriptions in this manner. Typically, this system, which currently serves approximately 3.7 million veterans, is used to treat long term conditions such as high blood pressure, asthma, or diabetes. The VA could expand the existing mail order program to serve more veterans.

A model for the implementation of this expanded service could be the Department of Defense, which has for years allowed private physicians to write prescriptions which are filled by the Military Health Services System. The Department of Defense currently fills approximately 30 million prescriptions a year which are written by civilian physicians, about one-half of the total number of prescriptions which are handled. The military does not require a second visit to a military physician.

The Department of Defense has improved its technology to improve medication safety Its computer system has a shared patient database which screens against adverse drug reactions and potential drug stockpiling Just like a retail pharmacy, the military pharmacy can always call the prescribing physician if there are any questions about the prescription.

As we all work together to improve access and quality of care for our nation's veterans, our focus should be on the veteran and not the bureaucracy. We must pursue solutions that serve the veterans who served us Congress has correctly made veterans health care one of our highest priorities. This is reflected by substantial funding increases and the enactment of legislation to expand hospital services and outpatient care. This bill further strengthens that commitment.

I thank the Committee again for your consideration of this legislation

STATEMENT OF
ANTHONY J. PRINCIPI
SECRETARY
DEPARTMENT OF VETERANS AFFAIRS
ON
PROPOSED LEGISLATION
BEFORE THE
SUBCOMMITEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

September 6, 2001

Mr. Chairman and Members of the Subcommittee·

I am pleased to be here this morning to comment on H. R. 2792, the "Disabled Veterans Service Dog and Health Care Improvement Act of 2001." If enacted, this bill would authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other changes in health care benefits provided by the Department of Veterans Affairs. This morning I would like to briefly summarize the various sections of the bill, and provide VA's views of these sections.

Section 2 - Service Dogs

The bill would amend the existing law to expand VA's authority to provide guide dogs to blind veterans. Current law limits the provision of guide dogs to blind veterans who are entitled to disability compensation. The bill removes that limitation and would authorize VA to provide service dogs to veterans who are hearing impaired or who have spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility Service dogs can assist a disabled person in his or her daily life and can assist that person during medical emergencies. They can be trained in many tasks, including, but not limited to, pulling a wheelchair, carrying a back-pack, opening and closing doors, helping with dressing and undressing, retrieving dropped items, picking up the telephone, and hitting a distress button on the telephone. Some service dogs can perceive when the disabled individual is in distress and can find help. Dogs can also assist the hearing impaired by alerting them to doorbells, ringing phones, smoke detectors, crying babies, and emergency sirens on vehicles.

The existing statutory authority allows VA to pay for certain travel and incidental expenses incurred by veterans while adjusting to seeing-eye or guide dogs. The bill would amend the language to allow VA to pay these expenses for all guide dogs or service dogs covered by this legislation.

Mr. Chairman, the benefit of guide dogs for the blind is well known, and we support having authority to also provide service dogs for veterans who are hearing impaired and who have spinal cord injuries or other chronic impairments, and to pay for certain costs associated with adjusting to the dogs. However, we believe the provision of guide dogs and service dogs should continue to be limited to veterans who are entitled to service-connected compensation. If this provision becomes law, we would promulgate prescription criteria and guidelines to insure that we provide dogs only to those veterans who can most benefit from them.

Section 3 - Maintaining Capacity

Section 3 of the bill addresses VA's statutory obligation to maintain the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness. As you know, Mr. Chairman, Congress imposed this requirement with the enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262. The law requires that capacity be maintained at its 1996 level. The bill would amend the statute to require that VA maintain this capacity not only in the Department as a whole, but within each geographic service area, or VISN, of the Veterans Health Administration Additionally, the bill adds new language stating that the capacity to provide specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities must be measured by the annual amount spent for the care of such veterans in dedicated programs that provide these services through specialized staff. VA's obligation to report on compliance with this requirement is extended through 2004.

Mr. Chairman, we do not object to the provision which would require maintenance of capacity within each geographic service area. This provision is consistent with our desire to ensure that there is equality of access to quality specialized services. However, in order to accomplish this, we propose that the capacity be based on the enrolled veteran population in each geographic service area In addition, we oppose the provision that would measure capacity by dollars expended The cost of care is not an adequate measure, by itself, to demonstrate whether VA is maintaining the quality of and access to specialized care. Cost alone is not a valid and reliable measure of capacity Limiting the capacity report to measurement of dollars expended will neither indicate nor ensure that VA is upholding its commitment to these high priority patients. Capacity must be measured by the actual number of patients receiving care in the specialized programs, the quality of the care provided, patients' health outcomes, and patients' access to that care, including waiting times for appointments.

Furthermore, Mr. Chairman, it is currently not possible to know whether the amount of care and the dollars expended in 1996 were optimal for measuring capacity in the targeted special programs The care provided in 1996 provides only a snapshot of what was then a rapidly changing VA health care delivery system. It is not clear that 1996 can or should serve as a baseline out to 2004, as proposed by this bill.

We understand that the staff of the Senate Veterans Affairs' Committee is developing a different position with regard to VA's obligation to maintain capacity. We would be happy to work with both the Senate and House staff on this issue to develop amendments that would allow us to provide the best possible information on VA's capacity for treating veterans with specialized treatment and rehabilitative needs.

Section 4 - Means Test Threshold

Mr. Chairman, section 4 would establish new geographically based income thresholds for VA to use in determining a non-service-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. This would be an alternative to the threshold presently set by statute. As you know, Mr. Chairman, the law now requires that most veterans enroll in our health care system in order to receive care. Enrollees are placed in an enrollment priority group that is based, in many instances, on their level of income and net worth. Although we currently provide care to veterans in all enrollment priority groups, if there were medical care funding shortages in the future, it might be necessary to determine that those non-service connected veterans with relatively higher incomes must be disenrolled, meaning they could no longer receive VA care. Current law establishes, on a National basis, the specific income thresholds that we must use to determine the priority group of any given enrollee with no service-connected disability or other special status. We place higher income veterans in priority group 7 and lower income veterans in priority group 5.

This provision would establish a new, geographically based income threshold that VA could use for placing veterans in priority groups. It would utilize a poverty index developed by the Department of Housing and Urban Development (HUD) to establish this alternative income threshold. The income threshold for the veteran would be either the specific income thresholds set forth on a National basis, or the amount set forth by the HUD index - whichever is greater. In most instances, this new income threshold would be greater than the current statutory income threshold used for determining whether a veteran should be placed in priority group 5.

We are very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment

priority groups. We recognize that the cost of living in large urban areas is much greater than in many more rural parts of the country. What might be considered a reasonably high income in some locations may be totally inadequate in other higher cost locations. However, at this time we cannot support the specific methodology proposed in this bill There are many poverty indices that are established in various ways, and there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem.

We are currently reviewing the various poverty indices in order to identify the best way to proceed. We expect to have this work completed in September. We would be happy to work with staff members from the Congressional Committees to consider the alternative indices and other changes to ensure that the means test for VA health care is equitable and affords reasonable access to VA health care services

Section 5 - Pilot Program for Coordination of Ambulatory Community Hospital Care

Section 5 is a provision that is essentially the same as a measure passed by the House of Representatives last year despite the strong opposition of VA The provision would establish a pilot program entitled "Coordination of Hospital Benefits Program." The program would authorize special benefits for some veterans receiving care in a VA outpatient clinic who need hospital care. Under the program, veterans with third-party health plan coverage (including Medicare and Medicaid) may receive different hospital care benefits from those without third-party coverage. Veterans with no third-party coverage of any sort would be offered hospital care in the nearest VA hospital with the ability to provide care. That facility may not be particularly close to where the veteran resides. On the other hand, veterans with third-party coverage would be offered a choice First, they could choose to use the nearest VA hospital Alternatively, they could

choose to use a private facility, with VA paying for certain costs, such as the health plan deductible, coinsurance, or the cost of inpatient care or medical services that are not covered by the health plan

The pilot program would be open only to veterans to whom VA "shall" furnish care, essentially all enrollees except those in enrollment priority group 7. To be eligible, the veterans must also meet certain additional conditions. Specifically, participants must be enrolled to receive medical services from a VA outpatient clinic, require hospital care for a non service-connected condition that could not be provided by a clinic operated by VA and elect to receive such care under the non-VA health care plan. The program would be limited to veterans who have received VA care during the 24-month period preceding the veteran's application to enroll in the pilot program In designating the geographic areas in which to establish the program, VA must ensure that at least 70 percent of the veterans who reside in a designated area reside at least two hours' driving distance from the closest VA medical center.

The provision also limits expenditures for the pilot program to $50 million in any fiscal year. Moreover, funds from the proposal must come from the Medical Care Collections Fund and no funds may be used that are otherwise available for treating veterans requiring specialized care.

We strongly oppose this proposed pilot program. The proposal would create a disparate eligibility status based on a veteran's third-party coverage and priority group. We are also concerned that the program would undermine our ability to maintain existing services, especially specialized medical services and programs for veterans. Limiting care to general medical and surgical services would mean that veterans needing specialty health services would still need to come to VA for care. The health care covered by this proposal would be inpatient care for non-service-connected conditions. A veteran currently receiving care for a service-

connected condition, for which VA does not or cannot contract locally, would also be forced to receive care in multiple locations These types of disparities are not consistent with our goals and strategies of improving access, convenience, and timeliness of VA health care to all eligible veterans

Funding for the program would be drawn from the Medical Care Collections Fund (MCCF). The Fund's collections, which are available to VA facilities to support current VA-provided medical care, would be reduced by this provision. MCCF collections supplement the dollars appropriated for medical care and are a necessary component of VHA's budget. Use of MCCF funds for this pilot would negatively impact care for veterans not enrolled in the pilot. In addition, this provision may affect the Medicare Trust Fund.

The bill would also require that not less that 15 percent of the veterans participating in the pilot program are veterans who *do not* have a health-care plan. This requirement is confusing, as the purpose of the pilot program is to allow VA to pay for the out of pocket costs that veterans incur through non-VA health plans. It is not clear how VA would achieve this goal for veterans who have no other health care plan The 15 percent limit might be a false floor or ceiling, depending on the actual number of veterans at a particular pilot site that have no insurance. This could affect the potential outcomes of the pilot. If there are a large number of insured veterans, the out-of-pocket expense covered by VA would be less that the expense of covering the full care provided to an uninsured veteran. This could make the pilot look financially successful. On the other hand, if the number of non-insured veterans is high, the expenses could make the pilot program less financially viable.

The bill also defines the term "health-care plan" by cross-reference to section 1725(f). The bill states that the term "health-care plan" has the meaning given that term in section 1725(f)(3). However, the referenced section does not define

the term health plan or health-care plan, but rather defines the term "third party" for purposes of reimbursement for emergency treatment. We believe that this reference might be an error, and that the intended reference was to section 1725(f)(2). Section 1725(f)(2) defines the term "health-plan contract" which includes, among other things, Medicare and Medicaid plans.

Section 6 - Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

This section of the bill would require the Secretary to conduct a three-year pilot program in which veterans receiving fee basis and contract hospitalization would be provided such care through a contractor who acts as a managed care coordinator. The provision states that the program shall be conducted in four selected geographical areas that have mature managed care markets. To the extent practicable all fee basis and contract hospitalization provided by VA in the selected geographical service areas would be provided through the contractor The contractor must be an experienced managed care coordinator with an in-place network of credentialed providers. All enrolled veterans in a selected geographical service area who are authorized to use non-VA care services through fee basis programs of the Department, or who are eligible for contract hospitalization, would be automatically enrolled for participation in the pilot program. Once approved to receive non-VA fee basis care, or when they seek care for a health emergency, participants would be given a directory of health care providers from which to choose.

In conducting the pilot program, VA would be required to use standards (commercial-industry or, in their absence, Department standards) for measuring access, timeliness, patient satisfaction, and utilization management. The contractor must establish a toll-free telephone system staffed by registered nurses to provide advice and health care referral information to veterans enrolled in the pilot program on a 24-hour a day, seven-day a week basis, and a veterans

service telephone line for the provision of information on eligibility, enrollment, and provider locations. The program also must provide concurrent review, demand management, disease management and health and wellness programs.

Each medical center participating in the program must have a primary care manager. The primary care manager at each VA facility would be responsible for the coordination and case management of each enrolled veteran who is participating in the pilot program to ensure that such veterans receive the appropriate care, and that veterans are brought back into the VA system for follow-up whenever possible and appropriate. The pilot program includes extensive reporting requirements by VA, and a mandatory review by the Comptroller General.

We are interested in a pilot program to examine the costs and benefits of operating our fee basis program in a new manner, however, we are concerned about some of the restrictive requirements in this specific provision For example, we would like ensure that VA retains clinical control with respect to the type of care that the patient receives, as well as the amount of care authorized. We would also want to ensure that the costs of any contract would be no more than the current cost for the fee basis program in the selected locations Finally, we believe that it would be appropriate for VA to continue to provide the toll-free telephone system providing information on eligibility, enrollment and provider locations. We would be pleased to work with staff members of the Committee to consider alternative language that would allow VA the flexibility to evaluate alternative delivery systems without some of the limitations and requirements mandated by this provision

Section 7 - Recodification of Bereavement Counseling and other Authorities

Mr. Chairman, section 7 of the bill would consolidate, in a new subchapter of title

38, United States Code, all of the various legal authorities under which VA provides services to non-veterans. The new subchapter would include a section on VA's provision of counseling, training and mental health services for family members of veterans who are receiving treatment. It would also include a section on bereavement counseling following the death of certain veterans. Both types of counseling are currently authorized in the definition of outpatient medical services This change will make the authority much clearer.

The authority under which we provide CHAMPVA benefits, presently section 1713 of title 38, would be transferred to this new subchapter A new provision in the bill provides that a dependent or survivor receiving CHAMPVA care would also be eligible for the bereavement counseling and the other counseling, training and mental health services provided to family members under this new subchapter. Finally, the existing authority to provide hospital care or medical services as a humanitarian service in emergency cases would be moved to this new subchapter.

The proposed changes would recodify the currently existing provisions. We support this change, as it would consolidate and clarify the existing statutory authority to provide care to non-veterans.

Section 8 – Extension of Expiring Collections Authorities

Mr. Chairman, this final provision would amend title 38 to extend VA's authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of the nonservice-connected disabilities of veterans with service-connected disabilities. We

strongly support and welcome the extensions proposed in this section These collections constitute an important and necessary supplement to our annual appropriations.

Mr. Chairman, this ends my statement. I will be pleased to answer any questions you may have.

STATEMENT OF

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

H.R. 2792, H.R. 1435, AND H.R. 1136

SEPTEMBER 6, 2001

Chairman Moran, Ranking Member Filner, members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA) I am pleased to present our views on H R 2792, the "Disabled Veterans Service Dog and Health Care Act of 2001," H.R 1435, the "Veterans' Emergency Telephone Service Act of 2001," and H R 1136 PVA would like to thank you, Mr Chairman, for including many of PVA's legislative priorities as part of H.R 2792

H.R. 2792, The "Disabled Veterans Service Dog and Health Care Improvement Act of 2001"

There are several provisions in H R 2792 that PVA supports, but there are several that we oppose at this time I will comment on each of these provisions

Section 2 Authorization for Secretary of Veterans Affairs to Provide Service Dogs for Disabled Veterans

The Department of Veterans Affairs (VA) is currently authorized to provide guide dogs to blinded veterans with service-connected disabilities only However, there are many veterans, both service-connected and non-service connected, who suffer from certain disabilities who would benefit a great deal from having guide dogs or service dogs These veterans include hearing-impaired veterans as well as veterans who suffer from

spinal cord injury or dysfunction or other chronic impairments that severely limit mobility or function

The Journal of the American Medical Association (JAMA) published a study in 1996 that assessed the value of service dogs for people with ambulatory disabilities The study found "reports of paid and unpaid assistance demonstrated dramatic economic benefits of service dogs " After one year, the study found a decrease of 68 percent in paid assistance hours and a 64 percent decrease in unpaid assistance hours

The JAMA study also detailed the many tasks that service dogs can perform, such as "open and close doors turn switches on and off, pull a person up from a sitting position or lying down position, assist a person in and out of baths and pools, help pull on clothing, procure and pick up objects, pull wheelchairs, and drag a person to safety in case of fire or other emergency."

PVA strongly supports Section 2 of H R 2792, that expands the authority of the Department of Veterans Affairs to provide guide dogs and service dogs to both service-connected and non-service connected veterans who are enrolled in the VA health care system We believe service dogs and guide dogs are essential to creating a better quality of life for sight or hearing impaired veterans as well as those veterans who suffer from a spinal cord injury or dysfunction that substantially limits mobility or function The dogs will give these severely disabled veterans a measure of self-confidence and independence that they would not otherwise have

We have concerns over the language, as introduced in the Senate, that would restrict service dogs to only those veterans in receipt of disability compensation With health care eligibility reform we moved to a uniform benefits package for veterans enrolled for VA care By limiting service and guide dogs to those veterans who are in receipt of disability compensation, we would again start down the path of a hodgepodge system of health care benefits, an approach repudiated only a few short years ago

The advantages provided by service dogs, both in terms of economic benefits and improvements in quality of life, should be made available to all veterans who are in need of this wonderful service For over half-a-century, PVA has fought for the integration of people with disabilities into the economic and social life of our Nation Providing service dogs to veterans who need them would be a major step forward in the ultimate realization of this goal As one participant, who has a spinal cord injury, stated in the JAMA study, "with my [dog], I feel safe and capable, and I am no longer afraid of the future Everyone needs someone to care for, and we care for each other with dignity "

Section 3 Maintenance of Capacity for Specialized Treatment and Rehabilitative Needs of Disabled Veterans

Congress, in 1996, mandated that the Department of Veterans Affairs (VA) maintain its capacity to provide specialized services such as spinal cord injury or dysfunction (SCI/D) The VA, until last year, defied this simple statutory mandate. After much negotiation, the VA issued VHA Directive 2000-022 stipulating that all SCI centers return to mandated capacity levels by the end of the fiscal year

PVA believes that the only way to adequately, and accurately, determine capacity is to account for the number of beds and staff Counting the number of patients treated, waiting times, outcomes, or resources are all interesting markers determining the extent of care provided, but we have found that counting staffed beds and dedicated staff assigned to SCI/D Centers are the only ways to truly measure capacity This is the only way to ensure that the VA is living up to its statutory requirements, and upholding its own directive.

PVA believes that Congress should address each of the VA's specialized services, in terms of capacity, separately This approach should be tailored to the distinct characteristics of each program, for elements that would address capacity for spinal cord injury/dysfunction care may well not adequately address the unique characteristics of mental health care, or blind rehabilitation

Unfortunately, Section 3 of H R 2792 does not go far enough Although PVA appreciates the efforts to require VA to meet the capacity requirements mandated by law, we are concerned that this language will undercut the agreement and directive we have negotiated with the VA, and it will allow the VA to default to a lesser standard Capacity should be determined by a true count of actual staffed beds, for acute and long-term care or residential beds, and specialized professional health care staff dedicated to providing care at SCI centers Any other method for accounting for capacity would only establish a standard based on wishes and good intentions that does not reflect the reality faced by SCI/D veterans seeking care

PVA also believes that there must be some accountability in the capacity reporting Just having an individual "monitoring" the reports or data is not enough The Veterans Integrated Service Network (VISN) directors must be held accountable for ensuring that VAMC's are meeting the capacity requirement We propose that the maintenance of capacity of the specialized services be included in the performance plans of the VISN directors

PVA supports the provision to extend the capacity reporting requirement for another three years It provides a guide for enforcing the capacity requirement mandated by law and directive

Section 4: Threshold for Veterans Health Care Eligibility Means Test to Reflect Locality Cost-of-Living Variations

PVA has argued in favor of a change to the means test used by the VA to determine whether veterans will be placed in enrollment priority Category 5 or 7 for a long time These category placements are important because veterans enrolled in lower categories, such as 6 or 7, whose incomes are above current means test levels are required to make co-payments for most of their care Most importantly, veterans placed in Category 7 are at a greater risk of losing access to VA health care due to budgetary constraints Congress, in establishing Category 5, demonstrated its intention to provide health care to veterans with lower incomes, thereby serving as a safety net Unfortunately, the current

national "one-size-fits-all" means test fails to take into account the higher costs of living faced by certain veterans in different geographic locations

As the attached white paper discusses, we have identified an established formula implemented by the Department of Housing and Urban Development (HUD) to set income limits for eligibility for low income housing benefits The HUD formula makes adjustments in means test eligibility based on the cost-of-living experience in most every locality in the United States As with the current VA system it also adjusts for the number of dependents in the applicant household

PVA supports Section 4 which seeks to adjust the national means test threshold by locality to reflect the differences in geographic cost-of-living This adjusted means test would help veterans who have incomes slightly higher than the existing threshold who have previously been designated as Category 7 but will be reclassified as Category 5 It is important to realize that the adjusted means test threshold would benefit veterans located all over the county—North, South, East, and West The new standard based on the Department of Housing and Urban Development (HUD) Low Income Index established by the U S Housing Act of 1937 used to determine eligibility for low income housing assistance would realistically and equitably reflect cost-of-living variations from one locality to the next without going below the current means test threshold

Section 5 Pilot Program for Coordination of Ambulatory Community Hospital Care

PVA opposes Section 5 that would allow non-service connected veterans in under-served areas to go to private health care inpatient facilities using their private health insurance The VA would pay for the co-payments associated with these health care visits PVA is not opposed to contracting for medical services when there is a demonstrable lack of availability of certain services within the VA, but we do oppose efforts that would turn the VA into an insurer of health care rather than a provider of health care. Passage of this provision would not only represent a major departure from the usual delivery of VA health care services, but would provide disparate treatment of veterans depending on whether or not they have private insurance, undermine the VA's ability to maintain its

specialized services programs by eroding the VA's patient and resource base, and endanger the well-being of veterans

PVA is concerned about the breakdown of the "hub-and-spoke" approach that the VA has used effectively in its health care system The outpatient clinics (spokes) are supposed to feed patients into the nearest major VAMC (hub). However, under this program, patients would be sent from the outpatient clinic into the private sector. Once a veteran is sent into the private sector, the VA does not maintain any responsibility to provide follow-up care or treatment for that patient Veteran patients would be lost to the system, as would any possible third-party payments VA hospitals would see fewer patients This would set a dangerous precedent that, if allowed to expand, could endanger the viability of a VA facility maintaining its full range of specialized inpatient services for all other veterans in the area as those resources go elsewhere

There was concern in the past about funding this program from money appropriated to the Veterans Health Administration hospitals In an attempt to overcome this problem, the bill proposes to pay for the program with funds from the Medical Care Collection Fund Although this appears to release the pressure on hospitals to take money from their own budgets, it does not because the hospitals usually use money from the Collection Fund anyway because of the annual shortfall in appropriations for health care in the VA. With current inadequate health care appropriations, VA is finding it difficult to care for existing enrolled veterans, let alone subsidize an expansion of non-VA benefits and services.

Section 6· Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

Currently, under 38 U S C § 1703, the VA may, under certain circumstances, contract with non-VA health care facilities to furnish care for veterans if they live in an area where a VAMC is "geographically inaccessible" or because the VA is "not capable of furnishing the care or services required[ ]" Under 38 U S C. § 1728, the VA has limited authority to reimburse veterans for health care received at non-VA facilities under certain special circumstances Section 6, "Pilot Program for Contract Hospitalization and Fee

Basis Ambulatory Care," of H R 2792 would force veterans in four geographic areas to receive their health care under these two statutory sections from a managed care provider We strongly oppose this section

People with disabilities are most at risk under a managed care regime Forcing disabled veterans into a managed care plan would put veterans at the mercy of the health care managers who would ration their care This could negatively effect the quality of care that a disabled veteran is receiving A managed care program would limit the veterans' choice of health care provider Likewise, private managed care programs do not have well-developed specialized services and direct access to specialists required by people with severe disabilities There is no guarantee that the specialized services that the disabled veterans need will be available in the private health system Severely disabled veterans would be forced to settle for low quality specialized care or none at all

Section 7 Recodification of Bereavement Counseling Authority and Certain Other Health-Related Authorities

PVA supports Section 7 of the bill For veterans who live at home, family members tend to be the primary care givers, and provide as much to the health and well-being of the veteran as a doctor or specialist For those family members who either provide care to a severely disabled veteran or who suffer from their own severe illness or disease, they deserve assistance from the VA They should be entitled to any bereavement counseling or support that they might need to improve their quality of life

Section 8 Extension of Expiring Collections Authorities

PVA supports the extension of collection authorities established by Section 8 of the bill The VA already maintains the authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of non-service connected disabilities of veterans with service-connected disabilities These collections serve as additional income for the VA on top of money that is appropriated by the government

H.R. 1435, The "Veterans' Emergency Telephone Service Act of 2001"

As we have testified, we are unable to support H R. 1435, the "Veterans' Emergency Telephone Service Act of 2001." As we stated before the Subcommittee on Benefits on July 10, 2001, we believe that the VA should operate any informational hotline that is created in addition to the service it currently operates The VA has the expertise, and the mandate, to accurately answer informational requests and to assist veterans with their benefits claims More can be done to make the general public aware of this resource, and more can be done to improve it, but granting money to an outside entity to create a hotline without fixing the current hotline is inappropriate

H.R. 1136, A Bill to Amend Title 38 U.S.C., to Require VA Pharmacies to Dispense Medications to Veterans for Prescriptions Written by Private Practitioners

PVA does not support H R 1136, a bill that requires VA pharmacies to dispense medications to veterans for prescriptions written by private practitioners The approximate $1 billion increase for health care slated for FY 2002 does not even cover salary increases and inflation for the coming year Moreover, it is estimated that next year the cost of pharmaceuticals will be three times the rate of inflation. The VA does not need to take on the role of the veterans' drug store Now is not the time, when the VA does not have the resources necessary to provide sick and disabled veterans the health care they need, to further burden the VA with additional demands on these scarce resources.

Again, PVA appreciates the opportunity to share our views on these important measures with this Subcommittee. It is clear that we need to work together to reach a common ground on capacity requirements, the means test threshold, and specialized care for severely disabled veterans The end result should be provisions that are equitable and fair and that do not diminish the quality and quantity of health care our veterans are receiving.

This concludes my testimony, Mr Chairman. I would be happy to answer any questions that you or any of the other members of the committee might have.

ATTACHMENT

Proposal to Adjust Veterans Health Care Eligibility Means Test to More Accurately Reflect Locality Cost of Living Variations

The Paralyzed Veterans of America (PVA) is requesting legislation to change the means test used by the Department of Veterans Affairs (VA) to determine whether veterans will be placed in enrollment priority Category 5 or 7 as set forth in 38 U S C § 1722 Category placement is important because veterans enrolled in lower categories (i e , 6 and 7) whose incomes are above current means test levels are required to make co-payments for much of their care In the "discretionary" Category 7, they could also be at greater risk of disenrollment should the VA budget require it in the future

JUSTIFICATION
In creating Category 5, Congress demonstrated its desire to provide health care to veterans who are unable to defray the cost of care For this reason, Category 5 veterans do not pay co-payments for health care received Category 7 veterans do pay co-payments In addition, VA hospitals receive reimbursement for providing care to Category 5 veterans Hospitals do not get reimbursed for Category 7 veterans

Currently, the VA uses a national means test income threshold of $23,688 for a veteran with no dependents and $28,430 for a veteran with one dependent This universal threshold applies regardless of the geographic cost-of-living differences A universal income threshold does not adequately address many individual veterans' inability to "defray the cost of care" as required by 38 U S C § 1722

RELEVANT STATUTORY AUTHORITY
38 U S C § 1722 establishes the criteria by which a veteran is determined to be unable to defray necessary expenses and establishes the income thresholds to be used in making this determination

38 U S C § 1705 establishes the VA s patient enrollment system § 1705 (a) establishes the seven categories with which the VA prioritizes the provision of care § 1705 (a) (5) establishes the fifth priority category as " veterans not covered by paragraphs (1) through
(4) who are unable to defray the expenses of necessary care as determined under § 1722 (a) of this title § 1705 (a) (7) establishes priority category seven as veterans described in § 1710 (a) (3) of this title

38 U S C § 1710 (a) (3) authorizes the VA to treat veterans in priority categories 6 and 7 on a 'funds permitting" basis and at the Secretary's discretion

42 U S C § 1437a (b) (2) defines the term "low income families" as " families whose incomes do not exceed 80 per centime of the median income for the area, as determined by the Secretary (of housing and urban development) with adjustments for smaller and larger families "

PROPOSAL
The most direct way to address this problem is to adjust the national means test by locality to more accurately reflect the differences in geographic cost-of-living This locality-adjusted means test would help veterans who have incomes slightly higher than the existing threshold who have previously been designated as Category 7 They would now fall below a newly-adjusted means test threshold for their area and be classified Category 5 The individual VA Healthcare networks, otherwise known as VISNs (Veterans Integrated Service Networks), would no longer be able to collect co-payments for the care provided to these veterans but would begin to receive reimbursement for their care

PROPOSED METHODOLOGY
We have identified the HUD Low Income Index as established through Section 3 of the U S Housing Act of 1937, as amended in 1998, as a viable index The HUD index defines "low income" for families with incomes that do not exceed 80 percent of the median family income for the area in which they reside The areas are broken down into a variety of categories including Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs) and counties This index has defined both geographic areas and cost of living within these areas and should be relatively easy for the VA to implement

Using the low-income methodology would mean that all veterans residing in a defined locality would have a means test threshold that was adjusted to reflect the cost-of-living determined by the HUD formula for that particular defined area This new threshold is more indicative of the veteran's ability to defray the cost of care Furthermore, to insure that no veterans are bumped from Category 5 into Category 7 when these new thresholds are implemented, we propose to maintain the existing $24,000 threshold, regardless of the number of dependents, nationwide as the lowest figure for any means test variations even if the HUD formula determines that the low-income rate for a particular area is actually under $24,000 In other words, for any location where the low-income index indicates that the new threshold should actually be lower than $24,000, the means test figure will stay at $24,000, regardless of the number of dependents in the veterans' household This provision guarantees that no VISN will lose any Category 5 veterans and only stand to gain category 5's from implementation of this new means test system

The following explanation of HUD's methodology for determining the median income and subsequent income amounts is taken from HUD's own briefing book

HUD METHODOLOGY FOR ESTIMATING FY 2000 MEDIAN FAMILY INCOMES (ECONOMIC AND MARKET ANALYSIS DIVISION, OFFICE OF ECONOMIC AFFAIRS, PD&R)

FY 2000 HUD estimates of median family income are based on 1990 Census data estimates updated with a combination of local Bureau of Labor Statistics (BLS) data and Census Divisional data Separate median family income estimates (MFIs) are calculated for all Metropolitan Statistical Areas (MSAs), Primary Metropolitan Statistical Areas (PMSAs), and non-metropolitan counties

The income adjustment factors used to update the 1990 Census-based estimates of MFIs are developed in several steps Average wage data from the Bureau of Labor Statistics (BLS) were available for 1989 through the end of 1997 at a county level, and were aggregated to the metropolitan area level for multi-county metropolitan areas Census Divisional level median family and household income estimates were available from the Current Population Report (CPR) March 1990-99 surveys, which measure incomes from mid-1989 through mid-1998 These data were then used to update mid-1989 income estimates from the 1990 Census to the middle of 1998 The mid-1998 estimates were trended forward to mid-FY 2000 using a factor based on past P-60 Series trends The step-by-step normal procedures as well as the exception procedures used are as follows

1 Estimate mid-1989 local median family incomes using 1990 Census data (Current HUD Section 8 Fair Market Rent (FMR) program definitions are used to define metropolitan areas, which are normally the same as Office of Management and Budget metropolitan area definitions)

2 Calculate the BLS wage change factors for each Census Division for the 1989-97 period as follows

Census Division BLS Wages (1997)
Census Division BLS Employees (1997) = 8-year BLS wage increase factor
for Census Division
Census Division BLS Wages (1989)
Census Division BLS Employees (1989)

3 Calculate the change in median family and household incomes for the nine Census Divisions for the 1989-1998 period using Census P-60 series data, as follows

Census Division P-60 MFI (1998) = 9-year increase factor for Census
Census Division P-60 MFI (1989) Division P-60 Median Family Income

4 Compare the BLS and P-60 series Census Divisional factors calculated in steps 2 and 3 to provide a means of adjusting local BLS wage factor changes so that they aggregate to the same change factor as P-60 changes in family incomes plus contain an added year of CPS trending

9-year increase factor for
Census Division P-60 MFI = Ratio of Census Division P-60
8-year increase factor for MFI to ratio of Census
Census Division BLS Wages Division BLS wage changes

5 Calculate the 1989-98 increase factors for the individual metropolitan areas and nonmetropolitan counties by applying the Census Divisional index factors from step 4 to local BLS data

Local BLS Wages (1997)
Local BLS Employees (1997) Ratio of Census 9-year income
* Division P-60 = adjustment
MFI to Census factor for
Local BLS Wages (1989) Division BLS wages MSA or County
Local BLS Employees (1989)
= 1989 to mid-
1998 MFI
Adj factor

6 Convert 1989-98 step 5 change factor to a 1989-2000 change factor by applying an annual trending figure of 4 0 percent to update the mid-1998 estimate to mid-1999, and applying a 3 0 percent factor (3/4 of 4 0 percent) to the mid-1999 to April 1, 2000 period (Use of a trending factor is necessary because of lags in Bureau of Labor Statistics and P-60 Series data availability the 4 0 percent factor is based on national income change patterns in recent years)

(Step 5 adj factor) * 1 04 * 1 03 = 1989 to mid-FY 2000 adjustment factor

7 Calculate median family incomes for FY 2000 by multiplying the step 1 Census estimate of median family income by the income adjustment factor derived in Step 6

1990 Census Median Family Income * Step 6 factor = FY 2000 MFI EST.

8 For American Housing Survey areas, compare the MFI estimates from step 7 with median family income estimates based on post-1989 American Housing Survey (AHS) estimates of median family income updated to 2000 Past analysis shows that there is 95 percent likelihood that the true local median family income is within 6 percent of the AHS-based estimate For areas where an AHS-based estimate differs by more than 6 percent from the Census-based estimate, local MFI estimates are increased or decreased so that they are within 6 percent of the AHS-based estimate

9 Compare the 2000 MFI estimate with the 1999 MFI estimate If the 1999 estimate is higher set the 2000 estimate at the 1999 level (This policy is applied except when estimates are revised with decennial Census data, and serves to minimize disruption in program activities due to temporary decreases in income estimates)

In addition to the above procedures, constraints are placed on annual changes in the Census Divisional and BLS change factors based on past experience These guidelines constrain increases for a small number of areas with unusually high increases

VA's ABILITY TO COLLECT COPAYMENTS AND THIRD PARTY REIMBURSEMENT

Applying a regional adjustment to the means test would not affect VA's ability to charge third party health insurers for the cost of care provided to a veteran because VA's authority to collect insurance payments is not tied to the means test However, the means test is used by VA to determine a veteran's obligation to pay co-payments for their care and adjusting the means test would therefore affect VA s ability to collect co-payments

The means test used by the Department of Veterans Affairs is set forth at 38 U S C § 1722 While this statutory provision sets forth the amount of the annual means test threshold, and prescribes the methodology for calculating whether a veteran's income exceeds this threshold, it does not state the purpose of the means test Rather, the means test set forth in §1722 is referred to in two distinct statutes that govern eligibility for care and the obligation to pay a co-payment

The means test threshold set forth in § 1722 is expressly referred to by the statutory provision governing VA's managed care system of enrollment *See* 38 U S C § 1705(a)(5) Under VA's enrollment system veterans are placed in one of seven priority categories based on consideration of such factors as income level of disability, and percentage of service-connection *See* 38 U S C § 1705 Each year, VA is required to enroll only those categories of veterans that can be treated within appropriated funding *See* 38 U S C §§ 1705, 1710(a)(4) Veterans with income under the means test threshold are placed in priority category 5, ensuring that those veterans determined to be unable to defray the cost of their care will not be among the first cut from care when appropriations are insufficient to provide care to all veterans Regionally adjusting the means test will therefore elevate some veterans from priority category 6 and 7 to priority category 5

The means test threshold set forth in § 1722 is also referred to in the statutory provisions governing the determination of a veteran's obligation to pay a co-payment *See* 38 U S C § 1710(a)(2)(G) Under this statutory provision, veterans with income under the annual means test threshold receive cost free care while those with income over the means test must pay co-payments for inpatient and outpatient care *See* 38 U S C §§ 1710(a)(3), 1710(f) Veterans with income over the means test must pay an inpatient hospital co-payment of $768 per 90 days of care, plus a per diem charge of $10 per day *See* 38 U S C § 1710(f) Veterans with income over the means test must also pay an outpatient co-payment of $50 80 per visit *See* 38 U S C § 1710(g) Regionally adjusting the means test will therefore exempt some veterans from these co-payment obligations if the means test is adjusted upward in their region to an amount in excess of their current income

The authority for VA to bill a veteran's private health insurer is set forth in 38 U S C § 1729 This statute neither references the provisions of § 1722 nor utilizes the means test threshold to determine whether a veteran's private health insurer may be billed for the cost of care provided Rather § 1729 broadly grants VA the authority to bill the private health insurer of any nonservice-connected veteran regardless of priority category placement or income level, for the full cost of care provided at a VA facility *See* 38 U S C § 1729(a)(2)(D)(ii) VA is even permitted to bill third party health insurers for the full cost of treatment provided for the nonservice-connected disabilities of veterans with service-connected disabilities *See* 38 U S C § 1729(a)(2)(E) Since VA 's authority to recover the cost of care from private health insurers is not related to the means test threshold set forth in § 1722, regionally adjusting the means test threshold will have no impact on insurance billing

ESTIMATES OF NUMBER OF VETERANS AFFECTED

The following chart estimates the number of veterans in certain MSAs that would be moved form category 7 into category 5 through this proposal These numbers are based on data obtained form the VA The MSAs listed in the chart were chosen at random

Please note, that while we are proposing that the bottom threshold be established at $24,000, regardless of the number of dependents per family

MSA	1 person family	2 person family	3 person family	4 person family
Abilene (TX)	0	0	0	4
Albany-Schenectady-Troy (NY)	275	319	514	422
Albuquerque (NM)	120	150	300	315
Allentown-Bethlehem-Easton (PA)	32	49	92	82
Altoona (PA)	0	0	0	0
Anchorage (AK)	190	237	216	167
Ann Arbor (MI)	97	100	77	52
Anniston (AL)	0	0	0	0
Appleton-Oshkosh-Neenah (WI)	15	27	41	30
Atlanta (GA)	1123	1060	867	647
Baltimore (MD)	1245	1133	970	709
Bangor (ME)	0	0	0	5
Baton Rouge (LA)	9	6	9	31
Bellingham (WA)	3	1	10	10
Bergen-Passaic (NJ)	685	634	500	358
Billings (MT)	7	12	23	25
Biloxi-Gulfport-Pascagoula (MS)	0	0	0	21
Bismarck (ND)	2	6	9	25
Bloomington (IN)	2	5	10	9
Boise City (ID)	40	88	129	139
Boston-Worcester-Lawrence-Lowell-Brockton (MA-NH)	1540	1568	1366	1003
Boulder-Longmont (CO)	21	21	18	13
Burlington (VT)	23	38	37	33
Casper (WY)	2	5	12	16
Cedar Rapids (IA)	4	14	9	23
Charleston (WV)	2	0	21	24
Charlotte-Gastonia-Rock Hill (NC-SC)	245	351	350	259
Charlottesville (VA)	4	3	1	1
Chattanooga (TN-GA)	10	40	47	51
Chicago (IL)	3622	3504	2792	1876
Cleveland-Lorain-Elyria (OH)	1043	1074	957	396
Corvallis (OR)	6	5	7	6
Dover (DE)	6	20	29	38
Enid (OK)	0	0	0	0
Fayetteville (NC)	0	0	0	18
Fort Lauderdale (FL)	322	384	417	303
Hartford (CT)	694	672	574	270
Honolulu (HI)	104	108	91	63
Las Vegas (NV-AZ)	542	770	866	709
Lawrence (KS)	13	7	7	10
Lexington (KY)	98	173	216	221
Lincoln (NE)	22	37	62	52
Little Rock-North Little Rock (AR)	74	170	264	275
Los Angeles-Long Beach (CA)	1006	1146	823	1064
Minneapolis-St Paul (MN-WI)	652	653	522	386
New York (NY)	2995	2844	3059	2093
Phoenix-Mesa (AZ)	422	559	722	602
Providence-Warwick-Pawtucket (RI)	78	157	217	211
Provo-Orem (UT)	5	9	14	27
Rapid City (SD)	7	5	22	38
St Louis (MO-IL)	198	309	434	486

CONCLUSION

Implementation of the HUD low-income rates to augment VA's single means test standard and methodology will create a system that realistically and equitably reflects cost-of-living variations from one locality to the next, reflecting a veteran's ability to defray the cost of his health care as per Congress' original intent Leaving the existing threshold as a base level guards against harm for any veteran currently meeting existing means test criteria While VA's health care networks will lose the ability to collect co-payments from veterans formerly enrolled in category 7 who would now be bumped into category 5, under the original statutory intent governing the eligibility category placement, where the ability to defray the cost of care is the determining factor in placement in either category 5 or 7, these veterans should never have been required to pay co-payments in the first place Furthermore, we believe that each VA health care system will be able to recoup the loss of the moneys collected as co-payments by "drawing down" reimbursement from VA central office for these new category 5 patients

RICHARD B. FULLER

Richard B Fuller is the National Legislative Director of the Paralyzed Veterans of America, a non-profit veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities PVA's primary legislative focus centers on issues supporting the Department of Veterans Affairs health care system and the specialized services VA provides to PVA members He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services, as well as oversight on all federal health systems – Medicare and Medicaid – and research activities which benefit veterans as well as all Americans with disabilities

Mr Fuller served for eight years on the professional staff of the Committee on Veterans' Affairs of the U S House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington, D C

Mr Fuller was Director of Public Affairs of the House Committee on Veterans' Affairs from 1979 to 1981 He served on the professional staff of the Subcommittee on Education, Training and Employment and for the Subcommittee on Hospitals and Health Care until 1987. In 1987, he joined the national government relations staff of PVA, serving first as Associate Legislative Director and then as National Legislative Director In 1991, he joined a Washington D C health care consulting firm representing the public policy and legislative interests of several national medical and research societies including the American Federation for Clinical Research, the American Gastroenterological Association, the American Geriatrics Society, and the National Association of Veterans Research and Education Foundations He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform

Mr Fuller graduated with a Bachelor of Arts degree from Duke University in 1968 He served in the United States Air Force from 1968 to 1972, stationed two and one half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $83,000 (estimated as of February 28, 2001)

Fiscal Year 2000

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U S C §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000

Federal Aviation Administration – Accessibility consultation -- $12,500

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $200,000

Fiscal Year 1999

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $240,000

The Value of Service Dogs for People With Severe Ambulatory Disabilities

A Randomized Controlled Trial

Karen Allen, PhD, Jim Blascovich, PhD

Objective.—To assess the value of service dogs for people with ambulatory disabilities

Design.—Randomized, controlled clinical trial.

Setting.—Environments of study participants.

Participants.—Forty-eight individuals with severe and chronic ambulatory disabilities requiring use of wheelchairs who were recruited from advocacy and support groups for persons with muscular dystrophy, multiple sclerosis, traumatic brain injury, and spinal cord injury. Participants were matched on age, sex, marital status, race, and the nature and severity of the disability in order to create 24 pairs. Within each pair, participants were randomly assigned to either the experimental group or a wait-list control group.

Intervention.—Experimental group members received trained service dogs 1 month after the study began, and subjects in the wait-list control group received dogs in month 13 of the study.

Main Outcome Measures.—Dependent variables evaluated were self-reported assessments of psychological well-being, internal locus of control, community integration, school attendance, part-time work status, self-esteem, marital status, living arrangements, and number of biweekly paid and unpaid assistance hours. Data collection occurred every 6 months over a 2-year period, resulting in five data collection points for all subjects.

Results.—Significant positive changes in all but two dependent measures were associated with the presence of a service dog both between and within groups ($P < .001$). Psychologically, all participants showed substantial improvements in self-esteem, internal locus of control, and psychological well-being within 6 months after receiving their service dog. Socially, all participants showed similar improvements in community integration. Demographically, all participants showed increases in school attendance and/or part-time employment. Economically, all participants showed dramatic decreases in the number of both paid and unpaid assistance hours.

Conclusions.—Trained service dogs can be highly beneficial and potentially cost-effective components of independent living for people with physical disabilities.

(*JAMA*. 1996;275:1001-1006)

THE AMERICANS With Disabilities Act exists to increase independence and enhance opportunities for individuals with disabilities.[1] Since the passage of this act, the development of assistive technology for individuals with severe ambulatory disabilities has accelerated. Although numerous high-tech devices address many important needs of people with disabilities, such advancements leave unmet several important daily living needs, including such personal activities as hygiene, dressing, shopping, and food preparation. Of at least equal importance, social needs, particularly those involving direct interpersonal contact and community integration, cannot be met solely by technology.

Typically, family, friends, and paid personal aides provide assistance in personal and social domains. Although the philosophy underlying the Americans With Disabilities Act rests on assumptions of the rights of individuals with disabilities to live as independently as possible in the community, the United States currently has no comprehensive national long-term care policy on affordable, home-based assistance.[1,2] Access to paid personal assistance varies throughout the United States with eligibility often tied to Medicaid programs. Such programs usually exclude certain disabling conditions and frequently do not offer comprehensive, round-the-clock service.[3] Finally, it has been suggested that major problems in the recruitment and retention of competent, dependable personal assistants are common.[4]

People in the United States who have severe ambulatory disabilities often live in relative social isolation. Not surprisingly, researchers have reported that these individuals have lower levels of self-esteem and higher levels of depression than the general population.[5-9] Negative attitudes, stereotypes, and stigmatization in society contribute to such seclusion.[10,11]

Many persons have advocated the role of service dogs to help individuals with severe ambulatory disabilities meet both personal and social needs. Such dogs, specially trained for the person they assist, can often perform nearly 100 tasks. For example, service dogs can open and close doors, turn switches on and off, pull a person up from a sitting or lying down position, assist a person in and out

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Table 1 —Summary Demographic and Disability Data on Matched Groups

	Group			
	Experimental		Wait-List Control	
Characteristic	Men	Women	Men	Women
Sample size	12	12	12	12
Race				
White	8	9	8	9
African American	4	3	4	3
Mean (SD) age, y	25 (1.5)	25 (1.2)	25 (1.3)	25 (1.2)
Marital status				
Married	1	3	2	2
Divorced/separated	7	3	8	4
Never married	4	6	2	6
Disability				
Spinal cord injury	7	4	7	4
Muscular dystrophy	1	1	1	1
Multiple sclerosis	2	6	2	6
Traumatic brain injury	2	1	2	1

of baths and pools, help pull on clothing, procure and pick up objects, pull wheelchairs, help with shopping, carry parcels, and drag a person to safety in case of fire or other emergency.

Much anecdotal evidence exists regarding the instrumental and emotional support service dogs provide for their owners. Furthermore, researchers have produced evidence that people without disabilities display fewer negative attitudes and feel less awkwardness and aversion toward individuals with disabilities who are accompanied by service dogs.[12-15]

Empirical evidence suggests the benefits of companion animals, particularly dogs, for people. For example, family companion animals can serve a social support role for people without disabilities. In one experiment, women under stress exhibited lower levels of cardiovascular reactivity and better task performance in the presence of their canine companions than in the presence of their closest women friends.[16]

Although the earlier study suggests that service dogs might improve the quality of life of people with disabilities, to the best of our knowledge a prospective, controlled investigation involving service dogs has not been published. The current study describes a randomized trial designed to provide key data regarding the impact of service dogs on the lives of people with disabilities and the economic impact of service dogs.

METHODS

Participants

Participation was limited to individuals who had expressed interest in a service dog and who currently required substantial personal assistance from family, friends, and paid aides. Qualifying individuals from New York, Pennsylvania, Massachusetts, and Connecticut were contacted through advocacy or support groups (for example, the Muscular Dystrophy Association, the Multiple Sclerosis Association). Forty-eight individuals who had been wheelchair mobile for at least 2 years participated in a split-plot, factorial-designed[17] clinical study. Although several disability groups were represented (Table 1), all individuals had ambulatory motor impairment, and many had additional motor and cognitive impairments including quadriplegia, large-muscle atrophy, lack of small-muscle coordination, aphasia, and problems with attention span and memory as well.

Individuals were matched on several characteristics, including age, sex, marital status, race, and the nature and severity of the disability, to create 24 pairs. Within each pair, individuals were randomly assigned to either the experimental or the wait-list control group. Participants in the former group were told that they would receive their dogs after 1 month, and those in the latter group were told they would receive their dogs after 13 months. Table 1 provides summary demographic and disability characteristics of the two matched groups.

Procedure

Individuals assigned to the experimental group received assistance dogs 1 month after the study began (in 1990), and subjects in the wait-list control group 12 months later (13 months after the study began). Data collection occurred every 6 months over a 2-year period, resulting in five data collection points for all subjects (months 0, 6, 12, 18, and 24), and all participants completed questionnaires at each collection point. Data were collected through questionnaires mailed to the participants themselves. Advocacy group representatives initiated telephone contact as necessary to ensure questionnaire completion.

Questionnaires

At each data collection point, participants completed questionnaires designed to ascertain psychological variables, demographic status, and assistance information. Measurements of psychological variables were performed using the following standardized instruments: the Spheres of Control Scale (to assess internal locus of control),[18] the Rosenberg Self-esteem Scale,[19] the Affect Balance Scale (to assess psychological well-being),[20] and the Community Integration Questionnaire.[21] In addition participants completed a specialized demographic questionnaire that included questions about current marital status, educational achievements, work status, and living arrangements. Participants also provided data regarding the number of hours of paid and unpaid assistance they received.

Service Dogs

Dogs were made available to participants in this study through trainers dedicated to providing dogs to people with disabilities. All the dogs were initially raised in family environments to socialize them. The dogs then entered training designed to teach them how to provide general assistance. Following this, each dog was paired with a person with a disability and was given individualized special training to expand the dog's commands to meet the unique needs of the person to whom it was assigned and to ensure that the person with a disability learned to handle the dog effectively. The total training time for the dogs ranged from 6 to 12 months.

Scoring

The selected demographic variables used to index quality of life included student status, work status, living arrangements, and marital status. Student status and work status were scored dichotomously to distinguish regular or no school attendance and regular (≥4 hours per week) or no part-time work hours, respectively. The living arrangement score reflected three levels of independence in living (ie, living alone with assistance, living with one's family, living in a group home). The marital status score reflected three categories (ie, never married, married, divorced/separated). The psychosocial status questionnaires were scored according to specific instructions provided by the questionnaire authors and developers.[18-21] Assistance data were tabulated from participant reports of biweekly paid hours (ie, the number of contracted paid as-

Table 2.—Frequency of Significant Dependent Variables by Month*

Variable	Month 0	6	12	18	24
Self-esteem score					
Experimental group	13.0 (2.1)	25.8 (1.6)	35.3 (0.6)	36.2 (0.8)	36.6 (0.7)
Control group	14.1 (1.2)	14.0 (1.2)	14.3 (1.0)	25.3 (1.2)	35.3 (0.5)
Internal locus of control score					
Experimental group	64.4 (4.3)	135.0 (5.2)	173.4 (3.7)	187.6 (3.9)	189.8 (1.6)
Control group	61.5 (2.3)	60.9 (1.9)	61.0 (1.9)	135.2 (3.8)	178.8 (3.7)
Psychological well-being score					
Experimental group	1.6 (0.5)	6.2 (0.5)	8.0 (0.3)	8.1 (0.4)	8.8 (0.4)
Control group	1.8 (0.4)	1.8 (0.4)	1.7 (0.5)	6.3 (0.5)	8.1 (0.3)
Community integration score					
Experimental group	2.3 (0.6)	15.3 (1.0)	25.3 (0.9)	26.7 (0.7)	27.2 (0.5)
Control group	2.4 (0.5)	2.3 (0.1)	2.3 (0.1)	15.7 (0.5)	25.3 (0.5)
School attendance, No. of subjects					
Experimental group	0	15	18	15	11
Control group	0	0	0	10	7
Part-time employment, No. of subjects					
Experimental group	0	9	14	21	23
Control group	0	0	0	15	17
Biweekly paid assistance hours					
Experimental group	87.9 (9.4)	37.1 (5.0)	28.0 (4.8)	20.6 (1.7)	19.6 (1.9)
Control group	83.5 (4.0)	83.5 (4.0)	84.2 (4.0)	42.1 (4.1)	21.3 (1.6)
Biweekly unpaid assistance hours					
Experimental group	38.4 (4.1)	24.5 (5.2)	14.9 (3.3)	12.8 (4.2)	12.0 (5.0)
Control group	39.8 (2.3)	39.8 (2.3)	39.8 (2.3)	22.5 (3.5)	13.4 (2.1)

*The values given are mean (SD) unless otherwise indicated. The comparisons made were performed at the same relative data points (ie, months 0, 6, and 12 for the experimental group and months 12, 18, and 24 for the wait-list control group) and are significant at $P<.001$.

sistance hours) and unpaid hours (ie, the number of biweekly volunteered hours from family members and friends).

Analytic Strategy

Parametric (analysis of variance [ANOVA]) and nonparametric (χ^2) statistical analyses using a dual analytic approach were performed as appropriate on dependent variables comparing the experimental and wait-list control groups. Although participants in the experimental and wait-list control groups were carefully matched, group was treated conservatively as a between-group factor in the ANOVAs. Thus, each split-plot ANOVA had one between-group factor with two levels, ie, experimental group and wait-list control group, and one within group factor, month, with three levels. First, experimental and wait-list control groups were compared at the first three data collection points (months 0, 6, and 12), that is, before the service dogs were assigned to the wait-list control group. Second, the first three data collection points of the experimental group (months 0, 6, and 12) were compared with the last three data collection points of the wait-list control group (months 12, 18, and 24), that is, we compared the same relative points in time for the two groups 1 month before and 6 and 12 months after the service dogs were provided. It was expected, a priori, that a statistically significant group-by-month interaction would emerge between the groups in the first but not the second analysis.

RESULTS

Comparisons at the First Three Data Points

These analyses revealed significant main effects for group and month ($P<.001$ for all comparisons) and significant interactions for group by month ($P<.001$ for all comparisons) for all psychosocial status variables (ie, self-esteem, psychological well-being, internal locus of control, and community integration). Similar main effects for group and month ($P<.001$) and significant interaction for group by month ($P<.001$) were found for assistance variables (paid and unpaid assistance). When we used χ^2 analyses, significant main effects for group and month ($P<.001$) and significant interactions for group by month ($P<.001$) emerged for school attendance and part-time employment, but not for marital status or living arrangement. Table 2 includes the relevant means and standard deviations for all significant dependent variables (see months 0, 6, and 12). The top panel of Figure 1 depicts the pattern of means for self-esteem. The patterns of means for psychological well-being, internal locus of control, community integration, school status, and part-time work status are all quite similar to the pattern for self-esteem. The top panel of Figure 2 depicts the pattern of means for paid assistance hours. The pattern for unpaid assistance hours is the same as for paid assistance hours. In sum, the canine-assisted experimental group fared much better than the non-canine-assisted wait-list control group on the dependent variables after month 0.

Comparisons at the Same Relative Data Points

These analyses showed significant effects only for month for all dependent variables ($P<.001$ for all comparisons) except marital status and living arrangements, for which there were no significant effects. Table 2 includes the relevant means and standard deviations for all significant dependent variables and indicates the comparisons at the same relative data points, ie, months 0, 6, and 12 for the experimental group and months 12, 18, and 24 for the wait-list control group. The bottom panel of Figure 1 depicts the pattern of means for self-esteem, which again was the prototype pattern for all significant psychological dependent variables as well as school and part-time work status. The bottom panel of Figure 2 depicts the pattern of means for paid assistance hours, which was also the prototype for unpaid assistance hours.

COMMENT

Substantial positive changes on most dependent measures were associated

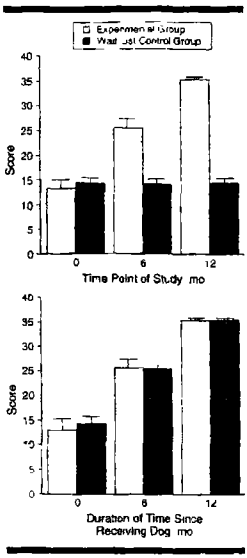

Figure 1.—Mean self-esteem scores by assignment group and selected month. The experimental group received their dogs 1 month after study initiation, and the wait-list control group received their dogs 13 months after the study began.

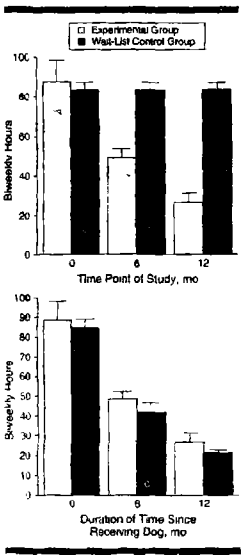

Figure 2.—Mean biweekly paid assistance hours by assignment group and selected month. The experimental group received their dogs 1 month after study initiation, and the wait-list control group received their dogs 13 months after the study began.

with the presence of a service dog both between and within groups. Psychologically, all participants showed substantial improvements in self-esteem, internal locus of control, and psychological well-being within 6 months after receiving their service dogs. Socially, all participants showed similar improvements in community integration. Demographically, participants demonstrated substantial increases in terms of school attendance and part-time employment. Economically, all participants showed dramatic decreases in the number of both paid and unpaid assistance hours.

That service dogs would improve the psychological well-being of individuals with severe disabilities was expected from the results of previous companion animal research.[15] However, the community integration measure revealed several intriguing new findings based on behavioral reports demonstrating increased levels of social interaction, employment, and use of public transportation.

Although the effects for marital status and living arrangement were not significant, there were improvement trends in both categories. After receiving their dogs, five participants who were separated or divorced were reconciled with their spouses. In addition, another divorced individual remarried after receiving a dog. To date, no participants who were married before receiving their service dogs have become separated or divorced. Although only five participants moved to more independent living arrangements after receiving a dog, and none to less independent arrangements, we learned that others had tried to increase their independence but failed due to specific group home policies prohibiting dogs.

Somewhat unexpectedly, reports of paid and unpaid assistance demonstrated dramatic economic benefits of service dogs. After 12 months, the presence of a service dog was associated with a decrease of approximately 60 (68%) biweekly paid assistance hours in the experimental group. Table 3 contrasts estimated cost data for individuals with and without service dogs based on several assumptions: total calculated costs of initial canine training at $10 000[22], lost investment income on initial training costs at 5% per annum compounded quarterly, $1000 per year in animal maintenance[23], an expected canine service period of 8 years[24], and $8, $10, and $12 per hour for paid human assistance. As Table 4 depicts, actual savings begin to accrue during the second year and increase to $60 000 or more after 8 years as a function of human assistance costs per hour. In addition to dollar savings, the presence of a service dog was also associated with a decrease of approximately 25 (64%) biweekly unpaid assistance hours, thereby diminishing a substantial time and economic burden for family and friends who were caregivers.[21,25] Figure 3 illustrates the relationship between various reduction percentages of paid assistance and total cost savings over an 8-year period.

According to the World Institute on Disability, more than 3.8 million people in the United States need personal assistance services, but fewer than 850 000 are actually receiving them.[2] Estimates from other national surveys suggest that between 2.7 million[26] and 4.3 million[27] people require some assistance from another person. Although currently available national survey data tell us little about the subset of people who have the level of need that warrants a paid assistant, the need may be substantial, and it has been suggested that dependable, competent assistants are difficult to find.

The extent to which the results of this study can be generalized to the entire group of individuals who require some degree of personal assistance remains to be determined because of the nature of our sample. Our participants were selected with the help of advocacy and support groups for each of the disability types included in the study, and little is known about possible differences between people who tend to join such groups and those who do not. We deliberately selected individuals for our study who wanted a service dog and had severe, chronic conditions requiring many hours of caregiving. We have demonstrated what dogs can do for such a group. We can only speculate that individuals with fewer needs would also find service dogs beneficial albeit with less, though perhaps substantial, savings.

Because it is not possible to conduct a masked investigation of the benefits of service dogs, we cannot completely rule out the contribution of participant expectations or demand characteristics to the results of this study. Regarding the former, the experimental treatment in

Table 3 —Long-term Reduction in Paid Assistance Due to Service Dogs*

Year	Quarter	Paid Human Assistance, h/wk	$8/h, $	$10/h, $	$12/h, $	Training, $	Upkeep, $	Discounted Total $8/h, $	Discounted Total $10/h, $	Discounted Total $12/h, $
				No Service Dog						
1	1	44	352	440	528					
	2	44	348	435	522					
	3	44	344	429	515					
	4	44	339	424	509					
2		2288	17 115	21 790	26 149					
3		2288	[illegible]	20 353	24 903					
4		2288	15 312	19 165	23 718					
5		2288	[illegible]	18 603	22 588					
6		2288	14 342	17 927	21 512					
7		2288	13 649	17 073	20 488					
8		2288	13 008	16 260	19 512					
Total			107 297	134 119	160 944					
				Service Dog						
1	1	44	352	440	528	10 000	250	10 602	10 690	10 778
	2	34	268	336	403		247	516	583	650
	3	24	187	234	281		244	431	478	525
	4	14	108	135	162		241	349	376	403
2		728	5547	6933	8320		952	6499	7885	9272
3		728	5283	6603	7924		907	6190	7510	8831
4		728	5031	6289	7546		864	5895	7153	8410
5		728	[illegible]	5989	7187		823	5614	6812	8010
6		728	[illegible]	5701	6845		784	5347	6488	7628
7		728	[illegible]	5432	6519		746	5092	6178	7265
8		728	4139	5174	6209		711	4850	5884	6919
Total								51385	60039	68691

*These calculations are based on a reduction of 68% in costs per week of paid assistance in the service dog group and a discount rate of 5%. Ellipses indicate not applicable.

Table 4 —Long-term Reduction in Paid Assistance Due to Service Dogs*

	Annual and Cumulative Discounted Savings					
	$8/h, $		$10/h, $		$12/h, $	
Year	Annual	Cumulative	Annual	Cumulative	Annual	Cumulative
1	(10 515)	(10 515)	(10 399)	(10 399)	(10 283)	(10 283)
2	10 933	418	13 905	3506	16 875	6594
3	10 413	10 831	13 243	16 749	16 074	22 667
4	[illegible]	[illegible]	[illegible]	[illegible]	15 300	[illegible]
5	14 445	30 132	12 611	41 272	14 578	52 552
6	[illegible]	[illegible]	[illegible]	52 912	13 884	[illegible]
7	14 587	47 254	10 836	61 706	13 223	9654
8	8159	55 912	10 376	74 082	12 593	92 252
Total	55 912		74 082		92 252	

*These calculations are based on a reduction of 68% in costs per week of paid assistance in the service dog group and a discount rate of 5%. Ellipses indicate not applicable.

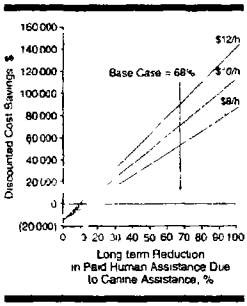

Figure 3 —Cost savings of service dogs by reduction in paid assistance at several levels of hourly wage and based on a discount rate of 5%.

our study necessarily included subject expectations as well as certain other factors inherent in the service dog–participant pairing process and the specialized training during which participants became acquainted with their dogs. In addition, because participants were selected from advocacy groups, it is possible that responses were somewhat biased for the purpose of promoting policy changes related to service dogs. We believe, however, that the primary or major aspect of the treatment was in fact the assistance provided by the dog. Several factors support this belief. First, whatever expectations existed did not appear to affect the wait-list control group prior to their acquisition of a dog, even though they had been accepted into the program. Second, third-party judgments based on written comments collected every 6 months corroborated the well-being and functionality of the participants before and after they received the dog. These judgments from family members and friends of the participants were consistent with the participant self-report measures. Although it is possible that subjects in the control group "put off" improving their own well-being and functionality until they received their service dogs (ie, for an entire year) it is, in our opinion, unlikely. Furthermore, even if they had, this argument is irrelevant to the comparisons between month 0, when no one had received a dog, and month 6 after receiving a dog.

Several factors reduce the possibility of demand characteristics. First, participants knew the dog was theirs to keep no matter what happened; they were told that they could drop out of the study at any time, with no changes in the medical and social services they were receiv-

ing. Thus, there was little personal incentive for participants to provide "good" data. Furthermore, in our opinion, the enthusiasm with which participants and their friends and family members described experiences with the dogs was too overwhelming and enduring to be anything but genuine. Finally, we believe that the longitudinal nature of the design supports our contention that the results were directly related to the presence of the service dogs.

Although this study demonstrates the utility and potential cost-effectiveness of service dogs, dogs can be only part of a comprehensive plan for long-term home assistance. Although all of our participants were able to reduce the number of paid and unpaid hours of required human assistance, they still need some human help daily. We suggest that service dogs are an economically sound and efficacious option for people who want canine assistance. In times of heated political debate regarding health care costs, the comment of one of our participants, who lives with the consequences of spinal cord injury, provides an insight: "With my [dog], I feel safe and capable, and I am no longer afraid of the future. Everyone needs someone to care for, and we care for each other with dignity."

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STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
SEPTEMBER 6, 2001

Mr Chairman and Members of the Subcommittee

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on several pieces of legislation before the Subcommittee.

Today's agenda includes H R 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001, H.R 1435, the Veterans' Emergency Telephone Service Act of 2001, and H.R 1136, a bill to require Department of Veterans Affairs (VA) pharmacies to fill prescriptions written by private practitioners. These several bills cover a range of issues important to disabled veterans and their families We support many of the provisions, but for the reasons we state below, we oppose or have concerns about a few

H.R. 2792—DISABLED VETERANS SERVICE DOG AND HEALTH CARE IMPROVEMENT ACT OF 2001

Section 2 of this bill would authorize VA to provide certain hearing-impaired veterans and veterans with spinal cord injury or dysfunction, in addition to blind veterans, with service dogs to assist them

Although DAV does not have a resolution on this issue, this provision is beneficial and will assist all enrolled veterans with certain severe disabilities The DAV is not opposed to the favorable consideration of this section of the bill by the Subcommittee

Section 3 of the bill pertains to maintenance of capacity for specialized treatment and rehabilitative needs of disabled veterans It proposes to amend the definition of capacity to include each geographic service area of the VA, in relationship to the maintenance of capacity in the Department for specialized treatment and rehabilitative needs of disabled veterans It would require VA to measure capacity by the annual amount expended for care (adjusted for inflation) in such dedicated programs Additionally, it would extend the annual Capacity Report requirement through 2004 We suggest that section 3 of the bill further clarify the obligation to maintain capacity and include a mandate for monitoring capacity at the network level

The VA noted in its draft annual Capacity Report for 2000 "[n]ationwide capacity appears to be maintained or improved for workload measures in seven out of eight special disability specialties.... For all disability programs except Substance Abuse, VHA can document that it has maintained or improved its workload capacity for its special disabilities programs "

As we previously testified before this Subcommittee, we disagree with these findings and assert that VA has not met capacity in accordance with the spirit of Public Law 104-262, which mandated that,

> [T]he Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of disabled veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that the overall capacity of the department to provide such services is not reduced....

It was also mandated that capacity would be maintained at levels reported in fiscal year 1996. Interested parties argued that capacity measures should be determined by the number of veterans treated and the dollars expended for their care, and that capacity is only maintained if both components are met. We agree that both of these variables are necessary to accurately access if capacity is being met. Including both components would allow us to monitor whether the necessary reinvestment of resources from institutional to outpatient-based care is occurring in certain specialized programs. Finally, we agree that these figures are only meaningful if a reasonable adjustment for inflation is included Maintaining acceptable capacity levels in each network is key to ensuring that veterans have timely access to specialized care in the appropriate treatment venue. It is essential that each network maintain capacity in its medical centers and community-based outpatient clinics so that veterans have access to the specialized programs they need.

We urge that additional requirements for measuring capacity be added to ensure veterans have equal access to specialized programs throughout the system. For example, the Capacity Report should include specific information about the types of programs available in each geographic service area, the number of patients treated in each program, the number of inpatient beds available, and the number of full-time employees that supports these programs. Additionally, there should be a means established by which network directors and medical center directors can be held accountable for providing this information and maintaining capacity levels of VA special disability programs as mandated by law.

Information provided in the annual Capacity Report is essential for determining the status of specialized programs within VHA. Unfortunately, there is still valid criticism about the reliability of the data contained in the report. It is imperative that uniform data collection standards be developed to ensure valid reliable data is generated for reporting purposes. Information contained in the Capacity Report is necessary for tracking the status of these important programs, and we agree there should be an extension of the annual report requirement as proposed in this section of the bill.

Section 4 of the bill would change the means test used by VA in determining whether a veteran will be placed in enrollment priority Category 5 or 7. The current placement eligibility threshold is set at about $24,000 nationwide. This legislation attempts to level the playing field to adjust the means test based on locality, thereby allowing veterans living in high-cost areas to be classified as Category 5 if they fall below the new threshold level.

DAV does not have a resolution from our membership on this issue however, its purpose appears beneficial. DAV does not oppose the favorable consideration of this section of the bill.

Section 5 of the bill would establish a pilot program designed to allow certain veterans in under-served areas to seek inpatient services in private sector hospitals utilizing their own health insurance, with VA becoming a secondary payer of any other out-of-pocket expenses A similar measure was introduced last year with which we took exception. Despite a few new revisions in this bill, our overall objection to this concept still stands.

This measure would pay for the costs of general medical and surgical inpatient care and services not covered by any applicable health-care plan of the veteran. To be eligible, the veteran would have to be enrolled in VA to receive medical care services, have received care within a 24 month period proceeding application for enrollment in the pilot program, and require care for a non-service connected condition if services are not available from a VA facility. The proposal contains language stating that VA would coordinate care by providing case management. Additionally, any expenditure of funds shall be made from amounts in the Medical Care Collections Fund (MCCF).

We are deeply concerned that this initiative would shift medical services and veteran patients from VA to the private sector. It would encourage VA to refer patients, and the dollars used to subsidize their care outside the system. VA would lose third-party reimbursements that veterans bring to help underwrite the provision of care for all veterans using the VA health care facility. This proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain their full range of specialized inpatient services for all veterans. It would erode VHA's patient resource base, undermining VHA's ability to maintain its specialized services programs, and endanger the well being of veteran patients.

Additionally, it would allow disparate treatment of veterans depending on whether or not they have insurance, in essence creating a new eligibility category for veterans' health care based not on veteran's need, but solely on the veteran's geographic location, and to a great extent, the veteran's own health insurance. Finally, although the provision includes language for case management, we believe the VA's ability to coordinate care would be limited at best.

Clearly, other initiatives should be considered to assist veterans who reside in under-served areas. We are, however, opposed to any initiative that would turn VA into an insurer rather than a provider of health care. For the benefit of all, we feel the VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers. This traditional form of VA health care has served well to offer an uninterrupted flow of services to veterans in need, and ensure the quality of those services no matter where or when they are provided.

Section 6 of the bill would establish a managed care pilot program for contract hospitalization and fee basis ambulatory care users All fee basis and contract hospitalization provided by the Secretary in selected pilot locations would be furnished through a managed care coordinator contractor. Eligible veterans would be provided a directory to receive non-VA care or to use in health emergencies in the case of contract hospitalization. This section provides that a primary care manager would be established in each participating facility to ensure that veterans participating in the program receive appropriate care, and that they would be brought back into the VA system for followup care whenever possible and appropriate.

Of great concern to the DAV is that managed care of VA fee basis patients may create a barrier for these veterans in getting the care they need. Managed care programs frequently do not offer the kinds of specialized services that disabled veterans may need. Fee basis and contract care are provided to veterans when needed services are unavailable at a VA health care facility or when veterans would have to travel too far to a VA facility to receive the care they need. Currently, fee basis patients are able to choose the physician they want to see for fee-based health care services. As part of a managed care plan, the veteran would be required to choose one of the participating clinicians or hospitals for care. Many veterans participating in the fee basis program have long established relationships with their health care providers and are satisfied with the care they receive. We do not see that this measure would assist veterans in receiving timely, quality medical care to meet their health care needs.

Section 7 of the bill would authorize certain bereavement counseling and counseling, training, and mental health services for immediate family members of certain service and non-service connected veterans.

Although DAV does not have a resolution on these issues, this provision is beneficial and will assist veterans' family members in coping with the loss of a loved one or in coping with a serious mental health illness of a disabled veteran. The DAV is not opposed to favorable consideration of this bill by the Subcommittee.

Section 8 of this measure would extend existing MCCF authority with respect to third party collections and medication co-pays. Congress authorized VA to collect co-payments for treatment of nonservice-connected conditions as a temporary measure to achieve savings for deficit reductions. Large budget surpluses have been projected over the next decade, and, under ordinary circumstances, veterans should not have to pay for benefits accorded them by a grateful nation.

The delegates to our last National Convention in Miami Beach, Florida, July 28-August 2, 2001, passed a resolution opposing any legislation that would require the VA to increase or extend the congressional authority for collection of co-payments.

DAV strongly opposes medication co-pays

H.R. 1435—VETERANS' EMERGENCY TELEPHONE SERVICE ACT OF 2001

This measure would authorize grants to establish a national toll-free hotline to provide information and assistance to veterans and their families, including crisis intervention counseling, general information regarding veterans' benefits under title 38, United States Code, and information about provisions of emergency shelter and food, substance abuse rehabilitation, employment training and opportunities, and small business assistance programs. The provisions of this bill limit a grant to a period of not more than two years, with payment subject to annual approval by the Secretary and subject to the availability of appropriations.

The proposed legislation would require a private, non-profit entity to contract with a carrier for use of a toll-free telephone line; employ trained and supervised personnel to answer incoming calls and provide counseling and referral service to callers on a 24-hour-a-day basis; assemble and maintain a current database of information; and publicize the hotline. The private, non-profit organization must demonstrate that it is a nationally recognized expert in the area of furnishing assistance to veterans and have a record of high quality service in furnishing such assistance, including the support from advocacy groups, such as veterans service organizations.

As written, the DAV is opposed to H.R. 1435. As stated in our July 10, 2001 testimony before the Subcommittee on Benefits, this measure attempts to take away an intrinsic part of VA's mission of service to veterans and their families.

Since about 1993, the VA has had a toll-free number whereby veterans or other VA claimants could obtain information about benefits and health care services. VA counselors also have available to them information on benefits offered by other federal departments and agencies and the states.

In March 2001, the DAV conducted a nationwide survey of VA's national toll-free hotline. The supervisory NSOs in all of our offices were asked to call the VA toll-free number and track how many times they had to call before they got through and how long they had to wait to receive the requested service. They were instructed to request the "new" Agent Orange Help Line toll-free number, which had been published by the VA the week prior to our survey.

The results of our survey were surprising and somewhat unexpected. In all but a few cases, our NSOs were able to access the help line on the first call. In one case, in Hartford, Connecticut, it took 14 tries before they were able to get through; however, very few NSOs received a busy signal when they called. For the most part, services were rendered in less than five minutes—this was total call time. In the vast majority of the calls, our NSOs received the correct toll-free Agent Orange Help Line phone number. In some cases, our NSOs were put on hold while the counselor obtained the phone number. In a few cases, our employees were referred to either the medical center or the Agent Orange registry. Overwhelmingly, we were informed that the counselors were polite and courteous. In some cases, the counselors offered to provide any additional assistance that might be needed on other matters.

The only complaint we received from a few of our supervisory NSOs dealt with the automated, recorded message they had to listen to before reaching a counselor. It was their

concern that older veterans might find it frustrating or difficult to maneuver through the automated message. However, it is difficult to imagine how a more effective system might be devised to avoid this situation and still provide a complete menu of available services.

In conclusion, it would appear that the experience from our survey confirms that the current VA toll-free number is working. As with any service, it must be continually monitored, evaluated, and improved.

If this Subcommittee believes that VA is not adequately meeting the needs of veterans or other VA claimants in providing needed information, then VA should be held accountable. If this Subcommittee also believes that 24-hour-a-day access to this information is necessary, then VA should be provided the resources to staff these toll-free telephone lines 24-hours a day.

The DAV does not believe that a private, non-profit organization would be better able to handle this function. Accordingly, we oppose this legislation.

This measure has been marked up by the Subcommittee on Benefits and amended provisions were considered by the full Committee and incorporated in H.R. 2540 as a pilot program for VA to expand its current service hours. This bill has passed the House and been referred to the Senate. DAV supports the language of section 407 of H.R. 2540.

H.R. 1136

This bill would require VA pharmacies to dispense medications to veterans for prescriptions written by private practitioners.

This measure would be beneficial to a large segment of the veteran population who do not currently receive their health care from VA. We recognize that requiring this group of veterans to use the VA system for all their health care needs just to receive prescription medications would further burden the system, cause additional delays in the delivery of health care services, and greatly increase the cost of VA health care. Indeed, VA is experiencing a large influx of veterans seeking care, apparently to obtain medication through VA. Perhaps this legislation would result in a net savings to VA. However, we foresee that, if veterans were authorized to access prescription drug benefits only, a significant number of veterans who are not currently using the system would likely choose this option and thereby cause a significant increase in overall pharmaceutical costs to VA.

Of great concern to the DAV is that, if this measure were passed and not appropriately funded to meet the presumed increased costs in pharmaceuticals, it would be extremely detrimental to the VA health care system and to currently enrolled veterans. It would place significant stress on an already overburdened system and cause a negative impact on veterans who depend on VA for all their health care needs. Additionally, we are concerned that if this mandate was not properly funded, VA may again propose to increase co-pays for medications as a way to offset rising pharmaceutical costs.

CLOSING

The DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important measures

Testimony Presented by Thomas H Miller
Executive Director
Blinded Veterans Association (BVA)

U S House of Representatives
Committee on Veteran's Affairs
Subcommittee on Health
Hearing on H.R. 2792
Thursday, September 6, 2001

Mr Chairman and members of this distinguished subcommittee, on behalf of the Blinded Veterans Association (BVA), I want to express our appreciation for your invitation to present our views on H.R.2792 The Disabled Veterans Service Dog and Health Care Act of 2001, currently pending before the subcommittee. I want to commend you, Mr Chairman, for introducing this important legislation We in BVA feel especially qualified to comment on the importance of the role of service dogs in assisting severely disabled veterans. Service dogs help veterans in coping with their disabilities and achieving successful reintegration into their communities.

Section 2 of H R.2792 would amend section 1714 authorizing the Secretary of the Department of Veterans Affairs (VA) to provide service dogs to disabled veterans with spinal cord injury or disease or other chronic impairments that result in limited mobility as well as service dogs for the hearing impaired. We are especially pleased that this bill makes all veterans enrolled in VA Health Care eligible for these dogs. In our view, eligibility for prosthetics services based on enrollment was one of the fundamental elements of the Eligibility Reform Act that contributed significantly to the transformation of the VA Health Care system. The removal of complex and unnecessary eligibility criteria for the provision of vital prosthetics services has substantially improved access for disabled veterans to needed services

As I mentioned above, Mr. Chairman, BVA feels especially qualified to comment on this provision of your bill because VA has possessed the authority to provide guide dogs to blinded veterans for many years The value of guide dogs for enabling people who are severely visually impaired or blind to overcome the problems associated with safe and independent mobility has been well documented and widely accepted by the general public. Guide dogs are permitted access everywhere, affording visually impaired individuals the opportunity for full participation in their communities

Despite the fact that guide dogs afford the fastest, safest, and most efficient means of travel for people who are blind, a very small percentage of people who are blind use guide dogs. The use of a guide dog is a personal decision, which is influenced by many factors. The utilization of guide dogs by blinded veterans reflects the general blind population, which is less than four percent. Consequently, the impact on VA is minimal This is especially true in that the guide dog schools do not charge a fee for the dogs, and generally will pay for the transportation to and from the school.

As you may know, VA Blind Rehabilitation Service (BRS) only trains blinded veterans in the use of the long cane for safe and independent travel. Whether a veteran chooses to apply for a guide dog is a very personal decision. Long cane travel is quite stressful, as you might imagine, requiring intense concentration and skill Some blinded veterans never develop enough confidence in the skills with the cane and turn to a guide dog The guide dog enables the person to travel more quickly, safely, and efficiently than when using a cane The choice therefore between the cane and a guide dog depends primarily on the individuals independent travel needs, confidence, and comfort level when using the long cane

BVA believes a very similar experience will result from providing VA the authority to provide service dogs to certain disabled veterans The service dogs, while not as common and widely accepted as the guide dog, clearly provide the same kinds of benefits Mr. Chairman, the most difficult aspect of accepting and adjusting to a disability is coping with the loss of independence Becoming dependent on others to perform basic activities of daily living, which are normally taken for granted, is the single most difficult aspect of disability to cope with

Restoring ones independence is essential to rehabilitation and fundamental to this process is the integration of prosthetic devices, sensory aids, appliances, and now service dogs It has been clearly demonstrated that using service dogs enhance the quality of life characterized by restored self-esteem, confidence, and worth Concurrently, the utilization of the service dog substantially reduces dependence on paid personal care assistants Without question, Mr Chairman, the VA should be authorized to provide service dogs to those disabled veterans who have a demonstrated need and can benefit from the use of a service dog Similar to guide dogs, we would not expect that a substantial percentage of disabled veterans would require or benefit from a service dog Regulations should be specific as to under what conditions a service dog is necessary. Guide dogs and service dogs alike are not intended to be companions, pets, or attack dogs

SECTION 3

BVA strongly supports Section 3 of this bill, which requires VA to maintain its capacity to provide specialized treatment and rehabilitation for disabled veterans This requirement was originally established with the adoption of the eligibility reform Act of 1996 This act not only required VA to maintain such capacity, it also required VA to submit a report to congress annually known as the Capacity Report (CR)

The ERA only required VA to maintain national capacity in the Special-Disabilities Programs Sec 3 of H R 2792 requires not only maintenance of National but Network Capacity as well We believe this is essential to assuring disabled veterans equitable access to these vital services. The importance of this requirement is exemplified by a situation that occurred more than two years ago One VAMC hosting a blind Rehabilitation Center (BRC) arbitrarily closed fifteen beds dedicated to the delivery of comprehensive residential blind rehabilitation They also eliminated the professional positions dedicated to provide that service In an effort however, to comply with ERA, another fifteen-bed BRC was established in another Network While strong arguments can be made for the need for the new BRC, the loss of the fifteen beds at the original VAMC has only resulted in longer waiting lists and times for admission Consequently, blinded veterans are either being denied or at the very least delayed access to essential specialized rehabilitative services. The Special-Disabilities Programs are regional in nature, making it extremely important to maintain a national balance affording equity of access for disabled veterans

While BVA supports this provision in H R 2792, we have several concerns regarding its depth and scope. Specifically, the method utilized to measure capacity is problematic We believe it is not enough to only measure number of veterans treated and the dollars spent Certain Special-Disabilities programs such as blind rehabilitation and spinal cord injury/disease are carried out in residential settings Therefore, they require a certain number of beds dedicated to the provision of these very specialized services along with a specific number of Full-Time Employee Equivalent (FTEE) professionally educated and trained to deliver these services It follows, therefore, if these beds and essential FTEE are not counted, preserved, and protected, VA certainly cannot maintain its capacity

There are those who would argue that the Special-Disabilities Programs should mirror the shift from inpatient service delivery to outpatient settings In our view, the need for acute care provided on an inpatient basis will always exist as will the need for inpatient residential rehabilitative service for severely disabled veterans. The comprehensive benefits realized in the inpatient programs cannot be duplicated on an ambulatory basis There is no question, in some instances, outpatient services may be indicated and appropriate, but this does not negate the need for the residential training programs It is imperative, therefore, that beds and FTEE be integral elements of any methodology for measuring capacity.

VA will argue they have treated more blinded veterans than ever before and spent more dollars providing this treatment. This is the basic argument employed against counting beds and FTEE The fundamental flaw with this argument in our view is the increases in numbers of blinded veterans receiving treatment in the BRC's is due primarily to substantially reduced lengths of stays Limiting the programs enables VA to pump an increasing number of blinded veterans through the program, inflating the numbers treated and reducing the cost per blinded veteran. We are deeply concerned that quality of care is being compromised to achieve artificially high numbers Some BRC's have gone so far as to introduce shortened programs (1 or 2 weeks) in an effort to inflate the numbers treated as well as game the Veterans Equitable

Resource Allocation (VERA) model. Under VERA, blinded veterans who are admitted to a BRC and spend at least one night qualify their host Network for reimbursement at the high or complex rate Mr Chairman, these short programs are not residential blind rehabilitation, and only serve to improperly utilize beds dedicated for the comprehensive program

The CR clearly has been a numbers game. It does not address quality issues and accountability. Therefore, we strongly believe that maintenance of capacity must be included as a performance measure in the facility and Network Directors Performance contracts. They have vigorously resisted this in the past, insisting that they only be required to monitor these programs Monitoring is not the same as measure and they must be held accountable. We strongly encourage the inclusion in H R. 2792 such requirements

BVA is also deeply concerned that the outpatient programs currently in operation in VA Blind Rehabilitation Service (BRS) be included in the maintenance of capacity requirement. Specifically, I am referring to the Visual Impairment Service Team (VIST) Coordinators and the Blind Rehabilitation Outpatient Specialist (BROS) positions The VIST Coordinators are the case managers responsible for assuring the delivery of comprehensive service to all blinded veterans in their respective areas. They serve as the access point for blinded veterans into the system and for referral to the BRC's. The BROS are the professionals charged with providing blind rehabilitation services to blinded veterans unable to attend the BRC program Both positions are very vulnerable in the de-centralized management environment employed by the Veterans Health Administration (VHA). When vacancies occur, field managers either attempt to eliminate, or drastically alter the position descriptions, usually assigning collateral duties. This latter tactic prevents those professionals from meeting the demand for care and specialized rehabilitative services. Additionally, local management frequently attempts to fill these crucial positions with unqualified individuals. Therefore, we believe very strongly the full-time VIST coordinators and BROS must be counted if capacity is to be maintained.

BVA also firmly supports the requirement that VA continue providing the CR to Congress for the next three fiscal years. Although BVA has complained that data used for the CR's provided over the past several years has been flawed, we fervently believe, without the reporting requirement, the Special-Disabilities Programs would have possibly been damaged beyond repair. We believe it imperative that the focus on these specialized programs must be continued.

Mr. Chairman, on a personal note, I have had the honor of chairing the Federal Advisory Committee on Prosthetics and Special-Disabilities Programs for the past several years and I know first hand that our committee has failed to agree with VA's assertion that they have been maintaining capacity. Each year of the CR, we have reported the data utilized has been flawed, highlighting the limitations of VHA Information Management systems. Clearly uniform national standards for coding and costing must be implemented if valid and reliable data is to be generated for reporting purposes. The Advisory Committee, in its most recent meeting held at the end of May, strongly recommended the continuation of the CR reporting requirement and will certainly appreciate your efforts to that end.

SECTION 4

BVA supports Section 4 of this bill that would implement the Department of Housing & Urban Development (HUD) low-income index for establishing thresholds for veteran's health care eligibility means tests. We believe this is a more equitable method for conducting means testing of veterans and allows for variability in cost of living in certain areas of the country. Veterans burdened by a substantially higher cost of living associated with certain areas, should not be penalized, and required to utilize their limited resources to pay for care from VA. We appreciate your inclusion of this provision in the bill.

SECTION 5

Mr. Chairman, BVA is deeply concerned by this section of the legislation. We opposed this provision in the last session of Congress and feel compelled to do the same this time. Converting VA into a payer for veteran's health care rather than a provider is disturbing at the very least. The provision seems to be a cost avoidance measure and certainly not in the best interest of disabled veterans.

BVA is painfully aware of the financial constraints under which VA must operate its health care system, but question the wisdom of turning veterans over to non-VA providers which would insist that veterans rely on their own insurance or Medicare Proper management of veteran's care utilizing this model seems problematic at best

This provision requires that all payments by VA for deductibles, co-pays etc. must be made from the Medical Care Cost fund (MCCF) at the local level As you know, these are receipts collected from third party payers and retained at the local facility. Although these funds are used to offset the cost of providing care to certain Non Service-Connected (NSC) veterans, or for the care provided for treatment of NSC conditions, it is also available to enhance the overall capacity to provide service at any given facility for all veterans including those with Service Connected (SC) disabilities Therefore, the proposed pilot projects contemplated under this provision would avoid costs by providing care in non-VA facilities. Potentially, this could result in reduced capacity and quality of care of SC disabled veterans Fundamental to maintaining quality is maintaining a sufficient workload at facilities, assuring professional opportunities for learning, education, and the acquisition and maintenance of skills and expertise necessary for the provision of high quality services. This is particularly important in specialty areas VA cannot provide specialized services without the availability of the full array of medical and ancillary services necessary to support the Special-Disabilities Programs

We are also very concerned this approach to service delivery sets a precedent that can be perceived as the first step towards vouchering out all VA health care We also believe this approach would not be in the best interest of disabled veterans VA possesses a long history of experience, expertise, and knowledge in providing specialized health care and rehabilitative services rarely available in the community The drive to reduce the cost associated with the delivery of VA health care should not result in disabled veterans being forced out of the system especially designed to address their unique and special needs

SECTION 6

Mr Chairman, BVA also has reservations to Section 6 of this bill Requiring all contract or fee basis treatment to be provided through managed care programs raises serious concerns Managed care programs do not offer all the specialized services that might be required by disabled veterans nor make appropriate referrals to VA providers who do indeed possess this expertise Again, is cost avoidance warranted at the risk of disabled veterans not receiving essential service in a timely manner?

SECTION 7

BVA supports this provision The families of severely disabled veterans who have suffered for years, or are burdened by catastrophic illness or disease, deserve all the bereavement counseling assistance VA can provide Typically, family members are the primary care givers and, in many cases, devote much of their adult lives caring for veterans Without this devoted care, the burden would fall to VA Clearly, VA should provide counseling to support and assist these devoted Americans in coping with their loss

SECTION 8

BVA supports this provision of H.R 2792

CONCLUSION

Again, Mr. Chairman, BVA appreciates the opportunity to appear this afternoon to share our comments on H.R 2792 and commend you and the subcommittee for introducing this important legislation. As always, I would be pleased to respond to any questions you or other members might have

STATEMENT OF
JACQUELINE GARRICK, ACSW, CSW, CTS
DEPUTY DIRECTOR, HEALTH CARE
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNTIED STATES HOUSE OF REPRESENTATIVES
ON
HEALTH RELATED LEGISLATION

SEPTEMBER 6, 2001

Mr Chairman and Members of the Committee.

The American Legion appreciates the opportunity to comment on these important health care benefits that affect the nation's veterans and the Department of Veterans Affairs (VA) The bills and draft legislation under consideration have been reviewed by The American Legion and we offer the following comments and recommendations

H.R. 2792-Disabled Veterans Service Dog and Health Care Improvement Act of 2001

Sec 2. Authorization for Secretary of VA to provide Service Dogs for Disabled Veterans

The American Legion is aware of the vital services these animals offer in assisting persons with disabilities The companionship and aide service dogs offer is well documented in the private sector. This level of care goes a long way to improve the quality of life for the disabled community Veterans should be no different VA should make every effort to assess and provide veterans requesting service dogs with that option

Sec 3. Maintenance of Capacity for Specialized Treatment and Rehabilitative Needs of Disabled Veterans

The strength of the VA healthcare system is the experience it has in handling the unique health care concerns of the service connected and catastrophically ill veteran's population Some maladies, such as spinal cord injury, blindness, amputation, traumatic brain injury and mental illness, are more prevalent in veterans than in the general population because of the dangerous nature of military service The specialized treatment and rehabilitative needs of disabled veterans is critical

The American Legion does not believe that this legislation will ensure that the maintenance of capacity for specialized treatment and rehabilitative needs of disabled veterans will be protected. VA has been measuring capacity using this formula since eligibility reform passed, and each year The American Legion and her sister veteran service organizations have testified on the lack of capacity for the special emphasis programs This provision seems to be an attempt to circumvent the need for VA to return to its previous level of capacity. Therefore, The American Legion believes that VA should not be allowed to reduce its capacity below the October 9, 1996 level.

Sec 4. Threshold for Veterans Health Care Eligibility Means Test to Reflect Locality Cost-Of-Living Variations

Subsection (b) of section 1722, Title 38 United States Code, sets forth the income threshold used for the determination of low-income families These thresholds are also used to determine the ability of veterans to defray the cost of medical care. Currently, the threshold is

set at $17, 240 for a veteran with no dependents and $20,688 for a veteran with one dependent, plus $1,150 for each additional dependent

The American Legion fully supports the proposed increases to $23,688 in the case of a veteran with no dependents and to $28,429 for a veteran with dependents These threshold increases are more in keeping with today's cost of living

Sec 5. Pilot Program for Coordination of Ambulatory Community Hospital Care

Access and timeliness of VA health care are two monumental concerns The American Legion consistently monitors and seeks to improve When The American Legion surveyed Legionnaires this past year, it asked veterans to rate VA access by defining it as appointment availability, travel distance and waiting times The average score for how veterans rated VA access was 78 percent. Although VA has made significant progress in these areas, there is much room for improvement With the dramatic shift in the last several years from inpatient to outpatient care, both in VA and the private sector, a cost-effective means of providing hospital care to veterans residing in under-served areas in the country is fundamental It is well known that there are many veterans and their families who have to drive several hours to receive hospital care in VA inpatient facility

In a nutshell, the proposed program would allow veterans to obtain inpatient medical care at the local community hospital as opposed to a VA inpatient facility two hours away The program would cover both service-connected and nonservice-connected conditions VA would pay the costs for the hospital care and medical services to the community hospitals Also, VA may cover the costs for applicable plan deductibles and coinsurance and the reasonable costs of inpatient care and medical services not covered by any applicable healthcare plan of an enrolled veteran. Eighty-five percent of the participating veterans would be required to have some type of healthcare plan The American Legion believes this should also include Medicare and the dependents provision from the GI Bill of Health VA would coordinate all care being given to veterans in non-Department hospitals to include the pre-approval of inpatient admissions.

In the past, the American Legion has supported VA's use of contracts to expand access into rural communities where no VA care exists However, The American Legion through its National Field Service site visit process has learned that in some cases contracts were poorly written and resulted in additional expenses and lack of control over the quality of patient care The American Legion passed resolution # 2, *The American Legion Policy on VA Contract Health Care Services,* at the National Executive Committee held October 18-19, 2000 in Indianapolis, IN This was done to ensure that VA contracts were written to include pre-certification, utilization review, concurrent screening, repatriation of patients, and be negotiated by the Veterans Service Integrated Network (VISN) office In addition, the community hospital must be accredited for the level of care it is contracted to perform and must meet the same benchmarks for performance by which a VA facility would be held accountable Under these circumstances, The American Legion would support the proposed pilot program Furthermore, there is no clear delineation for psychiatric services under this pilot and if VA could contract as outlined by The American Legion resolution, then patients with psychiatric diagnoses should not be discriminated against and should be offered the same type of access to inpatient care

Sec 6. Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

The American Legion recognizes the need to explore alternatives in the management and delivery of care to our nation's veterans Additionally, we realize that with the shift of care from inpatient to outpatient, VA may need to rely increasingly on contracted care and services With the rising cost of health care, delivering quality care, with the added bonus of cost savings, is a challenge The pilot program suggested here would monitor the possible success of that challenge over the next three years

Under this program the Secretary would provide, through a managed care coordinator contractor, contract hospitalization and fee basis for veterans already receiving such care The managed care coordinator would be experienced and have a network of credentialed providers already in place. Veterans will be automatically enrolled for participation Each enrolled veteran would receive a pre-approved directory of providers they could choose from to receive non-VA care or to use in emergencies The VA would assign a primary care manager at each

VA medical center who would participate in the program The responsibilities of the primary care manager would include coordination and case management of each enrolled veteran This manager would ensure that veterans receive appropriate care and that the veteran is returned to the VA system for any needed follow up care The contractor would provide a 24-hour a day, seven-day a week, help line primarily for health care advice and referral information The contractor would also establish a service telephone line that would provide veterans information on eligibility, enrollment, and provider locations

The American Legion views this provision with trepidation VA oversight of the contracting process has not been stellar, as previously noted in this statement The American Legion believes each contract proposal should be evaluated based on its enhancement of services and access to care for veterans within their community and meet the VA benchmark to provide veterans with care within thirty minutes or thirty miles from their home As outlined in American Legion resolution #2, contracted care must comply with VA standards of quality and all contracts must include pre-certification, utilization review, concurrent screening, the ability to repatriate VA patients, and be negotiated by the network office to meet specific needs of the geographic service area.

The American Legion is also concerned with the added burden placed upon the nursing population with the assignment of a primary care manager at each VA medical center Case managers are usually registered nurses and in previous hearings, it has been documented that there is a critical nursing shortage within VA. The addition of a new category of employment may intensify the existing recruiting and staffing problems

Finally, The American Legion believes that the severing of long standing relationships between the veterans and their VA care providers, if the providers are not part of the managed care network, will ultimately result in the dissatisfaction of the veteran. This managed-care network is too reminiscent of the Department of Defense's Tricare system, which has left too many retirees and their families frustrated, dissatisfied, and disconnected from their healthcare providers

Sec 7. Recodification of Bereavement Counseling Authority and Certain Other Health-Related Authorities

The American Legion has long been a proponent of allowing veteran's dependents access to VA health care and includes this very concept in its GI Bill of Health The expansion of services to bereaved spouses and families coping with mental illness is a step in the right direction, but The American Legion strongly urges congress to consider full implementation of the GI Bill of Health component that deals with dependents access to VA care.

The American Legion also recognizes the need for VA to be able to provide humanitarian care in the event of emergencies and supports this section

HR 1435 - Veterans' Emergency Telephone Service Act of 2001

This act would give the Secretary of Veterans Affairs the authority to award a grant to a private, nonprofit entity for the purposes of establishing a toll-free telephone number that veterans may call to inquire about, and receive assistance on, any number of issues as they relate to veterans' benefits

The VA currently has a toll-free number for veterans to call when they need assistance on their benefits When called, this toll free number goes through an inclusive litany of possible choices for benefits and medical care information Whatever selection the caller makes, general information on that particular benefit is given along with suggestions to call the nearest VA medical center or regional office for more detailed information The caller may also choose to stay on the line to talk with a representative

Given the complex nature of veterans' benefits and its administration, The American Legion is skeptical that the establishment of such a service by a private entity would not result in

chaos, especially if there were two different toll free numbers in operation H R. 1435, as currently understood, would duplicate VA's current toll-free outreach service.

It is the opinion of The American Legion that it would be better to expand and improve upon the VA's current telephone information system rather than trying to establish a new, expensive, and privately owned operation.

H.R. 1136 - Requires Department of Veterans Affairs Pharmacies to Dispense Medications to Veterans for Prescriptions Written by Private Practitioners.

The American Legion has carefully weighed both sides of this issue as presented by VA leadership and in the July 24, 2001 testimony given by the Honorable Richard Griffin, Inspector General (IG) before the Senate Committee on Veterans Affairs VA leadership has expressed serious concerns over patient safety and accountability if it were to act as a "drug store" and simply fill prescriptions written by outside providers

Currently, if a veteran does have a prescription written by a private physician and brings it to VA, the veteran is scheduled to see a VA provider who re-evaluates the veteran, sometimes duplicating lab work or x-rays done in the private sector before re-writing the prescription. There is obviously a time-delay in this process and the veteran, in the meantime, is going without a medication, which can result in intensified symptoms, worsening of a condition, and result in the need for hospitalization, longer courses of care or additional medication

However, when the IG testified, he did not support the concerns for quality or safety VA leadership has purported. The IG did not find evidence that filling outside prescriptions would result in pooter quality of care as long as safety provisions were in place The Department of Defense (DoD) does operate its formulary in this manner and there have been no known documented cases whereby retirees suffered because DoD filled a wrongly written prescription or there was a drug interact

The American Legion has received numerous e-mails, letters, and phone calls about this process and veterans seem very much in favor of having their non-VA provider prescriptions filled at a VA pharmacy In its recent VA Local User Evaluation (VALUE) survey, The American Legion documented that 88 percent of veterans use VA because of the prescription drug benefit. In responding to the survey, many veterans offered comments on expanding access to the VA formulary. This is a tremendous issue for the entire veterans' community since the cost of pharmaceutical products is skyrocketing and acts as barriers to getting them

Many of these veterans who are trying to get VA to fill prescriptions are Medicare eligible and do not have other prescription drug benefits They are using their Medicare coverage in the private sector to avoid the current VA $50 80 office visit co-payment, but then seek VA services to fill the expensive prescriptions they could not otherwise afford, not knowing that VA will make them see a provider The government ends up paying twice for these Medicare/VA users since there is no coordination of care between these two systems Medicare subvention would go along way to alleviate this replication of services and dual expenditure

However, in the absence of Medicare Subvention and since private provider prescriptions are written for other categories of veterans, The American Legion at this time feels there is enough evidence to support expanding the VA pharmacy benefit to include outside prescriptions. This mandate would have to be funded to take into account the increase in workload this will generate for VA

Mr Chairman and Members of the Committee, that concludes this statement The American Legion is available to answer any questions or concerns you may have

SERVING
WITH
PRIDE

TESTIMONY

of

RICHARD JONES
AMVETS NATIONAL LEGISLATIVE DIRECTOR

before the

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

on legislative proposals:

H.R. 2792, the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001; H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001; and H.R. 1136, a bill to require Department of Veterans Affairs' pharmacies to dispense medication to veterans for prescriptions written by private practitioners.

Thursday, September 6, 2001
2:00 P.M., Room 334
Cannon House Office Building

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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to be here today to present the views of AMVETS regarding H.R. 2792, the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001; H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001; and H.R. 1136, a bill to require Department of Veterans Affairs' pharmacies to dispense medication to veterans for prescriptions written by private practitioners.

H.R. 2792, the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001:

AMVETS supports H.R. 2792, the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001. It is welcomed, compassionate legislation that will help provide independence to many disabled American veterans. And, because it will change lives for the better, we encourage your subcommittee to approve this bill and ready it for full House consideration as soon as possible.

Mr. Chairman, I don't know if any on the subcommittee, other than yourself, have seen the success and direct benefits of a service dog to individuals with impaired mobility, hearing, or related disability. I am so very proud that, some time ago, AMVETS recognized the critical importance of assistance dogs and began a donor-partnership with *Paws With a Cause*, a national nonprofit group headquartered in Wayland, Michigan, that trains service dogs and matches them with disabled people.

Since 1979, *PAWS* has been one of the premier organizations in America working to explore the realistic possibilities of improving the lives of disabled individuals through assistance dogs. Like everyone else, disabled veterans want to manage their lives with as much dignity and independence as humanly possible; and, highly trained dogs can make a valuable contribution toward the miracle of independence.

While AMVETS supports the bill, we would like to make certain that it specifically authorizes payment for the cost of training service dogs. If the secretary is to provide a service dog, as outlined in new subsection (c), we presume that he is also granted the authority to pay for the trained dog; as he is granted authority under subsection (d) to pay travel and incidental expenses incurred by the client-veteran.

It should be understood that not every organization would require veterans to travel to a training center, for which, under this legislation, the veteran would be reimbursed. Some organizations deliver the service dog directly to the veteran through a field representative These organizations first make an assessment of the individual's needs, provide training to the dog to assist with those physical needs, and deliver the dog to a field instructor in the area for further, personal "in-home-and-community" training suited to the individual's specific requirements. In effect, they work in close quarters to develop a working team, with no travel involved.

It takes different amounts of time for training, due to the nature of the placement, but it is proven that these dogs can be trained to assist people who have been challenged by any of more than 25 different disabilities, beyond those covered in the bill, including cerebral palsy, muscular dystrophy, spinal cord injuries, epilepsy and varying degrees of hearing impairment and vision loss.

AMVETS would note another potential benefit of service dogs – cost effectiveness In an April 3, 1996, study published in **JAMA, the Journal of the American Medical Association**, the value of service dogs is measured in economic terms. The study, entitled "The Value of Service Dogs for People with Severe Ambulatory Disabilities," finds that one service dog saves an average of $16,000 a year in costs that would otherwise go to pay for direct attended care. Extrapolated over a 10-year life span of a dog's active assistance, the value of these service dogs helps make this legislation economically sound, too.

With regard to other sections of this legislation, AMVETS supports Section 3 to maintain VA capacity for specialized treatment and rehabilitation of disabled veterans. AMVETS strongly believes that the core focus of the VA health system should be on assistance to and treatment of disabled veterans.

AMVETS supports Section 4 regarding the use of an index among geographic localities as a way to determine who is, in fact, "unable to defray the expenses of necessary care" of VA health care services. Clearly, the current use of a single, national "means test" to determine the priority classification of veterans for VA health care fails to account for variations in the cost-of-living in the area where the veteran resides. Our preference, however, is to eliminate the means test for veterans who served their country during periods of national emergency or war. A veteran is a veteran. We do not apply a means test when we send him or her into harm's way. Why then should we impose a post service price?

AMVETS supports the goals of Sections 5 and 6. We, too, want every veteran who has an injury or illness incurred in the defense of America to receive appropriate, world-class health care. We want their access to the system improved. Our bottom line is access to care for veterans; especially for those who need specialized services or who, because of their circumstances, rely on VA as their health provider. Our veterans deserve no less.

AMVETS remains concerned, however, about the resources currently available to the VA health care system. The challenges faced by VA and the veterans it serves are not easy. Clearly, the health care system is in dire need of additional funding caused by years of inadequate budget proposals. With next year's appropriations likely to fall short of meeting the challenges that face the system, it is difficult to see a positive effect on the quality, timeliness, and accessibility of heath care received by our veterans, including those residing in your districts.

AMVETS supports Section 7 to expand counseling services for family members of veterans receiving VA treatment. We believe it is the government's responsibility to care

for those in uniform who have served our country and to help their families and orphans This sort of benefit is what the Department of Veterans Affairs is all about; to help not only those who gave so much on behalf of the nation but also their families who, in turn, help our heroes do what they do so the rest of us can live in freedom.

H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001:

AMVETS supports H.R. 1435 to establish a national toll-free telephone hotline for veterans and their dependents. By virtue of the service and sacrifice they have rendered to the nation, our veterans deserve the very best support services we can provide. The establishment of a national information and assistance hot line could further strengthen VA's integrity for veterans' service. AMVETS believes, however, that the opportunity to provide these services should not be limited solely to America's private, nonprofit community, as outlined in this bill. The bill should be amended to allow free, open American competition, thereby giving the secretary the opportunity to choose the best provider for the job. We feel such a service would compliment a series of 800-services already available to veterans and dependents, including the following: VA Benefits 1-800-827-1000, Life Insurance 1-800-669-8477, Debt Management Center 1-800-827-0648, CHAMPVA 1-800-733-8387, Headstones and Markers 1-800-697-6947, and the Persian Gulf Hotline 1-800-PGW-VETS among others.

H.R. 1136, a bill to require Department of Veterans Affairs' pharmacies to dispense medication to veterans for prescriptions written by private practitioners:

AMVETS has no position on H.R. 1136, a bill to require Department of Veterans Affairs' pharmacies to dispense medication to veterans for prescriptions written by private practitioners without providing them primary care. We recognize that pharmaceutical costs are rising as a proportion of overall medical care expenses. And in some respects, the rising costs make it difficult for VA to carry out its other priority healthcare services AMVETS is aware of estimates that suggest the open-filling of prescriptions would require additional resources equal to as much as one-third of VA's current healthcare

budget, a level of funding equivalent to providing VA medical care to more than one million veterans.

Clearly, if we are to come to grips with our honor and obligation to the brave and dedicated men and women who have worn this nation's uniform, we must understand their legacy as defenders of freedom. And, in this understanding, we see that freedom is not free. Its costs are measured in terms of lives lost and citizen soldiers who, together with their families, bear the scars and infirmities of their service throughout the remainder of their adult lives.

Mr. Chairman, the common theme in efforts to provide appropriate health care for our veterans today and into the future is that our veterans are indeed special. They are a unique national resource to whom we owe an enormous debt of gratitude for their service, their sacrifice, their patriotism and their unswerving dedication to America.

In sum, AMVETS firmly believes, as stated in *The Independent Budget*, that adequate funding remains the central issue challenging the future of the VA healthcare system.

This concludes my testimony. Thank you for extending AMVETS the opportunity to appear before you today, and thank you for your support of veterans. We believe the price is not too great for the value received.

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August 27, 2001

Bobby L. Harnage
National President

Jim Davis
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8b/107128

The Honorable Chris Smith
Chairman, House Veterans' Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

The Honorable Jerry Moran
Chairman, House Veterans' Affairs Health Subcommittee
338 Cannon House Office Building
Washington, DC 20515

The Honorable Lane Evans
Ranking Member, House Veterans' Affairs Committee
333 Cannon House Office Building
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The Honorable Bob Filner
Ranking Member, House Veterans' Affairs Health Subcommittee
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Dear Chairman Smith, Chairman Moran, Ranking Member Evans and Ranking Member Filner.

On behalf of the American Federation of Government Employees (AFGE), AFL-CIO, and the 600,000 federal workers AFGE represents, including roughly 135,000 Department of Veterans' Affairs (DVA) employees, I oppose Section 5 and Section 6 of H R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001

AFGE opposes Section 5 of H.R. 2792 titled, "Pilot Program For Coordination Of Ambulatory Community Hospital Care." This provision would authorize DVA to cover a veteran's costs of inpatient care at non-DVA facilities DVA would become the secondary insurance for any out-of-pocket expenses of veterans with insurance, including Medicare, when veterans seek inpatient services in private sector hospitals

This provision establishes an entirely new eligibility category for veterans' health care based not on the veteran's status or need, but purely on the veteran's geographic location, and to a great extent, the veteran's own health insurance Accordingly, Section 5 will create a disparity between the health care available to veterans who chose to use DVA health care facilities and those, primarily with their own insurance, who have previously chosen not to use DVA facilities.

This pilot will also set a precedent for sending veterans to non-DVA providers for inpatient services that are paid by veterans' own insurance. DVA would now subsidize care outside of the DVA system, losing both the direct and appropriated dollars and any third-party reimbursements If this precedent is set and expanded, DVA health care facilities would only become local referral centers without the resources to sustain the full range of care, including the specialized services such as spinal cord injury care and substance abuse treatment, for which it is well known

Under Section 5 of H.R 2792, DVA would not really have control to manage the veteran's case once referred because it would be a secondary payer, not the provider of care.

AFGE is for increased access in veterans' care but not at the cost of unraveling the DVA operated health care system. Veterans deserve and need a unique health care system devoted and dedicated to treating their unique medical needs. Picking up the co-payments for veterans who have insurance will ultimately transform DVA from a health care system designed and focused on veterans medical care into an insurance company This proposal claims to give a few veterans improved "access" but will do so at the cost of maintaining a fully staffed and functioning DVA health care system. We urge you to omit this section from the bill.

AFGE opposes Section 6 of H.R. 2792, titled "Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care." This provision would require the DVA to conduct a pilot contractor run managed care program in four locations. All veterans eligible for fee basis programs and contract hospitalization would be directed through a managed care contractor

The medical care and treatment of veterans, like the administration of other benefits and services owed veterans, is an inherent responsibility of the Federal government – not the private sector. DVA focuses all of its medical staff and resources exclusively on treatment of and research on veterans' illnesses and disabilities. This focus on veterans' health care needs is not found in the private sector As a result of DVA's undivided focus on veterans, DVA staff has world-class expertise in treating spinal cord injury, blindness, traumatic brain injury, amputation, serious mental illness, and post-traumatic stress disorder.

DVA medical facilities play a role in veterans' health care that the private sector either cannot or does not provide. Indeed, research reported in leading medical

journals suggests that veterans who go to DVA facilities have better medical outcomes than patients do in non-DVA hospitals.

AFGE opposes DVA's excessive reliance on fee basis care and contract hospitalization to treat veterans. DVA shunts veterans to non-DVA hospitals and fee-basis physicians for care because DVA lacks adequate in-patient beds and is understaffed. During the past six years DVA cut its direct patient care staff by one in six and increased its use of fee nurses and other medical professionals by 32 percent. DVA also increased its dependence on private hospitals for inpatient care by 26 percent. It appears that rather than hire the staff it needs, DVA is already turning to contractors

Section 6 of H.R. 2792 would make an already bad situation worse. It would increase the escalating cost of contracting out veterans' care by adding a "managed" care review by one contractor over another contractor It would also reduce DVA's direct ability to care for veterans

Section 6 of H R. 2792 would also ultimately reduce — not expand — veterans access to quality care. Managed health care organizations increase their profits by denying or restricting a patient's access to care. Of course a managed care contractor will claim they are controlling costs by preventing unnecessary utilization of services. Shouldn't a DVA physician and their veteran patient decide what services and care a veteran needs, without having to submit their decisions to a DVA contractor?

Veterans' deserve and should have increased access to the care they need at DVA run-hospitals. Because DVA physicians are not working for a profit-driven hospital or managed care group they put the patient care first. A managed care contractor, by virtue of their business, must put profits margins first and foremost.

AFGE does not believe Section 6 of H R. 2792 would increase quality of care for veterans or conserve the already inadequate funding for veterans' health care. AFGE urges this provision to be deleted from the Disabled Veterans Service Dog and Health Care Improvement Act of 2001.

AFGE urges you to delete Section 5 and Section 6 from H.R. 2792.

Thank you for considering our views on this important legislation. Should you or your staff have any questions regarding our concerns, please contact Linda Bennett in AFGE's Legislative Department at (202) 639-6456

Sincerely,

Bobby L. Harnage, Sr.
National President

WRITTEN TESTIMONY

of

MICHAEL D. SAPP, SR.
CHIEF OPERATING OFFICER/CO-FOUNDER
PAWS WITH A CAUSE®

before the

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
US HOUSE OF REPRESENTATIVES

on legislative proposal:

HR 2792, the Disabled Veterans Service Dogs and Health Care Act of 2001

Mr. Chairman and Members of the Subcommittee:

On behalf of Paws With A Cause, I am pleased to provide our written views regarding HR 2792, the Disabled Veterans Service Dogs and Health Care Improvement Act of 2001.

The objective of this bill is commendable and welcomed, however, Paws With A Cause has concerns regarding how the bill is currently written and interpreted. While we are certain that no exclusion was intended, we are concerned that as currently written, this bill may not provide equal access for Service Dogs to all eligible American Veterans.

Subsection '(c) of Section 2 states: "The Secretary may provide... service dogs.. ", however, there is no explanation of what "provide" means. It is stated in Subsection '(d) "In the case of a Veteran provided a dog under subsection (b) or (c), the Secretary may pay travel and incidental expenses for that Veteran..." We question if "provide" is defined the same as "pay", and if not, how exactly is "provide" defined?

Upon thorough review of HR 2792 by key staff members, two distinctly different interpretations were found One interpretation was that the bill would cover the sponsorship of the Service Dog, i e., the costs incurred to the organization that trains the dog or a portion thereof, as well as the travel and incidental expenses of the eligible Veteran to receive their Service Dog if necessary.

The second interpretation was that the bill would provide only for the travel and incidental expenses and not the cost to train the dog If this interpretation is correct, we cannot support the bill, as not all Service Dog programs require, nor are all people with disabilities able to travel, and therefore there would be no benefit to the eligible Veteran Requiring a Veteran with a disability to travel a great distance to receive their Service Dog and spend two (2) or more weeks at a training center learning to properly use and care for their dog may not only pose a financial hardship, it may also be extremely taxing on their physical and emotional health. Arranging travel, job or school furlough and having attendant care accompany them, in addition to the physical requirements of long days of training can easily become overwhelming fatiguing

We appreciate the opportunity to offer our thoughts and concerns regarding this bill. Having worked with many American Veterans in the training and placement of Service Dogs, we believe this bill has the potential to offer greater avenues to independence to men and women with disabilities who have given so much to our country. It is our hope that our views will inspire further discussion and perhaps modification to this bill so that Service Dogs may be made available to all eligible American Veterans.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

PAUL A. HAYDEN, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO
H.R. 2792, DISABLED VETERANS SERVICE DOGS AND HEALTH CARE IMPROVEMENT ACT OF 2001 AND OTHER PENDING HEALTH-RELATED LEGISLATION

WASHINGTON, DC SEPTEMBER 6, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I would like to express our thanks for the opportunity to communicate our positions as they pertain to the following legislation

H.R. 2792
Disabled Veterans Service Dog and Health Care Improvement Act of 2001

Section 2 of this bill would authorize the Secretary of Veterans Affairs to provide service dogs for disabled veterans Trained service dogs have proven to be useful, cost-effective, assistive tools in helping individuals with disabilities meet both personal and social needs Currently, the Department of Veterans Affairs (VA) is only authorized to provide guide dogs to blinded veterans with service-connected disabilities

VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N E ● WASHINGTON, D C 20002-5799
AREA CODE 202-543-2239 ● FAX 202 543 6719

It is our position that all disabled veterans suffering from spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility deserve an enhanced quality of life through the independence that a trained service dog can provide. It is for this reason that the Veterans of Foreign Wars (VFW) fully supports section 2 to expand and provide service dogs to disabled veterans.

Section 3 seeks to amend VA's responsibility under the Veterans' Health Care Eligibility Reform Act of 1996, PL 104-262, to maintain the capacity to provide specialized treatment and rehabilitative needs of disabled veterans, including veterans that require specialized services such as spinal cord dysfunction, blindness, amputations, and mental illness at the 1996 level

The VFW supports the language that would require the VA to maintain capacity within each geographic service area of the Veterans Health Administration or Veterans Integrated Service Network (VISN) Equal access to specialized services should continue to be a priority.

We, however, are opposed to the concept that capacity be determined by the annual amount of dollars expended for care of veterans receiving specialized care and rehabilitative services. Instead, we offer that capacity to provide services can only be truly measured by the number of beds available or dedicated to those specific specialized services and the number of Full-Time Employee Equivalents (FTEE) trained and

equipped to handle veterans who require specialized care Only then can VA's ability to maintain capacity under PL 104-262 be adequately measured.

Extending the annual report requirement through 2004 is essential to maintaining oversight and compliance and enjoys our full support

Section 4 would increase the income threshold for veterans' health care eligibility to reflect locality cost-of-living variations The current income threshold utilized by the VA to establish eligibility is $23,688 for a veteran with no dependents regardless of geographic location This policy is somewhat arbitrary when you consider that a veteran who earns $23,688 while residing in New York City does not possess the same purchasing power that a veteran, say, residing in Tucson, Arizona would enjoy The VFW believes that this is an inherent inequity that places undue burden on certain veterans and we support this legislation designed to create a more equitable income threshold by taking into account geographic cost-of-living variations.

Sections 5 and 6 both attempt to establish pilot programs one would coordinate ambulatory community hospital care, the other would contract hospitalization and fee basis ambulatory care The VFW understands the reality that not every veteran enjoys equal access to inpatient facilities and we support expanded access for veterans residing in rural areas We also support VA's obligation to contract out care when services are not available within VA

These sections of the bill, however, would shift VA's responsibility to provide quality health care to a private sector third party that has no accountability to the VA with the VA picking up the bill or the co-payment. We oppose both of these sections and we challenge the Veterans Health Administration (VHA) to develop new models of direct health-care delivery

Section 7 would consolidate and recodify existing VA authority to provide services to non-veterans. The VFW supports this administrative change.

Section 8 seeks to extend VA's authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of non-service connected disabilities of veterans with service-connected disabilities The VFW favors this extension because these funds have proven to be a vital supplement to annual appropriations.

H.R. 1435
Veterans' Emergency Telephone Service Act of 2001

As we have previously testified before the House Veterans Affairs' Subcommittee on Benefits on July 10, 2001, we support this legislation that would authorize the Secretary of VA to award grants to companies for purposes of providing a national toll-free hotline to provide information and assistance to veterans

H.R. 1136
To amend title 38, United States Code, to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and...

The VFW does not support this proposed legislation that would authorize the VA to dispense medications to veterans for prescriptions written by private practitioners The VA is not a pharmacy like CVS or Walgreens It is a health care system that provides a high standard and continuity of care In order to ensure that veterans receive this level of care, it is imperative that they regularly see a VA physician Aside from the potential budget implications posed by the highly inflatable cost of pharmaceuticals, the VA's responsibility for the care of the veteran, once again, would be shifted to a private third-party that cannot be held accountable by the VA or Congress

Thank you once again for the opportunity to present our views This concludes my testimony, Mr Chairman, and I would be happy to answer any questions at this time

Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the Record

By

Philip A. Litteer

Chairman, National Government Affairs Committee

Before the Subcommittee on Health

House Committee on Veterans Affairs

Regarding

H.R. 2792, H.R. 1435 and H.R. 1136

September 6, 2001

Mr. Chairman, and other distinguished members of the Committee, on behalf of Vietnam Veterans of America (VVA) we are pleased to have this opportunity to provide our comments for the record on the three bills being considered by this committee today. We will begin by addressing our concerns over the implications of H.R. 1136, which seeks to amend title 38, United States Code, "to require Department of Veterans Affairs pharmacies to dispense medications to veterans for prescriptions written by private practitioners, and for other purposes."

Simply put, Mr Chairman, this measure represents an unfunded mandate for the VA. H.R. 1136 provides no offsets or other necessary revenue mechanisms to pay for this proposed expansion of VA pharmacy services. Given the fact that the entire VA healthcare system is underfunded by at least $3 billion by our estimates, it would be fiscally irresponsible and a disservice to the entire veteran population to force yet another unfunded mandate on an already overburdened VA system

Moreover, this proposal raises serious continuity of care issues. Under this proposal, a veteran who is receiving care from both VA and private sector practioners could request that his private sector physician or specialist write a script for the veteran without the knowledge of the veteran's VA health care provider(s)...a development that could, in certain situations, place the veterans health—perhaps even his or her life—at risk. Without proper safeguards in place, this proposal may actually increase the threat to a veteran's health.

Finally, VVA would argue that the proper response to this issue is to provide a genuine prescription drug benefit under Medicare. VA has testified before Congress that it is aware of a growing number of cases where dual eligible veterans have chosen access to VA for their prescription drug benefit because it is unavailable via Medicare. According to Richard J. Griffin of the VA's Inspector General's Office, the VA IG estimates that some 90% of Category 7 veterans utilize the VA pharmacy system as their primary or sole prescription drug supplier—in excess of 360,000 veterans without compensible service-connected disabilities and with incomes above prescribed limits. The influx of these veterans into the system has severely strained the VA pharmacy system; if enacted, H.R. 1136 might well break the system, absent appropriate offsets. Accordingly, VVA opposes this legislation.

H.R. 2792, the Disabled Veterans Service Dog and Health Care Improvement Act of 2001

Below we will address the specific sections of this bill that are of key importance to VVA:

Sec. 2: Authorization For Secretary Of Veterans Affairs To Provide Service Dogs For Disabled Veterans

VVA strongly supports the provisions of this bill which would allow the VA to provide service dogs for the hearing and ambulatory-impaired veteran population, in addition to the sight-impaired veteran population. VVA also notes that numerous published, peer-reviewed studies have demonstrated the positive emotional and physiological effects of pets on their

owners, and that any initiative that helps disabled veterans to live fuller lives should be supported by all those interested in the health and well-being of our nation's wounded warriors.

Sec. 3: Maintenance Of Capacity For Specialized Treatment And Rehabilitative Needs Of Disabled Veterans.

In subparagraph (a)(3), H.R. 2792 would add the following language to paragraph (1) of section 1706(b) of title 38, United States Code:

> *The capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities shall be measured by the annual amount (adjusted for inflation) expended for care of such veterans in dedicated programs which provide such specialized treatment and rehabilitative services through specialized staff.*

VVA believes that this language fails to capture the true essence of the problems brought about as a result of the original 1996 Capacity legislation: namely, that a) the entire VA health care system remains grossly underfunded, and b) that there are no oversight or accountability mechanisms in place to eradicate mismanagement within the VISN system.

Since fiscal year 1996, VA's spending on Post-traumatic Stress Disorder (PTSD) treatment programs has declined by over 8% even as the number of patients in need of services has increased by over 20%. VA's ability to provide inpatient or residential PTSD care has been virtually eliminated. If one counts medical inflation, then PTSD program resources have declined by more than 30%.

Likewise, programs for the seriously mentally ill have suffered a major reduction in capacity—a roughly 10% loss in resources against a nearly 10% increase in the number of patients.

Substance abuse programs have also taken a major hit. Despite a roughly 12% decline in the number of veterans seeking treatment, total resources declined by an astonishing 37%, amounting to a net reduction in services of 25%, not accounting for medical inflation. Even allowing medical inflation at only 8% per year (the private sector has been averaging over 10%), the sum total of reduction in substance abuse services is more than 60%!

What does this mean for the veteran? Veterans who should have been treated for PTSD on an inpatient basis are now dealt with infrequently and through outpatient programs that are inadequately staffed, underfunded, and unevenly allocated nationally. The seriously mentally ill veterans are now wandering our streets, without proper treatment or hope for recovery. Those plagued by drug or alcohol addiction illnesses are descending into personal oblivion.

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, explicitly

requires the VA to "maintain its capacity to provide for the specialized treatment and rehabilitation of disabled veterans within distinct programs or facilities dedicated to the specialized needs of those veterans." Instead, PTSD, substance abuse, mental illness, and homeless programs within the VA have virtually imploded due to inadequate funding.

Our organization has estimated that it will take a bare minimum of $3 billion—over and above additional funds to offset past medical inflation—to begin to restore VA health care programs to their pre-1996 levels. The administration and the Congress must come up with these funds if they wish to prevent further harm to at-risk veterans.

Additionally, Congress must mandate that the VA prepare a plan for rebuilding and recentralizing organizational capacity in the specialized services that has been lost over the past five years. The existing VA healthcare system consists of 22 unevenly managed and variably resourced mini-VA's—with no clear lines of authority or responsibility between the VA Central Office and the field. Some of these 22 "networks" are well managed. Others are not. The failure of the 1996 decentralization of prosthetics programs for veterans caused the Congress to subsequently recentralize that function within the VA, a move that successfully restored the VA's capacity to serve veterans in need of prosthetic devices. The same model should be applied to PTSD, homeless, substance abuse, and other programs as well.

Finally, Congress must also ensure that a genuine system of accountability—rewards *and* sanctions—is put in place to compel managers throughout the VA system to meet their obligations to the veterans they serve. Currently, not even the possibility exists for the VA to live up to the legal standards of the Government Performance & Results Act. Unless VA senior managers are held accountable for money spent (or misspent), the needed budget increases that are vitally needed by veterans—particularly disabled veterans—will ultimately be squandered.

Sec. 5: Pilot Program For Coordination Of Ambulatory Community Hospital Care

This provision of the legislation would establish "a pilot program in not more than four geographic areas of the United States to improve access to, and coordination of, inpatient care of eligible veterans." The bill further states that with regard to funding this proposed pilot program

> *the Secretary may pay the costs authorized under this section for hospital care and medical services furnished on an inpatient basis in a non-Department hospital to an eligible veteran participating in the program. Such payment may cover the costs for applicable plan deductibles and coinsurance and the reasonable costs of such inpatient care and medical services not covered by any applicable health-care plan of the veteran, but only to the extent such care and services are of the kind authorized under this chapter. The Secretary shall limit the care and services for which payment may be made under the program to general medical and surgical services and shall require that such*

services may be provided only upon preauthorization by the Secretary.

This stipulation would clearly put at risk the health care of veterans deemed "complex care cases" under the VHA diagnostic system, and accordingly VVA vehemently opposes this portion of the legislation.

Moreover, subsection (g) of the bill states that

(1) The total amount expended for the pilot program in any fiscal year (including amounts for administrative costs) may not exceed $50,000,000.

(2) Any expenditure of funds for the pilot program shall be made from amounts in the Medical Care Collections Fund attributable to collections under section 1729 of this title No funds may be expended to support the purposes of this section from any other funds available to the Secretary for the delivery of health care services to veterans, including funds appropriated or otherwise available for the care and treatment of veterans who require specialized care and resources

VVA is opposed to this funding scheme. As GAO noted in its report on the MCCF program in October 1997, the VA was experiencing difficulties in recovering monies from private insurers. For example, GAO reported that in FY96, VA only recovered about 31% of the billed amount ..and that was a 5% reduction from the previous year. We have no evidence to date that the VA's collection rate has improved, and that fact alone raises serious questions about the financial viability of the funding scheme proposed under this bill. Accordingly, VVA requests that if the committee seeks to mandate such a pilot program that it provide appropriate line item funding.

At the end of the day, the only meaningful outcome measure is whether veterans are restored to the best possible physical and mental health so that they can obtain and sustain meaningful employment or self-employment. We urge the committee to strengthen both the language of H.R. 2792 to achieve this end, and to revise the budget agreement in order to provide the funding the VA needs to properly care for all of our veterans.

H.R. 1435, the Veterans' Emergency Telephone Service Act of 2001

This bill would, as drafted, mandate that

The Secretary of Veterans Affairs may award a grant to a private, nonprofit entity to provide for the operation of a national, toll-free telephone hotline to provide information and assistance to veterans and their families, including crisis intervention counseling, general information with respect to veterans benefits under title 38, United States Code, referrals to appropriate individuals with expertise in such veterans benefits, and information with respect to the provision of emergency shelter and food, substance

abuse rehabilitation, employment training and opportunities, and small business assistance programs.

VVA is strongly committed to quality assurance system that are effective. Because of this commitment we have supported this bill in the past. However, upon further reflection and deliberation within our own leadership, VVA would respectfully suggest to the committee that a more appropriate response would be to have the General Accounting Office conduct a complete review of the VA's 800-number service system, and to make appropriate recommendations on how the VA's 800-number service system can best be improved. Based on our review of other VA programs, we strongly suspect that inadequate management oversight is the primary reason for any major problems in the VA's existing system. We believe it would be a serious mistake to attempt to have a nonprofit or other entity—particularly one not fully conversant in the range of programs and services offered by the VA—to be allowed to take over such an important public relations and outreach activity.

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these important pieces of legislation. We believe that they address matters of vital concerns to veterans. We look forward to working with this Committee and Congress on this and other important issues.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Post-Hearing Questions
Concerning the September 6, 2001 Hearing
For
The Honorable Anthony J. Principi
Secretary of Veterans Affairs
From
The Honorable Jerry Moran
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

1. Mr. Secretary, you testified that the 1996 capacity level might not serve as the best baseline for measurement. Your proposal is to base capacity on the enrolled veteran in each geographic service area. Would such a population baseline provide opportunities to "game the system" of capacity maintenance in the future, and what step could be taken to avoid such a gaming?

Response: If our veteran population data are accurate, then demographic changes across networks should be clear, whether we use total veterans living in a network, or total veterans enrolled for care. However, we cannot hold a network's capacity for these special programs constant at 1996 levels if that network shows either an increase or decrease in the target veteran population. Capacity for the special disability programs should also be increasing or decreasing accordingly, in order to address changing needs.

2. You testified that the VA strongly supports the extension of MCCF authority. If some day you must disenroll priority 7 veterans from the VA health care system, what impact would disenrollment have on MCCF collections? What impact would disenrollments have on VA's capacity to maintain specialized programs?

Response: VA has been able to provide quality care for all veterans seeking VA care in the past and disenrollment would occur only when resources are no longer available to continue treating veterans in all priority groups. The disenrollment of priority 7 veterans would reduce the VA's overall collections by an estimated $233 million or more. This is the projected collection amount for priority 7 veterans for fiscal year 2001. However, the total cost of treating priority 7 veterans may be greater than the amount lost in revenue, which would be utilized to cover the remaining enrolled veterans, including veterans in specialized programs.

Disenrollment of priority 7 patients may affect VA's ability to maintain an adequate patient population to support all of their specialized programs. By losing these patients, a medical center may not have enough work from the other

priority groups to maintain all of their specialized programs, and it could become necessary to send patients to other VA facilities for treatment or to contract for their care in the community.

3. You support the addition of service dogs, but only for service-connected veterans who are hearing impaired, have spinal cord injuries or other chronic impairments, and to pay for certain costs associated with adjusting to the dogs, with appropriate criteria and guidelines. Although we are yet to receive a formal cost estimate from CBO, we believe the costs of this measure are affordable. In 1996, Congress removed eligibility barriers Public Law 104-262, in the Eligibility Reform Act. If we accept your view, to limit this benefit to only service-connected veterans, doesn't this turn back the clock? How many veterans do you estimate would qualify for such a benefit, service-connected and others?

Response: Although the eligibility reform legislation did enhance and expand our authority to provide health care services to all veterans, it did not affect certain special eligibility programs. These included, for example, nursing home care, domiciliary care, fee-basis care, dental care, readjustment counseling services, adult day health care, homeless programs, and sexual trauma counseling, and the program for providing guide dogs. Eligibility for these programs remain basically the same as when eligibility reform was enacted. There have been changes to eligibility for nursing home care, but these essentially assured that VA would provide such care to certain veterans with service-connected disabilities.

If section 2 of H.R. 2792 were enacted, we estimate that 66,157 additional veterans would qualify for the benefit.

4. Mr. Secretary, you do not support the proposal to use the HUD supportive housing income index as a way to adjust the VA's means test, and you state that other, better indexes are available to achieve our legislative goal of making the means test a fairer test of ability to pay. You testified that VA would be prepared by month's end to present an alternative to my proposal. Can you elaborate – when would you be prepared to discuss the product of this work?

Response: VA continues to study the different methodologies and implications of a variable geographic means test. We are looking at many options but it is clear that they all have poorly understood potential for significant and unpredictable consequences. Each of the indices studied creates its own inequities and impacts on other VA programs and benefits.

Additionally, VA's current, finite budget authority and VA policy discussions related to VHA's future budget, have shown that VA would likely be negatively affected by consideration of a variable geographic means test. Thus, I am not inclined to support such indexing.

;. With regard to capacity, you refer to your desire to "provide the best possible nformation on VA's capacity for treating veterans." We do want good nformation, but what the law requires is VA's maintenance of capacity. The eport is but a reflection of evidence that you do so. Whatever measures we igree on need to be underscored with VA's commitment to maintain specialized ›rogram capacity. Do we have your commitment on this agreement?

Response: We will assure that capacity is maintained for all special disabilities is mandated, to the extent that resources are available and changing veteran lemographics are considered.

;. You indicated a VA "interest" in improving VA's performance in the fee-basis ınd contract program, a program that now costs over $600 million annually.)oes this stated interest include your intent to help us legislate an appropriate 'emonstration test, or do you have something else in mind?

lesponse: The non-VA/Fee Services program reimburses non-VA providers pproximately $1 billion a year for treatment of more than 100,000 veterans. 'his workload is expected to substantially increase due to the recent launch of mergency care benefits resulting from the Veterans Millennium and Health Care enefits Act, as well as several legislative proposals. VA is actively engaged in everal projects in order to administer more effectively the non-VA/Fee Services rogram.

A has already tested the use of a contracted provider network for non-VA care ırough several VA facilities. As a result of the pilot, VA found improved ffectiveness, efficiency, and cost avoidance for non-VA treatment of veteran eneficiaries. The success of these test sites has prompted VA to explore an xpansion of the program. VA is currently developing a "Statement of Work" for ossible procurement of a nation-wide contracted provider network.

ecent developments within the Veterans Benefits Administration have also ghlighted the need for improved monitoring of program activities; therefore, VA currently evaluating commercial fraud detection and claims scrubbing systems r the non-VA/Fee Services program. As the majority of fee providers also treat edicare beneficiaries, it is assumed that the same types of fraudulent activity in at program could also occur within VA programs. Therefore state-of-the-art ısiness solutions are being sought to replace current fee services program ›ftware.

A is also proceeding with regulating a Health Care Financing Administration ICFA) Common Payer methodology for inpatient, outpatient, ancillary services, ıesthesia services, and ambulance services provided to eligible VA ›neficiaries at non-VA facilities. The Department's experience with ıplementation of the HCFA Prospective Payment System (PPS) for non-VA ›atient services and the Resource Based Relative Value System (RBRVS)

indicated significant cost avoidance using HCFA payment algorithms. The adoption of this proposal would ensure that amounts paid for these services would be consistent with other large federal payer programs, avoid unnecessary costs, and take advantage of private industry claims processing systems, in an attempt to gain further efficiencies.

VA is also studying possible outsourcing of non-VA claims processing activities. The non-VA/Fee Basis program is currently supported by a VA-developed IT system that has had difficulty keeping up with legislative and regulatory changes. Of concern is the ability of the non-VA/Fee Services program to be in compliance with the Health Information Portability and Accountability Act of 1996 (HIPAA) by the required deadline of October 2002. The current VA-developed IT software will not be compliant with HIPPA requirements. Outsourcing would allow VA to take immediate advantage of up-to-date claims processing business systems (including fraud detection) that are HIPAA compliant and constantly evolving to meet ever changing HCFA requirements.

7. Mr. Secretary, I appreciate your desire to work with us in developing a better means test. We have received 2 "studies" from the VA on this concept. After considering them, they leave something to be desired on the quality of analysis. For example, one study suggests by simply reclassifying a veteran from priority 7 to priority 5, VA would incur thousands of more dollars in costs for this care. Reclassifying does not change health care requirements in a system that is supposed to be meeting all of a patient's needs. Also, one study suggests that changing the means test would serve as a lure that attracts more patients to VA care. Do you believe an index can be developed that addresses the need to be fair, but that also can be administered reasonably? When would you be prepared to discuss an alternative approach to the current proposal?

Response: Historically, Priority 7 patients become Priority 5 patients because of a reduction in income (for example, loss of a job). Their increased use of VA health care may occur because they have lost other health care coverage or because no co-payment is required as a result of moving into the higher priority group. Numerous studies in both VA and other health care settings have shown that the elimination of co-payments increases the amount of health care sought by patients. Therefore, we believe that reclassifying Priority 7 patients to Priority 5 patients would result in increased costs to VA. Moreover, regional increases in the means test threshold, and maintenance of the current threshold as a minimum eligibility level, as is likely to happen to due to adoption of a variable geographic means test, would likely attract more patients who would not be required to pay co-payments. This factor also would increase our costs.

The calculation of a perfect index to be used for a geographic means test may not be possible, and any index ultimately chosen is likely to be perceived as unfair to some. Currently, there are no officially published statistics that compare costs of living across geographic areas in the United States. A true cost-of-living

index measures the cost of all items that affect an individual's well being in one area relative to the cost of the same items in another area. The tool most commonly used to approximate differences in cost of living over time or across areas is the price index. A price index measures the change in the cost of buying a fixed market basket of goods and services. Most price indices, however, are only able to approximate changes in the cost of living.

Based on the reasons noted above, as well as in my response to question 4, VA is not inclined to support indexing, including the option proposed in H.R. 2792.

Post-Hearing Questions
Concerning the September 6, 2001, Hearing
For
The Honorable Anthony J. Principi
Secretary of Veterans Affairs
From
The Honorable Chris Smith
Chairman
Committee on Veterans' Affairs
U. S. House of Representatives

1. Mr. Secretary, many veterans in the 4th district of New Jersey believe that section 5 of H.R. 2792 is the answer to their plea for convenient access to comprehensive VA health care, including inpatient services. Their opinion is shared by hundreds of thousands of veterans who live in locations remote from major VA health care facilities. The Department's opposition to this provision could be interpreted as rejecting their reasonable expectation that the VA will make VA health care accessible. How do you respond to this interpretation?

Response: This provision of H.R. 2792 would create an eligibility status based on health care coverage; it would reduce the funds currently available for veteran health care; and it would undermine VA's ability to maintain existing services. For these reasons I have opposed section 5 of H.R. 2792.

Making VA health care accessible to all veterans is one of our priorities. It is stated in the Under Secretary for Health's 2000 Corporate Report and Strategic Forecast, *Journey of Change – Discovering Six for 2006,* and we have identified specific targets for increasing access. In setting these targets, we had to consider all veterans and all the services we provide. We had to be mindful of our resource constraints and plan accordingly. We are trying to provide the best access and care to the over 5 million veterans enrolled in VA's health care system.

Since the beginning of fiscal year (FY) 2000, VA has opened more than 140 community-based outpatient clinics, and more than 500 since the beginning of FY 1996. It is also important to note that the expansion of primary care has decreased the amount of inpatient care required. Of course, inpatient care cannot be expanded in the same way. The cost of the infrastructure is just too great. To compensate for this, we try to limit the burden of traveling to a VA hospital. The beneficiary travel program allows VA to pay for the travel costs incurred by service connected and low-income veterans as well as for veterans receiving compensation and pension (C&P) exams. VA also works with Veteran Service Organizations who provide transportation to and from VA facilities.

H.R. 2792 would have made different levels of services available to enrolled veterans. The availability of these services would not be based on current eligibility criteria, they would be determined by whether or not a veteran has health care insurance. In addition to a disparate eligibility class based on insurance coverage, it also limits the type of care that can be provided. Care limited to inpatient medical and surgical services only, means many veterans seeking clinic and specialized services would still need to visit VA. This would complicate the coordination of the veterans' overall health care.

Section 5 of H.R. 2792 would require that collections from insurance companies and veteran copayments through VA's Medical Care Cost Fund (MCCF) program, which are returned to the medical centers to support the health care needs of the enrolled veterans, would be used to fund this pilot project. These funds supplement the medical care appropriation and are a necessary component of the VHA budget. By reducing the availability of the funds collected, our ability to maintain existing services for veterans not enrolled in the pilot would be negatively impacted.

September 24, 2001

Honorable Jerry Moran, Chairman
House Veterans' Affairs Subcommittee on Health
335 Cannon House Office Building
Washington D C. 20510

Dear Mr Chairman.

The following are PVA responses to questions you proposed in writing following the September 6 hearing of the Subcommittee on Health

Question 1

> PVA originally proposed the HUD index as a good replacement for VA's means test. What were your motives for doing so? Has any of the testimony you heard at out hearing created any doubts about the merit of your proposal? Would you be willing to work with our staff and VA to fashion another approach that brings a fairer means test to veterans health care?

Answer. PVA continues to believe that the current "one size fits all" means test is grossly inequitable, discriminating against veterans by placing additional financial burdens on those already affected by additional expenses in high cost-of-living areas. We continue to believe that the HUD index, that measures the cost of housing, the single most burdensome expense faced by most Americans, is a good, established indicator of cost-of-living. At the same time, if some other measure could be developed that adequately and fairly addressed this inequity, we would be more than willing to work with the Committee and the VA.

Question 2·

> In your statement you briefly touched upon the economic advantages service dogs give to veterans with disabilities, but I would like you to comment on the social aspects regarding how service dogs might help disabled veterans regain function through their interaction outside the home. Can you comment?

Answer· By improving function and independence, service dogs have been shown to greatly improve self-esteem and foster greater interaction for many people with disabilities in social settings and in the work place. As one of the participants in the study published in the April 13, 1996 *Journal of the American Medical Association,* ("The Value of Service Dogs for People with Severe Ambulatory Disabilities" submitted for the hearing record) stated: "With my (dog), I feel safe and capable, and I am no longer afraid of the future. Everyone needs someone to care for, and we care for each other with dignity."

Question 3

> Why do you believe the maintenance of capacity for specialized services will be improved if it is included in VISN directors' performance plans? If it is only one of many factors on which performance is evaluated, how does this bring accountability?

Answer· As the Committee is well aware, the VA largely ignored the capacity requirement that was signed into law in 1996. For the most part, this occurred because no one at any level of the VA management structure could be held accountable, even to Congress, to see that capacity of specialized services was maintained The maintenance of capacity cannot be based on good intentions, it must be based on the performance of those directed to insure that capacity be maintained. For this reason we believe that both Medical Center Directors and VISN Directors must be judged on their ability to see that the intent of Congress is upheld. The performance measure system provides the yardstick whereby these managers can be held to a specific standard insuring that capacity is maintained

Honorable Jerry Moran, Chairman
September 24, 2001
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Question 4

> You do not support section 5 of H R 2792 Do you have any alternative proposal that would enable veterans in rural and remote areas, away from major VA facilities, to gain access to inpatient care?

Answer. PVA is concerned that, because of inadequate budgets, VA has been shrinking its funding for VA hospitals in rural or remote areas, to the point where they become candidates for closure. Two such hospitals were closed last year because of this situation. However, in answer to your question, we would point to two programs that have historically been used to provide veterans who have to travel long distances with better accommodation to VA inpatient care The first is the beneficiary travel benefit that reimburses veterans for the cost of mileage and distance traveled to VA facilities. Congress should enact legislation that would increase the beneficiary travel rates to make this benefit more meaningful The rates have not been changes in many years Second, VA should expand its hoptel program to provide additional lodging and accommodations for veterans and their families travelling to seek inpatient care at VA facilities Many private sector hospitals use these types of facilities very successfully providing services of great benefit for patients and their families

Question 5

> You express strong disapproval of section 6 in 2792 You state that section 6 "would force veterans to receive care from a managed care provider." This is true in the sense that providers would be a part of a network. Do you see it as VA's responsibility to pay billed charges to any private facility chosen by a veteran, without limit? Should any controls be imposed and why? What would be acceptable to PVA?

Answer· PVA believes that the fee basis program was designed to provide health care accommodations and options to disabled veterans - largely service-connected disabled veterans in the highest eligibility categories We believe these veterans, most of whom have severe disabilities, should not be restricted in their ability to obtain those services they need Managed care plans, because of their nature, are largely inhospitable to people with disabilities, basically because they restrict care based on cost and not the specialized needs of the individuals We believe the VA already has the ability to monitor utilization and costs under the fee basis program. We would continue to object to any proposal that would limit the choice of an individual seeking appropriate and necessary medical services.

Thank you for asking us for additional comments on these issues.

Sincerely Yours,

Richard B. Fuller
National Legislative Director

SEP 2 4 2001

September 24, 2001

Honorable Christopher H. Smith, Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington D C 20515

Dear Mr. Chairman·

The following is PVA's response to the question you proposed in writing following the September 6, 2000 hearing of the House Veterans' Affairs Subcommittee on Health.

Question:

> Many Veterans in the 4th district of New Jersey believe that section 5 of H R. 2792 is the answer to their plea for convenient access to comprehensive VA health care, including inpatient services. Their opinion is shared by hundreds of thousands of veterans who live in locations remote from major VA health care facilities. PVA's opposition to this provision could be interpreted as rejecting their reasonable expectation that the VA will make VA health care accessible How do you respond to this interpretation?

Answer·

PVA would strongly support providing access to VA health care services for all 25 million living veterans Unfortunately, successive Congresses and Administrations have not seen fit to provide the resources to expand VA health care in this way. Instead, we find the opposite happening. The purchasing power of the VA health care dollar continues to shrink in the face of inflation, inadequate budgets, and rising demand for services. Instead of trying to meet the needs of veterans in rural areas, we see VA closing hospitals in those locations after not providing the funds to keep them operating

PVA opposes section 5 of H R. 2792. While it may appear to be an expansion of VA health care, in fact, it is not VA health care at all. Basically, it is an attempt to stretch the already overly stretched VA health care dollar that is currently being used to fund care in VA hospitals to partially subsidize care in non-VA health care facilities for an entirely new segment of the veteran population in other areas While this may be an attractive new federal benefit for some veterans who chose not to go to VA facilities and who are concerned about the additional costs associated with their own insurance plans, it erodes the funding and patient base that support existing VA hospitals and services for other veterans who need to chose VA. The pilot program would allow VA to subsidize the veteran's care by being a secondary insurer, paying only the veterans co-payments and deductibles. For the most part, veterans with no insurance, those with the most need, would still have to go to the VA hospital for their care At the same time, most of the veterans receiving care in the private sector under the pilot (undoubtedly, higher income non service-connected disabled veterans) would have their co-payments covered at VA expense On the other hand, similar Category 7 veterans who seek care at VA hospitals would have to pay those co-payments out of their own pockets We object to the proposal on the basis of cost and inequity. As we stated in our testimony, VA needs to concentrate on what it was intended to be, a provider of health care, not an insurer of health care. We concur with Secretary Principi in objecting to the provision.

Thank you for your follow-up in this matter

Sincerely,

Richard B. Fuller
National Legislative Director

RESPONSE OF JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
TO QUESTIONS FROM
THE HONORABLE JERRY MORAN
CHAIRMAN
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH HEARING
Of SEPTEMBER 6, 2001, on H.R. 2792

Question 1: You testified the traditional form of VA health care has served well to offer an uninterrupted flow of services to veterans in need, and other initiatives should be considered to assist veterans who reside in under-served areas You do not support the proposal Dr Weldon advanced, do you have any proposal or other guidance for the Subcommittee that might aid VA in accomplishing this goal?

Answer: Section 5 of the bill would establish a pilot program designed to allow certain veterans in under-served areas to seek inpatient services in private sector hospitals utilizing their own health insurance, with VA becoming a secondary payer of any other out-of-pocket expenses

Mr. Chairman, DAV supports greater access to timely quality health care for our nation's sick and disabled veterans We recognize that this is your goal as well. It is simply our desire that VA be the provider of that care rather than just a payer. To that end, we believe Congress should provide VA with sufficient resources so it can make services reasonably accessible to our nation's geographically-remote veterans

Question 2: Currently, the VA pays community charges for treatment for and hospitalization of many service-connected veterans, and there is no systematic VA monitoring of this care. Given the VA's limited resources, wouldn't section 6 of H.R. 2792 allow the VA to continue to provide more benefits to veterans by more effectively managing the VA's limited resources? Is there any approach at cost control in fee and contract programs that would be acceptable?

Answer: We agree that this provision may help VA to reduce the costs for care provided to veterans who are authorized to use fee-basis for care We remain concerned however, that this initiative would disrupt established clinician-patient relationships for many veterans currently using fee-basis We would be willing to consider an amended version of this proposal for "new" fee-basis users Specifically, for those veterans authorized fee-basis privileges after the enactment of such legislation Additionally, we would want to be assured that physicians who were selected for the "managed care" system were free to provide the necessary care for fee-basis users without restrictions based solely on cost saving measures.

Question 3: In your testimony you state "under ordinary circumstances, veterans should not have to pay for benefits." Could you please explain to me what you mean by this statement? When are circumstances "ordinary?"

Answer: The statement " under ordinary circumstances, veterans should not have to pay for benefits accorded them by a grateful nation " was made in reference to section 8 of H R 2792 which would extend existing Medical Care Collection Fund authority with respect to third party collections and copayments. As you are aware, DAV is strongly opposed to copayments for veterans' medical services and prescriptions.

Through extraordinary sacrifices and contributions veterans have earned the right to certain benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of a grateful nation want our Government to fully honor our moral obligation to care for veterans, and generously provide them benefits and health care entirely free of charge Copayments are a feature of health care systems in which some costs are shared by the insurer in a commercial relationship between the patient and the for-profit company or of health care through our Government programs in which the beneficiary has not earned the right to have the costs of health care benefits fully borne by the taxpayers

Asking veterans to pay for part of the benefits a grateful nation provides for them is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans Copayments were only imposed upon veterans under urgent circumstances and as a

temporary necessity to contribute to reduction of the Federal budget deficit. In an effort to assist our nation get its fiscal house in order, veterans acquiesced in the imposition of copayments as a temporary deficit reduction measure, even though the concept was one that was totally foreign and totally contrary to the spirit and purpose of veterans' benefits.

Unfortunately, Congress has made copayments a permanent feature of some veterans' health care services and forgotten its traditional philosophy of providing free benefits to its veterans as repayment for protecting our freedoms, often at the expense of their own personal health and well-being. In times when deficits have been offset by record budget surpluses we do not see how Congress is justified with continuing the burden of copayments for veterans' medical services and prescriptions. "Ordinary times" is simply a reference to times when the country is not experiencing such extreme financial hardship as to require everyone to contribute to paying down the Federal budget deficit.

Congress' action to make copayments a permanent feature of veterans' benefits epitomizes the dangers for veterans when they do not object to legislation that approaches the "slippery slope" Congress seems unable or unwilling to restore veterans to their prior status, once it impairs, reduces, or eliminates a benefit purportedly on a temporary basis The DAV strongly objects to such insidious erosion of veterans' benefits

Question 4: Considering Mr Wicker's proposal, should VA pharmacies be held to a higher level of accountability than private pharmacies?

Answer: DAV does not believe VA pharmacies should be held to a higher level of accountability than private pharmacies but rather to the same professional level of accountability as other pharmacies.

Question 5: Should Congress authorize a test of the Wicker proposal, in one or a few VA facilities, or perhaps in one VA Network? Why?

Answer: DAV would not object to approving the Wicker proposal in one VA Network as long as Congress appropriated sufficient funding to pay for the mandate without causing other programs to be negatively impacted or cut As we acknowledged in our testimony perhaps this legislation would result in a net savings to VA. However, we are concerned that the anticipated increase in pharmaceutical costs for this initiative would far outweigh the estimated savings of this proposal For DAV to favorably consider this proposal Congress would have to increase the fiscal year 2002 VA medical care appropriation by the shortfall estimated by the *Independent Budget* as well as appropriate funding for the cost of this initiative

Question 6: How would your interpretation of H R 2792 change if I suggested the intent of section 5 is to provide access to health care facilities and treatments for veterans who currently receive little or no care from the VA because of distance, weather, transportation problems, and/or financial difficulties? Do veterans from rural areas such as Western Kansas or Western Illinois (where there are no VA medical centers) deserve some access to VA care? If this approach of coordinating community care is not acceptable, do you have an alternative to suggest?

Answer: Your proposed intent concerning section 5 of H R 2792 does not change our position on this issue

You also asked if DAV thinks that veterans from rural areas or areas where there is no VA facility deserve some access to VA care. Like you, we want all veterans, including those living in remote areas to have reasonable access to VA care However, we do not see section 5 of H.R. 2792 as providing VA care. VA would simply act as a partial payer for privately financed health care. As I stated previously in the first question, DAV believes Congress should focus its efforts on providing VA with sufficient resources so it can make services reasonably geographically accessible to our nation's veterans

This type of initiative may appear attractive on the surface and make it more convenient for some veterans to get care, however, we do not believe it would be in the best interest of all veterans who rely on the VA system for their health care needs The viability of the entire VA health care system is at stake. By authorizing this type of alternative to VA care we may see the gradual

dismantling of the VA health care system over the long term Once the VA health infrastructure is gone, veterans will have no guarantee of care or services that fully address their special needs For the benefit of all, we feel the VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers To that end, we hope that you will work to strengthen and ensure VA maintains its health care system for the benefit of all veterans

Similarly, given the recent terrorist acts upon our country and the President's resolve to take firm action against terrorists and countries that harbor them, it is essential now, more than ever, that VA is prepared to act as the principal backup for military health care as provided for in Public Law 97-174 We request that you focus your efforts on securing additional funding for veteran's health care to ensure all veterans, including those living in remote locations, and if need be, members of the active military, have access to quality timely VA health care services

RESPONSE OF JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
TO QUESTION FROM
THE HONORABLE CHRISTOPHER H. SMITH
CHAIRMAN
HOUSE VETERANS' AFFAIRS COMMITTEE
ON H.R. 2792

Question: Many veterans in the 4th district of New Jersey believe that section 5 of H R. 2792 is the answer to their plea for convenient access to comprehensive VA health care, including inpatient services. Their opinion is shared by hundreds of thousands of veterans who live in locations remote from major VA health care facilities. DAV's opposition to this provision could be interpreted as rejecting their reasonable expectation that the VA will make VA health care accessible. How do you respond to this interpretation?

Answer: Mr. Chairman, DAV clearly rejects this interpretation. I think you are aware that DAV supports greater access to timely quality health care for our nation's sick and disabled veterans. We recognize that this is your goal as well. It is simply our desire that VA be the provider of that care rather than just a payer To that end, we believe Congress should provide VA with sufficient resources so it can make services reasonably accessible to our nation's geographically-remote veterans.

We believe the effects of the provision in section 5 would erode the Veterans Health Administration's (VHA) patient resource base, undermining VHA's ability to maintain its specialized services programs. This type of initiative may appear attractive on the surface and make it more convenient for some veterans to get care; however, we do not believe it would be in the best interest of all veterans who rely on the VA system for their health care needs. The viability of the entire VA health care system is at stake. By authorizing this type of alternative to VA care we may see the gradual dismantling of the VA health care system over the long term. Once the VHA infrastructure is gone, veterans will have no guarantee of care or services that fully address their special needs. For the benefit of all, we feel the VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers.

We are willing to consider other initiatives aimed to assist veterans who reside in under-served areas. However, we will continue to oppose any initiative that would turn VA into simply a partial payer for privately financed health care rather than a provider of health care. We hope that you will work to strengthen and ensure VA maintains its health care system for the benefit of all veterans.

Similarly, given the recent terrorist acts upon our country and the President's resolve to take firm action against terrorists and the countries that harbor them, it is essential now, more than ever, that VA is prepared to act as the principal backup for military health care as provided for in Public Law 97-174. We request that you focus your efforts on securing additional funding for veteran's health care to ensure all veterans, including those living in remote locations, and if need be, members of the active military, have access to quality timely VA health care services.

Chairman Moran to AMVETS

Questions for the Record
Chairman Jerry Moran
Committee on Veterans' Affairs
Subcommittee on Health Hearing, H.R. 2792
September 6, 2001

Question 1: You mentioned AMVETS's donor-partnership with Paws With a Cause. Is this organization large enough that it could participate as one of the providers of service dogs for veterans? Are there others?

Answer: Yes, Paws With a Cause is large enough to participate as one of the providers of service dogs for veterans.

Since their founding in 1979, PAWS has trained and placed over 1,600 Service Dogs in thirty-seven states across the country. The one thing that holds back this outstanding operation from further service to disabled Americans is the availability and amount of sponsorship funding committed to the training of service dogs.

PAWS main headquarters facility located in a 3,400 square foot building with 8 acres of land at Wayland, Michigan. It has training space to house 200 dogs in training at any given time.

The PAWS network of support involves 124 Community Field Instructors in 34 states. These Field Instructors assist and teach the client how to use the skills that have been developed in the dog over the six-month training at their main facility. In their program the instructors work with the client and dog to develop a team in the client's home and community. While this work continues for another six months, instructors serve as a ready back-up and lifetime support for additional training aimed to meet new needs appropriate to a disability that may change over the life of the client.

In addition, PAWS maintains a re-certification of each team within the system at 18-month intervals. This effort assures that the client-dog team is working together at the highest level possible.

It is AMVETS understanding that money contributed to PAWS each year is used for the placement of more dogs. In addition, a reserve fund is in place and used strictly for replacement dogs that occur due to retirement or illness of the originally placed dog. The reserve fund ensures that clients do not fall to the bottom of the waiting list when they lose the use of their first dog.

Again, AMVETS believes that PAWS is large enough to participate under an expanded program. Their network is in place and could be expanded as appropriate to serve the needs of disabled veterans and prove the value of service dogs.

Regarding the question on other providers of service dogs, AMVETS no survey on this matter and cannot provide additional insight. However, it is clear to AMVETS that the PAWS approach to training is one of the best in the country. For surely, if the purpose is to assist the disabled, the best possible arrangement is to work directly with the client and the dog in the client's actual home and community. In this effort, the veteran would not have to travel beyond his home, and the final teamwork training would occur where it would be applied.

Questions for the Record
Chairman Jerry Moran
Committee on Veterans' Affairs
Subcommittee on Health Hearing, H.R. 2792
September 6, 2001

Question 2: Should VA pharmacies be held to a higher level of accountability than private pharmacies?

Answer: AMVETS remains deeply concerned about healthcare delivery, and we firmly believe that credible, accountable standards must be in place to assure veterans and all Americans that the life-saving or life-sustaining drugs, dispensed by VA are safe when used according to prescription.

Clearly, the Yankelovich Survey, a telephone survey of VA physicians on patient adverse drug effects (ADE), indicates serious deficiencies in VA oversight of negative outcomes. This survey found that more than 20 percent of the 418 VA physicians surveyed had personally had a patient experience an ADE. These experiences must be examined closely if pharmaceutical safety is to be improved.

As regards pharmaceutical safety, we recognize that prescription medicines, while providing many health benefits, are not risk-free. We believe that VA should embrace every reasonable effort to ensure VA healthcare professionals reduce risk by being provided a thorough medical history of their patients, including the medications a patient is now taking and has recently taken.

We remain committed to improvements of VA's medical care programs for the well-being of enrolled patients. And, though veterans and their families should not have to worry about the safety of drugs dispensed by VA, the patient shares the responsibility for safety. Patients need to know that they should never begin taking a new prescription or over-the-counter remedy without first asking their doctor, pharmacist, or other healthcare professional if it will interact with other medications.

Question 3: Do you believe the maintenance of capacity for specialized services will be improved if it is included in VISN director's performance plans? If it is only one of many factors on which performance is evaluated, how does this bring accountability?

Answer: Yes, including attention to specialized services on a VISN director's performance plan would assist in the improvement of such services. Accountability is nearly always improved when decisions and decision-making is highlighted. AMVETS firmly believes that VA's programs for veterans with special needs are an intricate part of the core of the VA health-care system.