

In conclusion, we, The American Legion, believe the VA health care system is worth saving, if not as currently configured, then in a better, more efficient system of health care. Whatever comes of our efforts, I would remind us all of the words spoken by our first President and warrior, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of earlier wars were treated and appreciated by our nation". Let's not let them down. Thank you.

(END OF ORAL TESTIMONY)

The American Legion endeavors to ensure objectivity and inclusion of veterans' perspectives in the outcomes of CARES. The American Legion Junior Past National Commander, Ronald F. Conley, authorized the creation of the Veterans Affairs Facility Advisory Committee on CARES (VAFACC). The committee's charge was to review the VISN market plans, planning initiatives and VA Facility Assessment Reports relating to the CARES process, keeping in mind VISNs were tasked to cut 10% of their vacant space by 2004 and 30% by 2005. The following concerns have been raised:

Funding - Clearly, billions of dollars in discretionary appropriations will be needed to accomplish the new construction and approved renovations. CARES is an ongoing process, and incremental changes are anticipated. With the proposed consolidations and transferring of services, it is imperative that no veteran experience any delays in access to the delivery of quality health care, and patient safety must not diminish. No VA medical facilities should be closed, sold, transferred or downsized until the proposed movement of services is complete and veterans are being treated in the new locations.

Veteran's Population - There is some concern that the projected veterans' population is underestimated. Indeed, it might be underestimated based on the war on terrorism. Certainly, with regard to long-term care, mental health, domiciliary and other specialized care populations, the CARES process has yet to incorporate projections.

Long-Term Care - With the enactment of the Millennium Health Care Act, demand will most likely increase due to the aging of the veteran population over the next decade. VA estimates that the number of veterans most in need of long-term care, those veterans 85 and older, will more than double to about 1.3 million in 2012. Yet, even with these numbers, veterans long-term care needs and projected growing demand are not included in Phase II of the CARES process.

Mental Health - Due to several factors concerning the initial projections, the National CARES Planning Office (NCPO) and several other experts are reviewing the mental health inpatient and outpatient projections. Because of the questionable decline of demand in several markets, networks were instructed to plan for increase in mental-health services only. Stakeholders are very concerned about the mental-health projections and express dissatisfaction with the model.

Unutilized Space - According to VA's office of Facilities Management (OFM), VA facility assets include 5,300 buildings; 150 million square feet of owned and leased space; 23,000 acres of land; and a total replacement value estimated at 38.3 billion. OFM assessed and graded 3,150 buildings for a total of 135 million square feet with correction costs estimated at \$4.5 billion. More development is needed by the VISNs to utilize more effectively this "unused" space instead of just selling or demolishing these buildings. Once the buildings are gone, there will be no way of getting them back. Before any unutilized space is sold, transferred, destroyed or otherwise disposed of, the CARES process must consider alternative uses of that space to include: services for homeless veterans, long-term care and the expansion of existing services.

Contracting Care - Throughout the VA health-care system, contracting out of care is prevalent. While contracting may be necessary in some circumstances, the wholesale use of this health care delivery tool should be used with caution. Contracting out of care was extensive in the VISN proposals. Some VISNs made the blanket statement that care would be contracted out to meet excess demand in 2012 and 2022. Considering that extensive research and cost analysis that will have to be done concerning available resources (if they are available) within each community, The American Legion does not believe that is much of a plan.

Enhanced Use Lease Agreements - Through the use of EU leases, VA can receive cash or "in-kind" consideration (such as facilities, services, goods, or equipment). Several of the VISNs proposed enhanced-use lease agreements with the public and private sectors. VA should continue to seek opportunities in the area of enhanced use leasing. It can certainly have a positive impact on service delivery to veterans and local communities.

VA/DOD Sharing - There are many opportunities for sharing between VA and the Department of Defense (DOD). Both VA and DOD benefit from these agreements, and every effort should be made by the VISNs to pursue this avenue in order to save money through cost avoidance, in particular pharmaceuticals, supplies and maintenance services.

The American Legion intends to remain an active partner with VA during this critical process of realigning the agency's capital assets to better serve American's veterans. Recent developments in the CARES process serve to reinforce our concerns outlined in this testimony. The Undersecretary for Health sent back the market plans to 15 VISNs and 20 facilities with instructions to develop other options and look at further consolidating inpatient services in many of the facilities. We will continue to be vigilant in monitoring the progress in CARES. Indeed, the CARES process may require congressional oversight given the above concern.

The American Legion's Support for VA Health Care is specific and steadfast. It believes that consideration to the following issues is essential to ensure the preservation of a viable, efficient and cost Veterans Health Care System for current and future veterans:

Mandatory funding of VA health care. America has an obligation to care for the men and women whose lives the government was willing to risk in order to protect national

interests. That obligation cannot be met without the funds necessary to do the job. The American Legion strongly supports proposals now before Congress that remove VA health care from the uncertainties of discretionary federal spending. VA health care must join such mandatory-funded federal programs as Social Security and Medicare to assure its present recovery and future viability. Resources must be provided on a cost-per-enrolled-veteran basis, with annual indexing for inflation. Discretionary funding has left VA health care woefully understaffed and unable to provide timely access to quality care in many locations across America. If it remains a discretionary budget issue, the VA health-care system will continue to suffer, incapable of keeping up with demand fluctuations, capital-improvement needs, staff shortages and long-term planning. Mandatory funding will ensure VA health care's financial foundation.

Expansion of third-party reimbursement authority to include VA's ability to bill and collect from Medicare and other health insurance for treatment of nonservice-connected conditions. Although VA has had authority to seek third-party reimbursements since 1986, it has not been permitted to bill and collect from Medicare. The American Legion supports VA billing third-party insurers, to include Medicare, for the treatment of nonservice-connected disabilities. Any veteran who is not eligible to receive the full continuum of care as a direct VA benefit should be able to use Medicare and private insurance to share in the cost of his or her own care. Veterans would be required to disclose any health-insurance policies they carry and make reasonable co-payments for treatment of nonservice-connected conditions and drug prescriptions. For those who lack insurance, VA should be allowed to provide its own medical-benefit package, with reasonable premiums and deductibles as an option. Such a model would empower the VA health-care system to cover more of its own costs, reducing the gap between resources and demand, as demonstrated successfully by other federal health-care programs, such as Indian Health Services and TRICARE.

VA health-care accessibility for all veterans. The administrative decision in early 2003 to suspend new enrollment for veterans in Priority Group 8 runs counter to the intentions of the Veterans Health Care Eligibility Reform Act of 1996, which made the system available to all veterans, regardless of their income levels or service-connected disability status, within existing appropriations. Appropriations have not followed the growing demand for VA health care. By denying Priority Group 8 veterans VA health care, VA denies itself the patient population most capable of providing third-party reimbursement sources, a revenue stream VA has asked some facilities to more than double this year.

Continued affiliations with college and university medical programs. The mutually beneficial relationship between VA health-care facilities and medical schools gives veterans some of the most advanced care available in the world. Symbiotically, health-care professionals are provided an excellent environment for research, training and the advancement of medicine. This relationship has led to dozens of medical break through while at the same time providing adequate medical staffing at VA health-care facilities. In the event a CARES (Capital Asset Realignment for Enhanced Services) decision closes or compromises a facility in proximity to an affiliated medical school, everyone loses -veterans, researchers, students and modern medicine.

A CARES (Capital Asset Realignment for Enhanced Services) process that improves the efficiency of health-care delivery. The national CARES Commission will soon provide recommendations for the future of VA health-care facilities throughout the nation. Those recommendations will range from closure of some facilities to the consolidation and expansion of others. The purpose of this effort is to reposition VA healthcare so that it may operate more efficiently, thereby providing better service to veterans. The purpose of this effort cannot be to close or downsize needed facilities primarily to trim costs from the federal budget.

Protection of VA health care from routine federal budget cutting. Under the current discretionary funding model, VA health care is subject to federal cost-cutting measures and cyclical reductions. Such reductions compromise the system's ability to provide competitive pay for doctors, pharmacists, nurses and other health-care professionals. Reductions also force administrators to tap into non-payroll funds, such as capital-improvement reserves, to provide competitive salaries, thus triggering a chain reaction of shortages in other areas. Such reductions also lead VA facilities to purchase non-VA care from outsourced physicians, often at substantially higher costs, due to budget uncertainty. VA health care must be protected from attempts to reduce its discretionary budget or offset it with increased co-payments or enrollment fees. Similarly, the Legion supports an exemption from the Budget Enforcement Act's "Pay-as-You-Go" requirement in budgeting for the care of veterans with service-connected disabilities.

VA's "fourth mission." VA's civil-defense role in the event of national emergency and as a backup for the Department of Defense health-care system is vital to our national security. Due to resource disparities, different facilities have different levels of preparedness for "fourth mission" roles. Standards for that role must be established and funded consistently.

Reconsideration of the VISN system and VERA funding formula. The 21 Veterans Integrated Service Networks (VISNs) under the VA health-care umbrella are funded through a Veterans Equitable Resource Allocation (VERA) formula that inherently creates competition among facilities and disparities of care from one VISN to the next. All veterans in the VA system are entitled to a consistent level of quality, timely care, regardless of geographic location or political influence. Fewer VISNs and a less-complicated resource-allocation model would reduce potential for imbalances and allow facilities that exceed their reimbursement targets to put those surpluses back to work in their own "facilities".

Reasonable expectations for third-party reimbursement targets. By aggressively raising targets for third-party reimbursements, VA is forcing facility directors to consistently start their budget years deeper in the hole with little or no incentive to meet or exceed targets. The Priority Group 8 suspension makes the prospect of ambitious third-party collections even more daunting.

Immediate action to mitigate medical staff shortages and reduce reliance by VA health-care facilities on short-term commitments and contracted services. Shortages are severe in nursing, pharmacy, radiology and technician positions throughout the VA health-care system. Contracted services, dictated by uncertain long-term budgeting capability, result in greater cost for fewer positions filled in the system. The ability to

make long-term payroll commitments would make a medical career in VA, those merely seeking fulfillment of J1 visas.

Consistent policy and separate treatment of long-term care, homeless care, hospice care, mental-health services and Alzheimer's/dementia treatment. Performance by VA varies widely by facility in the areas of long-term care, mental health, spinal cord treatment, blindness rehabilitation and other forms of specialized care. This is a function of inconsistent policy linked to similarly insufficient budgetary commitment.

Reforms in VA emergency-room policies and practice. VA hospital emergency rooms must be adequately staffed to meet demand 24 hours a day and the number of patients a doctor is expected to see must be kept to a reasonable level. The policy of diverting ambulances to non-VA hospitals solely on the basis of staffing short-ages would then be unnecessary.

Keeping VA health care separate because it is unique. To provide for the unique needs of those who served in the U.S. Armed Forces, a unique health-care delivery system is necessary. Veterans are not ordinary patients. They often have latent, extraordinary circumstances related to their military service -such as PTSD, hypertension or anyone of many VA-compensable diseases or illnesses -that non-VA facilities would not readily understand or be capable of treating. The American Legion opposes any proposals aimed at shifting VA health care toward a voucher system where treatment is provided at non-VA facilities.

There are telltale signs that the health care system that serves America's veterans needs more money. The American Legion's "I Am Not a Number" survey in May identified scores of the more than 200,000 veterans who must wait from six months to two years for their initial primary-care appointments at VA. Additionally, about 164,000 veterans in the lowest of VA's eight priority-treatment groups have been suspended from enrolling in the VA health care system because it lacks the resources to serve additional veterans.

Recent news media accounts of service members from the war on terror failing to access the system in a timely manner were glaring indicators that VA health care, albeit of sound quality by a myriad of standards, is hard to access because of chronic under-funding. The latter includes a front-page report in the Aug. 12 edition of The Wall Street Journal.

The American Legion is fighting to switch the VA health care budget from discretionary funding, which Congress must approve each fiscal year, to mandatory funding, just like Social Security and Medicare, whereby federal dollars are allocated by a formula to meet the system's demands. The nation's largest veterans organization also wants to end the restriction that keeps veterans from using their Medicare benefits to pay for treatment at VA.

I thank you again for your commitment to veterans and look forward to working with you on these important issues.

ISSUES:

Lack of health services in this area.

Lack of appropriate inpatient mental health care for PTSD/psychosis.

Lack of quality health options and medical plans.

Travel issues.

One nursing care facility in the area.

COMMENTS

The Native American veteran is unique in his service to his country. American Indians have participated with distinction in United States military actions for more than 200 years. Their courage, determination, and fighting spirit were recognized by American military leaders as early as the 18th century. It is documented in every conflict, that the indigenous people of this land participated. 12,000 fought in WW1; During WWII 44,000 American Indians out of a population of 350,000, served in the armed forces an additional 40,000 left their homes, their reservations to serve in ordnance depots, factories, and other war industries. Native Americans also invested more than \$50 million in war bonds, and contributed generously to the Red Cross and the Army and Navy Relief societies.

More than 42,000 Native Americans, more than 90 percent of them volunteers, fought in Vietnam. Native American contributions in United States military combat continued in the 1980s and 1990s as they saw duty in Grenada, Panama, Somalia, and the Persian Gulf. Today, there are nearly 190,000 American Indians and Alaska Natives military veterans.

It is well recognized that, historically, Native Americans have the highest record of service per capita when compared to other ethnic groups. In spite of this, Native Veterans are under-represented in the quantity and quality of benefits provided by the federal government.

A Prepared Statement of Ben Nighthorse Campbell Chairman, Senate Committee on Indian Affairs Hearing Regarding Native American Veterans Issues May 21, 1997

“Today, I hope to hear that the United States is committed to improving the delivery of services to Native Veterans and that these veterans will receive greater attention by the agencies charged with their health and welfare.”

There are four federally recognized tribes who use services to include the inpatient services at this VA facility.

Many Native Americans are raised on rural or remote reservations where access to quality health care options and medical plans is limited due to high cost of services. For our aging veterans, traveling and paying to receive health care is difficult at best. The VA recognized that Native American Veterans have difficulties in obtaining health care and drafted an MOU between the Veterans Health Administration and the Indian Health Administration.

There is no quality Mental Health facility to treat our veterans that suffer from PTSD and/or alcohol and drug issues. We have no CBOC or vet center. We have a high incidence of neglect when it comes to medical care because of lack of primary care.

You are asking our veterans to leave this area, to go further away from family, friends and home who have no form of transportation. There is no case management and services are already fragmented.

There is a lack of trust that the VA will follow through on services already promised to area veterans. And now they have to face more services being cut. Particularly the rural area. Demands for VA health care are already not being met. The priority groups were established for the purpose of "waiting list" for veterans to be seen.

Van transportation is available to Walla Walla but, what happens if services are moved to Spokane, Seattle, and Portland. They have to arrange for their own travel.

What happens with the aging population who needs more health care services and the veterans coming back from the Iraqi? Is there a non- VA facility who is qualified to treat the medical, and psychological issues of this new veteran?

In Montana, the VA has someone who goes to the reservations and does health screenings and check-ups. They will arrange transportation to the VA facility if the veterans need further medical attention. Those are services we could use in our area. Yet, instead of looking for ways to improve services in our area, you are discussing ways to cut these much needed services.

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VETERANS OF FOREIGN WARS OF THE UNITED STATES
DEPARTMENT OF OREGON



VA CARES HEARING

September 29, 2003

9:00 AM

Walla Walla,

Washington

Representative: Christopher C. Lanham Jr.

Mr. Chairman and Commission members,

Sir,

On behalf of the Veterans of Foreign Wars of the United States and the Department of Oregon, I am privileged to appear here today.

We have given into the philosophy that one must be sacrificed for the greater whole. That sir is what we have been doing all my life. When I first served in the Marines we worked with outdated material, in Viet Nam I ate C-rations dated 1951, we used ammo and other collateral equipment handed down from earlier generations and we were told that's the best that we could do. We were taught make something out of nothing. During my Viet Nam tour we were providing security for an Army Engineer Unit. My crew had been in the bush for about a month and we were hungry for something more than C-Rats. When we had

ensured the security for the Engineers, we were told to chow down. My observations indicated that the Marines were the only group eating which led me to believe that the Army was going to have hot chow. While my comrades were using C-4 and composition A to heat their chow, I waited and listened. I could hear the familiar sound of chopper rotary blades breaking the sound waves in the distance and my suspiciousness would soon materialize. As I watched the rotary wing birds drop their cargo I knew I was going to eat good tonight. We ate hot chow and even had real ice-cream for dessert. I learned a big lesson that day about patients. In the next 15 years or so we learned not to complain and take what was given us be grateful.

We are grateful, but what of the promises given when we stood up for our country?

We have been patient my generation's children are now fighting another war.

Why is it that we can give one of the richest countries in the world 82 Billion dollars and yet we can't find enough money to keep our Veterans Hospitals running, and even now you may have to make a decision on which group of veterans lose their health care.

In WWII the President of the United States needed to borrow some much needed cash to support the war effort. It just so happened that the Navy Retirement Home had money available. The President and congress stated that if the Navy Retirement home would lend their funds to the war effort, the men and women of the Naval

forces would never have to pay for their home, we now know that nothing is forever. We have been given many promises only to have them taken away.

It is time to provide an adequate budget to support those who gave to keep our Nation free.

Instead of having hearings to determine which medical facility to close, why aren't we having these hearings to determine how much money needs to be spent to care of those who made great sacrifices for our country. Please give the little guy a chance for once.