LEGISLATIVE HEARING ON H.R. 92, H.R. 315, H.R. 339, H.R. 463, H.R. 538 H.R. 542, H.R. 1426, H.R. 1470, H.R. 1471, H.R. 1527 H.R. 1944, AND DISCUSSION DRAFT OF THE "RURAL VETERANS HEALTHCARE ACT OF 2007"

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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THURSDAY, APRIL 26, 2007

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

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, Miller, Stearns, Moran.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to thank everyone for coming here today and I would ask unanimous consent that all written statements be made part of the record. Without objection, so ordered.

I also ask unanimous consent that all Members be allowed five legislative days to revise and extend their remarks. Without objection, so ordered.

Today's legislative hearing will be the first of many this Subcommittee plans on holding to provide Members of Congress, veterans, the VA, and other interested parties with the opportunity to discuss legislation within the Subcommittee's jurisdiction in a clear and orderly process.

I do not necessarily agree or disagree with the bills before us today, but I believe that this is an important process that will encourage frank discussions and new ideas. We have 11 bills before us and one discussion draft.

The discussion draft represents some of my ideas to improve the quality of care available to our rural veterans and the ability to access care, such as establishing mobile vet centers, improving information technology and technology sharing between the VA and non-VA providers, establishing a Rural Veterans Advisory Committee, creating Centers of Excellence to encourage research in innovative healthcare to address the needs of rural veterans, and encourage more healthcare professionals to work in rural areas.

I look forward to hearing the views of our witnesses and to a discussion on this and the other bills before us.

I also look forward to working with everyone here to improve the quality of care available to our veterans.

[The prepared statement of Chairman Michaud appears on p. 45.]

Mr. MICHAUD. At this time, I would recognize Ranking Member Miller.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Mr. Chairman, for holding this legislative hearing.

I also want to say thank you to the Members who brought these bills before us this morning and to all the witnesses that are going to be appearing here today.

I look forward to engaging in a productive discussion about the legislation that will help us provide the best care for our veterans, whether it is through contract care or requiring more VA medical centers to provide chiropractic services, and I yield back.

[The prepared statement of Congressman Miller appears on p. 45.]

Mr. MICHAUD. Thank you, Mr. Ranking Member.

Mr. Hare, do you have an opening statement?

Mr. HARE. No, Mr. Chairman. I will have some questions later though. Thanks.

Mr. MICHAUD. Okay. Thank you.

At this time, I would like to welcome two of our Members who are here today to present testimony. I know, Mr. Pearce, you have another hearing you need to go to. So why don't we start with you?

STATEMENT OF HON. STEVE PEARCE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. PEARCE. Thank you, Mr. Chairman.

I would like to thank Chairman Filner, Ranking Member Buyer, Subcommittee on Health Chairman Michaud, and Ranking Member Miller for the opportunity to discuss this issue that is critical to the veterans of the State of New Mexico.

Today I am asking for you and the Members of the Veterans' Affairs Committee to consider my legislation, House Resolution 315, the "Help Establish Access To Local Timely Healthcare For Your Healthy Vets Act."

In New Mexico's rural communities, many of our veterans are deprived of accessible medical facilities and face the high cost of gasoline to travel and to obtain care. My legislation would require the Secretary of Veterans' Affairs to contract with local doctors and hospitals on a case-by-case basis to provide medical services including primary care for those veterans who live far away from the Veterans Affairs medical facilities.

This would expand the capability of our local health providers in southern New Mexico to provide more convenient, efficient medical services for veterans who live in areas that are far away from established VA facilities.

Currently veterans residing in southeast New Mexico must drive between four and six hundred miles round trip to receive care at New Mexico's only VA hospital located in Albuquerque, New Mexico.

Just for example, it is 305 miles from my front door to Albuquerque. Now, you might think I live at the end of the Earth, but it is actually 40 miles further south to Jal, New Mexico. So those people have an even longer drive.

I consistently hear stories from my constituents about the detrimental impact this long-distance drive has on their ability to access timely care and overall health.

One Marine veteran amputee began having uncontrollable drainage from his good foot and was making two to three trips a week to the Albuquerque VA hospital. This equates to 18 hours of drive time a week. After 4 months, he finally lost his foot.

Several local civilian healthcare experts feel the unfortunate travel marathon contributed to the failure to save his foot.

Another 87-year-old Bataan veteran developed a serious bladder infection and was directed to make the 6-hour, round-trip drive along with his 85-year-old wife. Halfway through his treatments, prostate cancer was found and additional trips had to be made for chemotherapy. After 7 months of trips, he died and his wife's health was seriously damaged after the strain of such long-distance care.

My father is in his eighties. He is a veteran and I will guarantee you he is not able to make a 5-hour drive one way.

Today I know that you will hear from several National Veteran Service Organizations who may not support my bill and others under consideration today. That is because many of these groups have committed themselves to the goal of keeping VA dollars inside the VA. I understand this concept and believe at first glance it sounds like a commonsense approach to VA budgeting.

But following this logic, the only way to get more localized access to care for veterans in my district would be to build new facilities in areas closer to their homes. I believe there is a need for a full-service veterans' health center in south New Mexico and would love to see that come to fruition.

However, I am realistic as are the veterans living in rural New Mexico. With the tight budgetary constraints that our Nation faces and the smaller population in States like New Mexico, that idea is much easier said than done.

This is a reality veterans living in rural areas have been forced to accept. Since that solution is not realistic at this time, we must work to find other solutions to this problem that is hurting our veterans with every 6- to 8-hour, round-trip journey to the hospital.

Unfortunately, the idea of expanded contracting authority raises flags with certain Veteran Service Organizations that see it as a step toward privatization. Yet, if they understand what is going on, we are spending dollars for gasoline and mileage and we are not paying it for the healthcare for our veterans.

I will tell you that the Federal Government and the VA are not adequately living up to their commitment in serving my constituents in the rural parts of New Mexico.

John Taylor, life member of the Military Order of the Purple Heart and life member of Disabled American Veterans, lives in Roswell, New Mexico, which is approximately 200 miles away from Albuquerque. In a letter John wrote to me, rural veterans in New

Mexico are dying and losing body parts because of a 6-hour, round-trip drive to the nearest VA hospital in this State.

Our VSO legislative representatives from the DAV have no experience or do not live in contact with this issue as they are from large urban areas with massive facilities and infrastructure for support. The classic response to invitations requesting visits to our rural areas has historically been we will try. But it takes time to get there and we have a very busy schedule.

I submit the same time that is an inconvenience to executives is the same time that is killing my fellow veterans or at least causing serious exacerbation of their medical problems.

U.S. Army retired Lieutenant Colonel Charlie Revie, a member of the Uniformed Services Disabled Retirees, noted that the drive from Las Cruces to our only major VA facilities is a 250-mile, one-way trip.

The notion that providing contracted care to veterans through local doctors at non-VA hospitals is somehow a way to finagle them out of caring for them is absurd. Under my legislation, the VA will clearly still pay for the care of veterans obtained at non-VA hospitals.

Veterans in my district and across rural America have been hearing politicians talk about increasing access for years. It is simply imperative that Congress take these issues seriously.

Mr. Chairman, I will submit the rest of my statement, but I do appreciate the opportunity to come and testify before you today and yield back the balance of my time.

[The prepared statement of Congressman Pearce appears on p. 46.]

Mr. MICHAUD. Thank you, Mr. Pearce. Rural healthcare for our veterans is very important to me, coming from the great State of Maine. I appreciate your testimony.

Mr. Miller.

Mr. MILLER. I may have missed it in your comments, and it may be in the text of the legislation, but do you define geographically inaccessible?

Mr. PEARCE. Would you state the question again, Mr. Miller?

Mr. MILLER. Do you define geographically inaccessible? How do you define that in your legislation?

Mr. PEARCE. The definition, I think, is over 120 or 150 miles. I will have to check on that. But, yes, we do have a definition.

Mr. MILLER. Okay. Very good.

Thank you, Mr. Chairman.

Mr. MICHAUD. Mr. Hare, any questions?

Mr. HARE. Congressman Pearce, just a quick question. In terms of the total number of veterans that are having a difficult time getting to—you mentioned the long drives and things of that nature. Is there an estimate of how many folks, how many veterans in your district, in your State are having this problem?

Mr. PEARCE. Oh, Mr. Hare, I would guess that it is probably in the 20,000 range. In other words, most of the veterans in the southern district are a long way from a hospital. And the VA hospital in Albuquerque serves also Texas, so it reaches to the extremity.

Some of the places in the second district are within an hour or two, but most are at least 3 hours one way. The rest are 4 to 5 hours one way. Again, my home is 5 hours one way from the time I leave the front door. So it is probably in the 20,000 range. And we are just simply requesting that the Secretary consider on a case-by-case basis that people be allowed to get some care. We have had veterans talk about driving to Albuquerque 5 hours away one way, 5 hours back to take a blood test. And when they got there, they were told I am sorry, that has been rescheduled. These are the sorts of problems that the people who come from large metropolitan areas just are not familiar with.

I will tell you that we have had a significant improvement in the relationship with the veterans hospital administrator. He has actually not this past Saturday, but about two Saturdays ago came and met with me and local veterans in Roswell. That is still 120 miles north of my hometown and still 40 miles from the southern edge of our district.

And keep in mind, I am on one side and there is another side. He was about 7 hours from the sites that are equivalent to us on the other side, New Mexico Square. Albuquerque is about two-thirds through the middle. So when he was over here with us, he is 7 hours from those people over here.

But at least he is coming down. We could never get the former administrator of the hospital to do that. So we are having some discussion, but he needs the flexibility to allow these people to go to local providers to do commonsense things.

Mr. HARE. Well, my district is very rural too. And one of the things we have done, and I was just wondering if you have any of these, we have three veterans' outpatient clinics because, for example, we have people who have to go from Quincy, Illinois, to St. Louis or drive to Iowa City which was, you know, a tremendous hardship on them and people getting in vans and taking them to get prescriptions or a blood test or something.

Are there any VA outpatient clinics in your district?

Mr. PEARCE. We do have clinics. And I will tell you that the clinic in Artesia, New Mexico, has a big sign that says we are not an emergency facility, meaning if you have an emergency go somewhere else. That is extraordinarily disruptive.

So sometimes they do those things like the blood tests. Sometimes they do immunizations. Sometimes they say, no, we are too busy, you have got to go to Albuquerque.

Mr. HARE. So you had a veteran drive 5 hours——

Mr. PEARCE. Yes.

Mr. HARE [continuing]. For a scheduled blood test only to find out that——

Mr. PEARCE. Absolutely.

Mr. HARE [continuing]. They canceled it and you had to drive—so 10 hours for absolutely nothing?

Mr. PEARCE. Yes. And that is one of the things that we had the VA hospital administrator, he said he would commit that if they are going to start cancelling people's appointments, they would at least do it the day before or 2 days before.

Some of these people have to go on their own money. There is no hotel compensation allowed and they have to go on their own

money. And they may leave a day and a half early because the drive is so hard.

I will tell you that I suffer from varicose veins and they have recently gone in because I had this pooling of blood problem. And the worst thing you can do is drive with that situation. And to be describing this Marine veteran that was having to drive 5 hours with a foot that is leaking is to me the worst thing that you could do. And, sure enough, he ends up losing his foot.

They tell me sitting on the airplane, though it is 9 hours for me to commute home from here to Washington, they tell me the worst thing I can do is sit in the airplane and, yet, that was the prescription for him.

Mr. HARE. Thank you, Congressman.

Mr. MICHAUD. Mr. Stearns, any questions?

Mr. STEARNS. No.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. No.

Mr. MICHAUD. Now I am pleased to recognize an honorable Member of this Committee, Mrs. Ginny Brown-Waite.

Once again, Mr. Pearce, thank you very much.

Mr. PEARCE. Thank you, Mr. Chairman. You have been very gracious.

Mr. MICHAUD. Thank you.

STATEMENT OF HON. GINNY BROWN-WAITE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. BROWN-WAITE. Thank you, Mr. Chairman, and thank you, Ranking Member and the Members who care enough to attend. I know that many people have simultaneous hearings going on that they also have to be to as I do, so I will be leaving after the testimony.

I appreciate the opportunity to testify on House Resolution 92, the "Veterans Timely Access To Healthcare Act." When I first came to Congress in 2003, I introduced this measure after hearing of the long wait times facing some veterans in need of healthcare.

We recently checked with the VA and the VA is saying that 96 percent of the patients seeking primary care can get an appointment within 30 days. I think that every Member of Congress, if they were polled, knows that they are hearing otherwise. I do not know where the VA is getting their figures from, but we hear otherwise.

The stories that many of us have heard about these delays are unacceptable. The holdups can worsen the veteran's health and pose a greater financial hardship on everyone involved. In some situations, these waits can be the difference between life and death.

Events in Iraq and Afghanistan also remind us of the urgent matter at hand. With thousands of soldiers returning from the front lines, many will require immediate healthcare. VA medical facilities face a difficult task. Unless Congress takes action, wait times will only grow.

My legislation would help ensure that our Nation's veterans receive timely healthcare. For veterans seeking primary care from the VA, the bill would establish a 30-day timeframe as the standard for access to medical services. This standard would cover from

the time the individual schedules a visit until they actually see a medical provider. In the event this standard is unachievable, the VA would have authorization to contract for care from a private provider.

At the same time, my bill also grants the VA some flexibility in meeting the standard. For those facilities in geographic areas that have a 90-percent or greater rate of complying with this requirement, the contracting provisions would not be necessary.

Finally, Mr. Chairman, this legislation would establish comprehensive reporting requirements on wait times for individuals seeking care at VA medical facilities.

As Members of Congress, we have an extraordinary responsibility to veterans. These brave men and women answered the call in our time of need and it is only fitting that we take care of them at their time of need.

I look forward to working with my colleagues on the critical issue of wait times, and I would be happy to take any questions regarding the legislation.

When I first got elected, I contacted all of the clinics in my area and asked what the wait times were. It did not jive with what I was being told by veterans. I then said I want you to tell me the real wait times that they have.

Mr. Chairman, I am embarrassed to tell you that there was a big difference between their quick and dirty analysis and the true wait times that the veterans had to wait for the primary care.

This is unacceptable, and because we have stayed on top of it, those numbers are somewhat within the acceptable range, but still not where they should be. Everybody in Congress wants to make sure that our veterans are taken care of and timely access to healthcare is very important.

And with that, I yield back the balance of my time.

[The prepared statement of Congresswoman Brown-Waite appears on p. 47.]

Mr. MICHAUD. Thank you very much, Ms. Brown-Waite.

Mr. Miller.

Mr. MILLER. To my colleague from Florida, I think you have already answered the question, do you have any confidence in VA's numbers in regards to wait times?

Ms. BROWN-WAITE. No, sir, I do not. I honestly do not. I question it and every Member of Congress who hears from their veterans has to also question it. I know you have a large number of veterans and that you are very much on top of their needs as we all are. That is not what we hear.

I am known as the nag in the 5th District. And I am fine with that because unless you nag the VA and let them know that you track those numbers, they do get out of control. And also they play games. They will schedule an appointment within "30 days" and on the 25th day perhaps cancel it. So it is not really an appointment within 30 days. So we need to constantly question their numbers.

Mr. MILLER. You also talk in your legislation about requiring that veterans be referred to private physicians. What about the instance of the veteran that says he is willing to wait and go ahead and go through the system as normal? It does not preclude them from continuing on through VA?

Ms. BROWN-WAITE. If they are willing to wait, they certainly would have that flexibility.

Mr. MILLER. That is all, Mr. Chairman.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. I was just interested in where the VSOs are coming down on the legislation and if you could tell me why, from your perspective, there is opposition to the bill.

Ms. BROWN-WAITE. Most of the VSOs that represent the veterans up here want to make sure that all the healthcare resides within the VA. And that certainly is their job. However, I think each of us when we go back home hear different from the veterans who want a much more timely access.

Historically the VSOs have always wanted to contain the healthcare only within the VA system. And in a perfect world, that would be the ideal because of continuity of care. But we also do not want the veteran waiting inordinate amounts of time and the VA playing games with the wait times.

Mr. HARE. Could you give me an example or two of what you have seen in terms of wait times. I know you mentioned a little bit about it, but maybe from in your district because, as you said, when we go back and we hear from the veterans, I just wondered if you had an instance or two that you could——

Ms. BROWN-WAITE. Certainly. Mr. Chairman, if I may respond. I have had veterans tell me exactly this situation that I just described of, yes, they had an appointment within 30 days, but on the 21st or the 25th day, VA called to reschedule it 30 days later. That is not timely access and that is not serving the veterans.

Certainly the VA clinics, and we are fortunate we have many in Florida, the VA clinics do all that they can, but they are also having trouble hiring for positions that are open. They do not have enough doctors. They do not have enough of the nurses and the medical technicians there.

We are expanding clinics regularly, but people are still having trouble with the primary care access.

Mr. HARE. Thank you very much.

Mr. MICHAUD. Mr. Stearns.

Mr. STEARNS. Yeah. Thank you, Mr. Chairman.

My colleague from Florida has been a leader on this ever since she came to Congress and I commend her for it and for particularly in an informal basis to try and understand the facts.

Ginny, you had indicated that it takes 30 days, that that is the question. But have you looked at once a person gets the appointment and then has to come back sometimes and it is not just the first appointment that takes a long time, it is coming back for the second and third? And I heard complaints that they can get within the 30 days, but then when they come to get the referral sometimes takes longer. And I just wonder if you had any experience on that.

Ms. BROWN-WAITE. Mr. Stearns, it depends whether or not the second appointment is for specialty care. I know that there is a much longer wait for specialty care. I recently heard from a veteran seeking dermatology care and that was an inordinate amount of time that he had to wait.

As you all know in Florida, dermatologists are, even in the private sector, there is a long wait for the dermatology appointment.

But very often they will get that first appointment and then there is a delay in the followup appointment. So, yes, I am hearing that as are other Members of Congress.

Mr. STEARNS. Yes. That is what I hear that some complain, well, okay, I can get into the front door, but I cannot get any response beyond that.

I do not know. I heard you talk about your informal investigation. What did you find was the real time when you talked to these veterans themselves? What have they been telling you? Like some of my veterans have told me well beyond 45, 50 days.

Ms. BROWN-WAITE. Oh, absolutely. I hear well beyond that, as much as 2 months and longer that they are waiting. And that is just not acceptable and, yet, the VA tell us that overall 96 percent are being seen within that 30-day period. I guess it is in, you know, dog years that they are counting it because it is not 30 days in human days.

Mr. STEARNS. Just your option you talked about, about the referral of veterans to private physicians if a network fails to meet the standards of access. I guess the question is, is your intention not to give an individual veteran the option of waiting to receive it or just, in other words, the veteran could decide, okay, I will wait 45, 50 days or is it a mandate that he has to go to a private physician?

Ms. BROWN-WAITE. No, sir. Obviously the veteran could wait for the VA care if that is their choice.

Mr. STEARNS. Yeah. Mr. Chairman, I think it is important to point out that the legislation is not a mandate to go private, but giving the veteran the choice which is what I think ultimately the veteran wants to have.

And I thank you.

Mr. MICHAUD. Thank you.

Dr. Snyder, any questions?

Mr. SNYDER. Thank you, Mr. Chairman.

I did not realize we had such Florida domination of the Veterans Committee until this very moment.

Ms. Brown-Waite, I guess just two comments or questions, and I like what you said about nagging. I think that is what we all do sometimes on different issues. And I think it is really important that we all do that.

The concern I have about this bill and some of the other bills is there is no new source of funds in this bill and if we pass any kind of language that requires the VA to hit this mark or we have to pull money out of our system, that money is going to be pulled from some place. And if you magnify that all over the country or at some point, then they say, well, we need to lay off a primary care doctor because we got to pay these bills down the road.

And it seems like we dealt with this a few years ago and I think there was a decision made that trying to find healthcare in the private sector because we do not like what is going on in the VA system that we love so much, at some point, it leads into a spiral of funding problems for the underlying system.

How do you respond to that? I mean, I applaud you. I mean, this is kind of a sophisticated form of nagging you are doing here this morning. I think it sends a message that we, I agree with you 100 percent, we need to be working on these problems. But how do you

respond to that criticism that we have heard through the years and which I have agreed with, by the way?

Ms. BROWN-WAITE. Dr. Snyder, as you know, we have increased funding. This is my fifth year here and we have increased veterans' funding for healthcare substantially during that time. It has been over 40 percent in those 5 years that the funding has been increased.

We need to continue to increase that funding. No, this bill itself does not have a pricetag attached to it. That would be certainly part of the appropriations process.

Mr. SNYDER. Yeah, which I think has some problems.

Then the other, there is this other issue, too, which I think the VA system, as we all know, gets accolades for things that it does better than the private sector, but I was nagging one of my employees not long ago about I thought he had a dermatological thing he needed to have checked out and he finally succumbed to my verbal pressures. And it was like it was going to be almost, I think, like 2 months before he could get in. I said that is not acceptable. So then he was calling around and he finally did find somebody.

But the standard at a private community on some of these specialty things is not all that great either for getting in. But thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Dr. Snyder.

And, once again, thank you, Ms. Brown-Waite for your testimony.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

Mr. MICHAUD. Next on is Mr. Ortiz. I want to thank you for coming here today as well and to present your legislation.

STATEMENT OF HON. SOLOMON P. ORTIZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ORTIZ. Thank you, Mr. Chairman, Ranking Member, and Members of the Committee, for this opportunity to speak to you on behalf of south Texas veterans and help this Subcommittee understand the urgent need for a veterans' hospital for the men and women who fought for us.

We have this map before you because I will be addressing the Rio Grande Valley. The valley is way at the bottom with a population of close to 600,000 people, but the nearest hospital is about 6 hours away.

I would like to echo what my good friend, Mr. Pearce, testified to about the distance. Here with me today are the Veterans Alliance of the Rio Grande Valley so you can see the faces of the south Texans affected by the lack of a hospital.

The Rio Grande Valley is the southern-most tip of my district. And these young men fought bravely for us in different wars, from the Korean War to the Vietnam War, and some of them still fighting the Iraqi and Afghanistan War.

Here with me today is Jose Maria Vasquez, Ruben Cordova, Max Belmarez, Polo Uresti, Frank Albiar, and Mr. Felix Rodriguez. They wanted to be here today to put a face to the problem that we face in south Texas.

My legislation gives the government flexibility in establishing a way to deal with hospital services in south Texas, but the only real

solution, my friends, and I know you understand this problem, is a hospital.

Most of the clinics that we have do not have any inpatient care. All they do is have outpatient care. We did try to contract out, but 10 beds is not sufficient. The bottom line is veterans' inpatient healthcare must be available where the veterans reside, not several hours away.

Part of the healing process is for the family to be able to be close to their loved ones who are recuperating from wounds. Now we are beginning to see wounds that we did not see before because our young men and women are surviving this war because they have body armor and better equipment.

These guys have fought, bled, sacrificed for this Nation. They need something that belongs to them, a hospital that gives them the care that they need where they reside.

And we know that the VA plays the numbers game, but the numbers do not reflect the need, particularly in the Rio Grande Valley.

When the VA commissioned the CARES study, they recognized the far south area of south Texas was in need of acute, inpatient care. They decided to meet this demand through contracting and leasing beds with the local hospitals, an approach that we tried but simply did not work.

Veterans are still traveling in large numbers to San Antonio for care. And for many who are treated for emergencies at area hospitals, the bills go unpaid.

Before, you can imagine this, these young men went and fought a war thinking that we as a government were going to take care of their problems. Now they have a five and a half hour drive, and do not even have vans. They do not have an ambulance. They have to get volunteers, my friends, to drive them for five and a half hours to the nearest VA hospital which is in San Antonio.

Some of the Second World War veterans are bedridden and no ambulance to drive them and are dependent on volunteers to drive them. They have a van. How in the world can you see the Second World War veteran on a van when he is bedridden? Some of them just simply do not go to the hospital anymore or to the clinics that we have.

Many of the veterans are so disgusted by the level of VA healthcare that they just simply do not sign up anymore. They have given up.

You have heard me describe the conditions of south Texas veterans today, but they want to show you experience of veterans themselves, veterans who shed blood for our Nation.

What I have done and what they wanted to do was give you testimonies, and it is a stack this high, of some of the sacrifices that they have gone through to go five and a half hours to get a 15-minute checkup because the locals do not have the equipment, because the locals just cannot do it. They go up there for 15 minutes. They drive five and a half hours. Then they come back another five and a half hours' drive.

Some of them, the older people are having prostate problems, in the eighties. They go there just to see that their appointment was canceled. Then they have to drive back again, and they say come back in 6 months.

This is just something that I cannot understand. You know, we can find money to go fight a war, into the billions of dollars, but for some reason we cannot find enough money to take care of the promises that we made.

I am a veteran. I served. We must give them what they fought for. And Vic and I, you know, we served, Congressman Snyder and Jeff Miller. This is something that we do every day. We talk about readiness, about military, about personnel, and about funding into the billions of dollars.

I am afraid that what we are doing today is going to have a huge impact if we do not try to resolve some of these problems on retention and recruitment.

I was at a fair that we had for veterans and I see this older man on crutches with his two young grandsons. And as I was talking to him, he says do you think I am going to recommend for my grandsons to go join the military when you look at my condition and they have not been able to take care of me?

This is why we need something to address the needs of our soldiers, people who have fought, people who have bled, many have died, have never come back.

We just had a recent young man come back from Iraq. He was shot in the back. His spinal cord is gone. He cannot walk anymore. He says I remember when I was in Iraq and I saw those young men lose their legs and I felt sorry for them, you know, and I still do. But you know what? Those young men who lost their legs can walk because of prostheses. There are a lot of us coming back with spinal injuries with our legs, but we cannot walk.

When he was coming out of anesthesia, my friends, he was fighting. He thought they were taking him prisoner. We need competent people, trauma care, who understand what they are faced with. And this is something that we do not have.

I have a large testimony, but I know that time is limited. Look at my legislation. I will leave with you some letters that you can read about the sacrifices that they go through.

Thank you so much for listening to us. Hopefully you will take a look at my bill, and I will give you the testimony that the veterans and some petitions because this is something. I have been in Congress 25 years. I have been fighting for a hospital for the last 24 years.

What they have done in the past is to consolidate some of the clinics, shut down some hospitals, and now we are getting more and more soldiers coming back with different wounds from Iraq and we need to take care of that.

Thank you so much.

[The prepared statement of Congressman Ortiz appears on p. 48. The petition submitted by Congressman Ortiz is being retained in the Committee files.]

Mr. MICHAUD. Thank you, Mr. Ortiz. And do you have a copy of that map, so we can have it for the record?

Mr. ORTIZ. We do. We are going to pass you a copy of the map with the testimonials of several of the veterans.

Mr. MICHAUD. Okay. Great. I appreciate it.

And it is my understanding that under the Capital Asset Realignment for Enhanced Services (CARES) process there is no hospital, but we will check with VA to make sure.

Mr. Miller.

Mr. MILLER. Solomon, I assume that the closest DoD facility to south Texas is Corpus Christi. Is there a Navy hospital there at the Naval Air Station?

Mr. ORTIZ. We had a Naval hospital. It was shut down. And sometime back, I testified before the VA Appropriations Subcommittee. They came down and they looked at the hospital. Again, the lack of funding. And then they came down and they said this hospital is obsolete, you know, does not conform to the American Association Guidelines. So we do not have a facility.

Another problem that we have is the influx, you know, we have a lot of winter tourists, veterans that live in the area for 4 to 6 months, they are vets who need treatment, about 20,000. We have about 140,000 people, soldiers who have served in the military. We do not have a facility. We tried contracting out with the local hospitals.

One young man was having a cardiac arrest and he called his people at the VA, who say go to the hospital, go to the nearest hospital. He did. Then he got a bill for $10,000 that he still has not been able to pay.

These are the problems that we face on an everyday basis. There is not a hospital. It is all outpatient care.

Mr. MILLER. You said that the contracting side was not working. Is it not working in regards to them being able to get the care? Is the breakdown just in paying for the bills? Where is the breakdown?

Mr. ORTIZ. It is both, because when you have 140,000 eligible people and you only have about 10 beds, you know, either they are full, they cannot take anybody, or if they take somebody else, they do not have room, then they charge the patient coming in.

So this is why the system, we tried it before, it is not working. And when I meet with a veteran, they say, you know, when I enlisted, they told me that they were going to take care of my health and now I am back and I have to wait 6 months for an appointment. I cannot get inpatient care. It is all outpatient care.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Congressman, let me just say thank you for two things. One, first and foremost, for introducing this legislation. You know, you were absolutely right. I was listening to your testimony and the amounts of money that we spend, you know, $11 million an hour on this war and, yet, I sat at this Committee and I keep hearing people say how are we going to afford this. And my answer has always been the question is not can we afford, the question is how can we afford not to do this.

So, Congressman, I would be honored to be a cosponsor of this bill. I think it is something that your veterans need and you have been a champion for veterans. And so I just want you to know that.

And we will find the money. We have got it. You know, and I said before maybe we ought to take it out of Paris Hilton's tax break. I do not know. But we will get it.

But let me just suggest this to you, too, or thank you for this too. I thank you for taking the time to come in. Lane Evans is my predecessor as you know. And I want to thank you for coming in helping us complete the Hero Street Memorial with your help.

And for those of you who do not know what that is, that is a Hispanic area in my district, one street where five young men gave their lives in World War II.

And thanks to you, Congressman, that memorial is now finished. And I want to, on behalf of the people of Hero Street, I have not had a chance to thank you yet, but I want to thank you for doing that.

And, again, thank you for introducing the legislation and I will do everything I can on my end to help you with it. And, you know, you are right. When you bring veterans in and you put a face on it, you know, I think it is a wonderful thing to do because sometimes we look at charts and numbers, but we are talking about people here.

And from my perspective, I cannot think of anything more important to do than to support this bill. So thank you for taking the time.

Mr. ORTIZ. Thank you so much for your comments. Thank you, sir.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. I have no questions.

Mr. MICHAUD. Well, once again, thank you very much, Mr. Ortiz, for bringing the legislation forward.

Mr. ORTIZ. Thank you so much.

Mr. MICHAUD. The last panelist for this panel is Mr. Rothman.

STATEMENT OF HON. STEVEN R. ROTHMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. ROTHMAN. Thank you, Mr. Chairman.

Ranking Member, Members of the Committee, thank you for having me here today.

I am here to testify today about the moral responsibility and national security obligation of the Federal Government to honor its commitment to all veterans, namely the commitment to provide them with quality, affordable healthcare.

It is a moral responsibility because the American Government makes a promise to every veteran. We say that you volunteer to put your life on the line for freedom, because you are willing to sacrifice yourself for the good of all Americans, because of this courage, we will take care of you when you leave the service.

We do not make that promise with our fingers crossed. We do not tack on fine print or attach a bunch of strings to the promise. We make that promise freely because our veterans gave freely of themselves in the service.

It is a national security obligation because without question, the morale of a young soldier, I believe, is seriously hurt when he meets a 35-, 45-, 55-year-old veteran, combat veteran who is battling cancer or who had a heart attack but had no health insurance and was banned by his government from getting healthcare through the VA. It is outrageous.

As a representative for more than 156,000 veterans, I have heard story after story from veterans in Bergen, Hudson, and Passaic counties of New Jersey who tell me that their government has broken its promise to them. That is because in January of 2003, the Bush Administration decided to cut costs by telling veterans designated as Priority 8 that they are banned from enrolling in the VA health system and will no longer have access to VA hospitals, clinics, or medications.

The Administration defended its decision by saying that Priority 8 veterans make too much money to be worth the added expense to the system. Just so you know, the amount of money they said was too much was anything over $26,902. I say that Priority 8 is wrong and that the Bush Administration has the wrong priorities.

We made a promise to those men and women to take care of them and there is absolutely no justification for breaking our word. Those veterans often live in areas where the cost of living more than eats up the $26,902 of income that the Bush Administration seems to think is so great.

In Bergen County, New Jersey, we have the second highest concentration of veterans in the State of New Jersey and the largest number of Priority 8 veterans. There are 73,000 Priority 8 veterans in New Jersey alone, 273,000 Priority 8 veterans throughout the country, 273,000 veterans who have been told they make too much money making $26,902.

So an example, if you served in combat in Iraq or Afghanistan for a number of years, three, four deployments, five deployments and thank God you come home without any physical injuries, 5 years later you get cancer, you cannot use the VA if you make more than 26,000 bucks. In my district, the number is a little bit higher, but it is certainly not enough to cover the costs of healthcare.

Turned away, 273,000 veterans turned away from the VA. What is the message we are sending to our soldiers? We are saying that even though the government made this promise, even though all Americans believe that this is the case that if we serve, we are going to be taken care of, that is not the case. It is a lie.

The President may promise to love veterans and love people in the Armed Forces, but that is not what he is doing. He had this Congress or he had his Administration come forth with a plan that has cut 273,000 veterans from healthcare through the VA. We need to keep our promises to our veterans.

Mr. Chairman, Mr. Ranking Member, and Members of the Committee, again, we did not make those promises with our fingers crossed or our hands behind our back. They deserve this healthcare.

And one of my colleagues was asking where we get the money. In my book, I think the way most Americans feel is this is an obligation, this is a promise we made. It is a moral imperative that we live up to our promise to those who put their lives on the line for us. It is a national disgrace, a national dishonor.

Where should we get the money? Well, you know, if you have a lot of different needs, you take care of the most urgent need and the promise to those who did the most, that would fall into this category. And if, my goodness, because the health of the veterans' healthcare system cannot take care of all of its veterans because

this Administration will not provide the money, then maybe we ought to rethink our healthcare system. Oh, my goodness.

The first thing we need to do, though, is live up to our promises to our veterans and take care of them if they get sick when they come home.

Thank you, Mr. Chairman, Mr. Ranking Member, Members of the Committee.

[The prepared statement of Congressman Rothman appears on p. 71.]

Mr. MICHAUD. Thank you very much for your testimony.

Mr. Miller.

Mr. MILLER. Thank you very much for your testimony, and I think we all agree that there are many things that we can work on and do better. Certainly the VA system gets that from this Committee and Subcommittee all the time.

Are you aware, Mr. Rothman, that an Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) combat veteran can, when they come home, get 2 years of healthcare, so they do have that. I do not know if there is a lie being perpetrated on those veterans at all, and I do not think that is what you were trying to characterize, but——

Mr. ROTHMAN. Thank you for the clarification. But with regards to those veterans whose service preceded Iraq and Afghanistan, if they get a heart attack, if they get cancer and they do not qualify for Medicare because they are too young, they are under the age, they are in their thirties or forties or fifties, they are out of luck. They do not get any healthcare. And that is a lot of folks, 273,000 in the United States.

Mr. MILLER. I concur. Again there is an issue, but I think a lot of times while we are at war, we use current stories about veterans as they are returning home and there is a clear distinction in regards to their ability.

Mr. ROTHMAN. I accept that distinction and I appreciate that.

Mr. MILLER. Thank you for your testimony, Steve.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. I would just concur with you. I mean, a promise made to veterans is a promise that we have to keep and for the life of me I continue to shake my head because even if we did not care about the health of the veteran, which should be first and foremost, I do not know how we are going to recruit other people to go in when they see the kind of treatment, or lack thereof, that we are giving to the current veterans.

I really applaud you for doing this because I do not care what category you are, it just seems to me if you served this country, you are honorably discharged, this country makes a promise, and, as you said Congressman, we did not make it with fingers crossed or wink and a nod. We made the promise. So if we are going to make it to veterans we have to keep it. And for those two hundred and how much? I am sorry.

Mr. ROTHMAN. Two seventy-three.

Mr. HARE. Two hundred and seventy-three thousand veterans, I mean, what does that say for the service that they have given to this country?

Mr. ROTHMAN. If I may, Mr. Chairman.

Mr. MICHAUD. Absolutely.

Mr. ROTHMAN. There are a lot of our service men and women who are not in combat as defined under the law that my friend from Florida referred to. Nonetheless they are in harm's way. There are terrorists who would seek to blow up any servicemember in uniform or out of uniform. And so there is a justified distinction in those who served in combat, but I think every veteran deserves the right to, especially after 9/11, to, and before, to get this kind of care.

And by the way, if you ask yourself is this not so sad and shocking for veterans, is it not sad and shocking for an industrialized nation, the richest in the world, if one of the people that served in the military gets a heart attack or cancer and they cannot afford health insurance, they are going to suffer in the United States of America?

Mr. HARE. I just want to say, Congressman, you know, when people are sworn in to any branch of the service, they swear that they are going to protect this country and they do. And once they are discharged, I think we have a moral obligation to protect them.

And for the life of me, I do not know why the Administration decided they were going to do this unless it was a cost-saving factor and even if that was the excuse, that is about as lame as it gets. So I think we have to restore this. I think your bill does that.

And, again, I think, and I know one of the Members on the other side, what do you want to do, do you want to cover everybody? The answer is, yes, I do. And I think it is something that is terribly important.

And, again, this Committee, and I love this Committee a great deal, we have been able to do some wonderful things. We have a great Chairman, great Subcommittee Chairman, great Members, and I think we finally decided that enough already. We have put the brakes on this.

And I look forward to working with you on this because I think it is a moral obligation that we have as a country.

I yield back.

Mr. ROTHMAN. Thank you. I hope you will consider my bill, Mr. Chairman, Mr. Ranking Member. I appreciate your service for all of the veterans. We need to do more and to find the money to do it.

Mr. MICHAUD. Thank you very much, Mr. Rothman, for your testimony.

And since there are no further questions, I would ask that the next panel come up.

We will be having votes shortly, so what we will do is have the next panel give their testimony before we ask questions. Keep in mind that we do have votes, and we have two more panels after this panel.

I would ask unanimous consent that Chairman Filner be invited to sit at the dais for the Subcommittee hearing today. Hearing no objection, so ordered.

I would like to welcome the second panel with us here this morning. And what we will do is start with Congresswoman Solis and move down the line.

Congresswoman.

STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you very much, Mr. Chairman, Ranking Member Miller, for holding this very important hearing.

I feel real privileged with this opportunity to present, I think, a case that has not been stated very clearly here in the Congress and it is with respect to a bill that I have introduced, Culturally Competent Veterans' Care, House Resolution 542.

The bill requires that the Department of Veterans Affairs conduct a thorough assessment identifying non-English languages that are likely to be encountered and ensure that such services are available in both English and a language in which a veteran is proficient.

And as you will see by the posterboard here, these are servicemen that have actually come from the district, served in Afghanistan or Iraq. Unfortunately, they did not come home. There are 14, so some are missing. But if you can see their faces, you can tell that they are predominantly of Latino background.

One of the cases that came to my attention when the war began was one of our fellow soldiers who had fallen. I went to visit the family. The mother was not proficient in English. The son was about 20 years old, passed away, was killed in Iraq. And the mother had no idea about the information that the military was relaying to her. We tried to get them an interpreter.

What they ended up doing was actually getting another service officer, about 18, 19 years of age, to try to interpret what choices the family had in terms of burial services and life insurance and everything else, all the details that you would think somebody would be proficient and competent in.

When I came to realize that, I saw a serious gap, but it kept repeating itself. And so different families that I would encounter in my district in LA, and this is typical of the southwest where you see a large concentration of Hispanic communities serving our military, you are finding these households, whether it is the family itself or the soldier, who is proficient in another language, which is in this case, I am arguing, Spanish, but it could be Asian, it could be Filipino, it could be Asian-Pacific Islander, because we have those individuals, too, serving in combat.

And what I am finding is that upon calling the VA to ask them about services that could be provided in their language so that there is less resistance and more understanding and sensitivity in applying for services through the VA, that that should be a part of what the VA does.

Well, apparently what they do is they receive grants and they decide what languages they want to provide information. And in many cases, I do not think a booklet or a piece of paper goes far enough. We need to have staff out there. And you cannot rely on another soldier who might be misinterpreting information, who is not trained properly to give that information to a family member, to a spouse, or to the soldier, him or her self. And we have encountered this situation multiple times.

Upon inquiring with the VA, they said, well, we do not have enough staff available. We know that there are guidelines that we are supposed to be abiding by, they say, and, yet, in most of their

facilities, I am told that only 43 percent of the entire VA services it is supposed to be providing the service is actually being applied.

So I have a serious, serious concern and that is why I have introduced the bill. I think it goes a long way and I would just ask for your consideration and support.

In addition, while you may see male members here, I have met several times with many of our recruits in our district and there is a large Latino population as well. And there are special circumstances there where women also need to be treated differently with respect to service-related benefits that they may have.

So I think that that is something that we have to keep in mind as well, and I will gladly work with the Committee and hope that you may somehow incorporate our efforts here, if not possibly see the bill come through your Committee.

But I thank you for the opportunity to be here this morning.

Mr. MICHAUD. Thank you very much for your testimony.

Mr. Latham.

STATEMENT OF HON. TOM LATHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. LATHAM. I thank the Chairman and the Ranking Members, Members of the Subcommittee.

I am honored to have the opportunity to testify before you today regarding House Resolution 1426 which is the "Veterans' Access to Local Healthcare Options and Resources Act," also known as the "VALOR Act."

I introduced this legislation in response to a growing concern expressed by veterans in my district regarding access to VA healthcare. Veterans who live in rural parts of my district must travel long distances to VA medical facilities to receive the healthcare that was promised to them.

Oftentimes they have to wait for months to get an appointment. They are frequently forced to give up a full day sometimes in fragile condition to travel for healthcare.

Despite the remarkable improvement in the quality of VA healthcare during the past decade, the fact remains that not all America's veterans have equal access to these services.

One example of this inequity is the story of a Vietnam Army veteran from Fort Dodge, Iowa. He is a recipient of the Bronze Star and is service disabled. And he estimates that he has made the 4-hour round trip from Fort Dodge to the VA medical facility in Des Moines more than 100 times in the past 3 years. Because he cannot drive, he relies like most veterans on a shuttle graciously provided by one of the Veteran Service Organizations which takes up to 10 or more veterans to Des Moines at a time.

Since they have to wait for the last appointment to return, the trip takes an entire day, sometimes starting at 5 a.m. and returning late in the evening.

Countless similar cases have been reported to me by veterans in my district. This situation leads me to ask the question, can we really say that we are providing top-quality care for our veterans when so many have limited access to it?

Out of nearly 8 million veterans enrolled in the VA healthcare system last year, only 5 million veterans actually receive VA

healthcare. Recent reports show that the VA healthcare system continues to match or outrank private-sector healthcare in overall quality and consumer satisfaction.

Out-of-pocket costs are extremely low, in particular for service-connected veterans, so why are less than two-thirds of the veterans enrolled in the system actually using it? I believe that access problems account for a great deal of this disparity. For millions of veterans, VA healthcare is simply not readily accessible, and again especially in rural areas.

VA-funded research conducted by Dr. William Weeks and his colleagues from the VA Outcomes Group highlights the urgent need for action to increase healthcare access for our rural veterans. This research supports the conclusion that, compared to their urban counterparts, rural veterans have a higher prevalence of mental and physical problems and the least access to the VA healthcare system.

I am concerned that this disparity will continue to grow over time unless we do something now about it. First, rural residents are over-represented among veterans. The VA Outcomes Group found that 22 percent of veterans are rural compared to 14 percent among the general population.

Furthermore, rural veterans are over-represented among those serving in Iraq and Afghanistan due to the increased use of the National Guard and Reserve units. These units are often dispersed in rural areas far from large urban centers or concentrations of veterans where VA facilities tend to be located.

As I previously mentioned, rural veterans are already likely to experience more health problems. While large numbers of these veterans return from combat, the need for VA healthcare in rural areas will increase dramatically in the coming years.

The "VALOR Act" aims at meeting this need by providing veterans with an option, and I will emphasize it is an option, they are not mandated to do anything, to receive healthcare that they would otherwise be eligible to receive in a VA facility at the local hospital or a physician's office.

To provide this option, the legislation builds on the existing VA system for contracting with non-VA providers known as fee-basis care. The VA already has specific statutory authority to contract with non-VA facilities for medical care, but it is subject to way too many restrictions.

The "VALOR Act" would require an expansion of fee-basis care to allow greater access to VA-funded healthcare in our local communities.

Under the bill, covered services would include hospital care, medical services and rehabilitative services and preventative health services that a veteran would be eligible to receive at any VA facility. It also clarifies that VA drugs can be obtained with prescriptions written by contract physicians.

Mr. Chairman, I see my time is up and I want to submit the rest of it for the record. But let me just say this is the number one veterans' issue in my district. I hear about this all the time. So many of these people are World War II, Korean veterans and it is just virtually impossible for them to withstand a 5 o'clock in the morning to 8 o'clock, 9 o'clock at night situation just to get healthcare.

And I appreciate the opportunity to testify, and I look forward to answering any questions.

[The prepared statement of Congressman Latham appears on p. 72.]

Mr. MICHAUD. Thank you very much. I really appreciate it.

The next is Mr. Altmire who is a freshman Member of Congress. I want to thank you for your willingness to become very active in veterans' issues and look forward to your testimony as well.

STATEMENT OF HON. JASON ALTMIRE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. ALTMIRE. Thank you, Mr. Chairman, Ranking Member Miller, for the opportunity to testify before the Committee today.

My bill, House Resolution 1944, the "Veterans Traumatic Brain Injury Act of 2007," is bipartisan. And I introduced this legislation to increase the screening and treatment for traumatic brain injuries (TBI), for our Nation's veterans.

TBI is an impending crisis in this country. Our brave service men and women are returning from Iraq and Afghanistan with TBI at an alarming rate. Of those treated just at Walter Reed Army Medical Center, it is estimated that 65 percent have been diagnosed with TBI as a primary or co-morbid diagnosis. Many now consider TBI to be the signature injury for those returning from Iraq and Afghanistan.

And I am concerned that the VA health system may not be properly identifying and treating TBI among our Nation's veterans. It is estimated that more than half of all combat casualties have associated brain injuries. Most of them include mild TBI which is often missed in initial exams as physicians attend to other more visible injuries.

My bill improves the coordination of TBI care for our Nation's veterans by requiring the VA to screen veterans for symptoms, develop and operate a comprehensive program of long-term and post-acute TBI rehabilitation, establish TBI transition offices at all poly-trauma network sites, and create and maintain a veterans' TBI health registry.

And I do want to take the opportunity to commend the work of this Committee and the full Committee under Chairman Filner's leadership for the work that has been done in just the first 4 months on veterans' healthcare.

The 110th Congress is taking enormous strides in meeting its commitments to veterans. Here in the House, we voted for more than $11 billion in increased funding for veterans' healthcare and we passed the "Wounded Warrior Assistance Act" to provide for the management of their medical care.

And I know every Member of this Committee agrees that no group should stand ahead of our Nation's veterans when it comes time to make Federal funding decisions.

We owe no greater debt than to our veterans and while we have made some progress, more needs to be done. To this end, the bipartisan "Veterans Traumatic Brain Injury Treatment Act," House Resolution 1944, will allow us to properly screen America's returning heros for TBI and improve their treatment.

I would be happy to answer any questions that you have, and I do thank the Committee for allowing me to testify today.

[The prepared statement of Congressman Altmire appears on p. 73.]

Mr. MICHAUD. Thank you very much, Mr. Altmire.

Next is Mr. Moran who is a distinguished Member of this Committee.

STATEMENT OF HON. JERRY MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. MORAN. Mr. Chairman, thank you very much. I am pleased to be on this side of the table this morning with you and Chairman Filner, Ranking Member Miller for the opportunity to testify.

This is a topic that you have heard me speak about in the Committee before and it in many ways mirrors the comments of Mr. Latham, the gentleman from Iowa. We share the same kind of challenges when it comes to a rural district.

I represent a congressional district that is about the size of the State of Illinois. It is almost 60,000 square miles and although there are 75 hospitals in my congressional district, there are no VA hospitals.

And so the veterans, just as Mr. Latham described, have long distances to travel. We have been successful in bringing Community Based Outpatient Clinics (CBOCs) to the congressional district and I am very grateful for that, but I am convinced there will never be enough construction dollars to justify enough new clinics to serve the needs of veterans who live in the remote areas of Kansas and really across the country.

I want to share just a couple of stories with you, again a World War II veteran. This letter comes from his wife. My husband has been a resident of a long-term care facility for 2 years and is unable to drive the 65 miles it takes to get a physical at the Hayes VA Clinic as is required by the VA to receive his prescription drug benefit. They stopped filling his prescription medicine.

Veterans like Ralph gave several years of their lives for our country and I feel that he is being treated in a very ungrateful way.

Another example, Hoxie, Kansas, in which the gentleman, the elderly veteran needed a new pair of eyeglasses. The veteran was told he must travel 4 hours to Wichita to the VA hospital to receive his new pair of glasses, a distance of about 260 miles, yet his hometown has an optometrist who is unable to meet his needs because he is not part of the VA.

This does not make sense to me and I know that it does not make sense to many of my colleagues. It is long drives, bad weather, limited financial resources and ailments that make it very difficult for our veterans to make that trip and, therefore, many of them, I would say most forego getting treatment.

It is no wonder that studies highlight the poor health of America's rural veterans. It is not right that we penalize veterans because of their choices of where they live.

This legislation, the "Rural Veterans Access To Care Act," has the goal of stopping these disparities in access. The legislation would give our country's most underserved veterans, those who live

the farthest from VA facilities the choice to receive care closer to home at a local hospital or physician's office.

This legislation requires the VA to coordinate care with the Department of Health and Human Services and to contract with qualified providers. These rural providers already supply healthcare, quality healthcare to America's rural population.

To further ensure quality standards for the veterans' care, the VA should write quality criteria into contracts, monitor the service delivery, and put in place mechanisms to share healthcare information.

The legislation would also require the VA to fill prescriptions written by outside physicians for eligible veterans.

And I understand there are concerns. Mr. Michaud, I chaired this Subcommittee at one point in time and I promoted this legislation for a long time. It is not always supported by the Veteran Service Organization community. And I understand the concerns that are raised about the budgets and that there is a fear that if we enhance contracting that our VA hospitals will suffer.

And I believe that it is important that we do both, fund the hospitals and CBOCs as well as provide contracting for our most rural veterans the outreach that they need.

This legislation has not been scored, but I believe in order to lessen its budgetary impact, we can create criteria which the bill does. A veteran must live at least 60 miles from a VA primary care facility like a CBOC when seeking such outside care or 120 miles from the VA hospital or 240 miles from a VA tertiary care facility.

So we have placed mileage restrictions in this legislation to minimize the budgetary impact. These requirements are based upon the VA's own care system in which they establish the goals for service to veterans and using their criteria of distance and time for veterans that they desire to serve.

Mr. Chairman, I believe that allowing highly rural veterans to take advantage of the convenience of an existing rural healthcare infrastructure is a commonsense solution to providing VA care when it is not otherwise available.

I am not suggesting we abandon the VA healthcare system, a system that has served veterans well and continues to improve, but I do request that we put in place practical reforms to account for the reality of those who live on the fringes of the VA's ability to care for them.

I ask the Committee's full consideration of this legislation and would work with others to supply other ideas and suggestions of how it can be improved or altered so that our veterans will finally have the access that we have promised them years ago.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Moran, for your testimony.

And the final panelist is our distinguished Chairman of the full Committee on Veterans' Affairs, and I would like to thank you, Mr. Chairman, for assisting us in having this hearing on several pieces of legislation that are important to veterans and individual Members of Congress. So thank you, Mr. Chairman.

STATEMENT OF HON. BOB FILNER, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FILNER. Thank you. Mr. Chairman, thank you for your leadership. There are a lot of good bills here.

Mr. Altmire, before you leave, I just want to thank you for your leadership on the traumatic brain injury situation. We are going to have a national symposium on brain injury and bring in a lot of creative and outside ideas about treatment to deal with it. And your bill will be there to be considered, so we thank you for that.

And I thank also Mr. Latham and Mr. Moran. We are going to address a rural health agenda for our Nation's veterans and we look forward to having your bills to look at as we proceed. So thank you for your leadership here.

I have two bills on our agenda today, H.R. 1470 and H.R. 1471, and I appreciate the opportunity to speak on these bills.

I think a special opportunity presents itself in that over 40 percent of the medical problems for returning servicemembers from Iraq and Afghanistan are what we call musculoskeletal and many can undoubtedly benefit from chiropractic care. As one American who has benefited from chiropractic care, I can promote it in absolutely good faith.

H.R. 1470 which was introduced in the last Congress by former Congressman Jeb Bradley, who was a Member of this Committee from New Hampshire, is called the "Chiropractic Care Available to All Veterans Act." It requires that chiropractors are phased into the VA with not fewer than 75 medical centers by the end of December 2009 and all of our centers by the end of 2011.

House Resolution 1471 is the "Back Our Veterans Health Act," which means better access to chiropractors to keep our veterans healthy. It requires that veterans have direct access to chiropractic care at the VA hospitals and clinics so that veterans do not have to go through a general practitioner, or gatekeeper, as this doctor is sometimes called.

We must remember that since the creation of the VA healthcare system, the Nation's doctors of chiropractic have been kept outside and all but prevented from providing proven, cost-effective, and much-needed care to our veterans. So, we are grateful that access is becoming greater.

The support for VA chiropractic care is bipartisan and you may recall that the previous Secretary of the VA, Anthony Principi, released a policy directive before his departure regarding the true and full integration of chiropractic care in the VA.

I hope that Secretary Nicholson will be equally open to this and, of course, both Republican and Democratic Members of this Committee have supported this bill.

I have worked very closely with chiropractic patients, including our Nation's veterans, on these bills as well as the American Chiropractic Association and the World Chiropractic Alliance. I see members of both groups here today. Thank you for your support and your energy in promoting these important concepts.

Hopefully the VA will do some of this administratively, but I think we have to pass this legislation to make sure that there is direct access for our Nation's veterans to this proven healthcare.

And I thank the Chairman.

[The prepared statement of Congressman Filner appears on p. 74.]

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Are there any questions of the panelists that are remaining?

Mr. MORAN. Mr. Chairman, I would only suppose any Member of the Committee should compliment Chairman Filner. It is probably the political thing to do, but I appreciate his continued effort in regard to chiropractic care.

I introduced legislation that ultimately became law 3 or 4 years ago, 5 years ago maybe, in requiring that the VA develop a chiropractic care protocol. And it is a slow process by which the VA has integrated chiropractic care.

And I would join with Mr. Filner in trying to encourage that to occur and look forward to working with you to see that that is accomplished.

Mr. FILNER. Thank you.

We have passed three important bills in the last 5, 6 years and each time, we have gotten more direct because the VA just has not cooperated. So we continue to make sure, and we will have also oversight to make sure, that it does occur.

Mr. MORAN. Thank you.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Mr. Chairman, I want to ask questions of the Members that are not here because I will find that less stressful.

Just a couple comments on Ms. Solis' bill and I have not studied the bill, but I am sure my family doctor back down here, she is dealing with primarily counseling and mental health treatment issues with people who were raised in other countries or cultures and so their language skills are different than those of us who are native born.

And I think at first blush, someone may say, well, they are veterans, they are in the service, what do we have to do that for. Well, just remember that the skills that are required to, you know, drive a striker or shoot or go on patrol are a whole lot different kind of language skill requirement than the kind of language that you need to talk about your relationship with your wife, your relationship with your children, what is going on with your feelings in terms of the rage that you may feel or fears that you may feel. There are just levels, different kinds of language skills and different cultural sensitivities.

Like I said, I do not know if her bill is the answer to this and I do not know what the current VA policy is with regard to these issues, but I have, you know, worked in refugee camps where you try to provide mental health services to people that you do not have good language communication with and it is a challenge.

And the second issue is with Mr. Altmire's bill on TBI. We have talked about this issue before, but I hope in the mix, we will be sure that we are doing a good job of funding all the good research opportunities that are out there on traumatic brain injury because that is going to be a huge issue as Mr. Altmire pointed out.

Thank you for your indulgence.

Mr. MICHAUD. Thank you very much.

I would like to ask the third panel to please come up. On the third panel we have Shannon Middleton, Deputy Director of Healthcare for the American Legion; Kimo Hollingsworth, Legislative Director for American Veterans; Adrian Atizado, Assistant National Legislative Director for DAV; Carl Blake, Legislative Director for Paralyzed Veterans of America; Dennis Cullinan, Director of the National Legislative Service of VFW; and Rick Weidman who is the Executive Director of Vietnam Veterans of America.

And I would like to thank all of you for coming here. I look forward to your testimony. Why don't we start with Ms. Middleton and I would ask you to try to keep within the time limits because we do have to go vote here pretty quickly.

Ms. Middleton.

STATEMENTS OF SHANNON MIDDLETON, DEPUTY DIRECTOR FOR HEALTH, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; KIMO S. HOLLINGSWORTH, NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS); ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF SHANNON MIDDLETON

Ms. MIDDLETON. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present The American Legion's views on several pieces of legislation being considered by the Subcommittee.

Providing quality healthcare in a rural setting has proven to be very challenging given the factors such as limited ability of skilled care professionals and inadequate access to care.

The American Legion commends the Subcommittee for holding a hearing to discuss these very important and timely issues. My comments will address just a few of these bills.

House Resolution 92, the "Veterans Timely Access to Healthcare Act," seeks to establish standards of access to healthcare provided by the Department of Veterans Affairs. The American Legion believes that setting standards for timeliness in the delivery of healthcare and requiring VA to report on how these standards were executed will provide a realistic illustration of the ongoing challenges for rural veterans in gaining timely access to care. It will also allow VA and lawmakers to determine the best ways to improve timely access for rural veterans.

House Resolution 315, the Help Establish Access to Local Timely Healthcare for Your Veterans bill would require that VA contract with community healthcare providers to improve access to healthcare for veterans in highly rural areas.

The American Legion believes where there is limited access to VA healthcare, it is in the best interest of veterans residing in highly rural areas that local care be made available to them. This

would alleviate the unwarranted hardship rural veterans encounter with seeking care.

House Resolution 463, the "Honor Our Commitment to Veterans Act," discussed lifting the healthcare enrollment restriction on Priority 8 veterans. The American Legion supports removing the healthcare enrollment restriction to Priority 8 veterans.

We believe that it is a more effective method to ensure that VA can continue to provide quality healthcare by assuring that there is sufficient funding to care for the veterans' needs, not limiting access to those who have incomes that fall above the means tests thresholds.

And, finally, House Resolution 1944, "Veterans Traumatic Brain Injury Treatment Act of 2007," seeks to have certain veterans screened for traumatic brain injuries and discusses the creation of a comprehensive program for long-term care and rehabilitation that includes residential, community, and home-based components.

The American Legion believes that the provisions in this bill are both necessary and timely. Symptoms of traumatic brain injury may not be obvious and may be dismissed or may occur over time. Screening those who were known to have been subjected to blast trauma in theater, even if they have no visible physical wounds, would aid in diagnosing injuries more quickly and improve the chances of a successful rehabilitation.

Again, thank you, Mr. Chairman, for giving the American Legion this opportunity to present its views on such important issues. We look forward to working with the Subcommittee to bring an end to the disparities that exist in access to quality healthcare in rural areas.

[The prepared statement of Ms. Middleton appears on p. 74.]

Mr. MICHAUD. Thank you very much.

Mr. Hollingsworth.

STATEMENT OF KIMO S. HOLLINGSWORTH

Mr. HOLLINGSWORTH. Mr. Chairman, Members of the Subcommittee, I am pleased to appear to offer testimony on behalf of American Veterans for the pending legislation.

The central problem for veterans with regards to the VA healthcare system in a timely fashion has generally been access. Over the years, VA has become increasingly effective in providing timely access, although problems still do remain.

Regarding the legislation before this Subcommittee, we would like to reaffirm our commitment that service-connected disabled veterans should have the highest priority healthcare and that these services should be of the highest quality. We believe VA does provide that service today.

Many of today's proposals do risk some unintended consequences to include quality control, safety, and potential adverse impacts on some mandated programs that VA is required to keep.

Overall, the proposals seem to move VA toward higher cost. The escalating costs of healthcare in the private sector are well documented and, quite frankly, VA is doing a pretty good job at keeping healthcare costs down.

We believe the central question to all of these contract proposals is whether or not Members of Congress believe the VA healthcare system is a national asset worth preserving or abandoning.

This in turn is reliant upon appropriate levels of funding to hire staff, operate facilities, and clinics, and provide unique and specialized services. Appropriate levels of funding would also allow VA to open outpatient clinics where needed and provide other contractual arrangements to provide VA-sanctioned healthcare.

Many of these proposals have some triggering mechanism that would mandate the Secretary contract care. These triggering mechanisms appear to be a one-time event that authorizes veterans to essentially opt out of the system and have VA pick up the cost.

VA was mandated to establish an office of rural healthcare within VHA and we would encourage Congress to fully fund the office and allow VA to conduct the mandated assessment.

The issue of nonservice-connected veterans accessing VA care is not new and obviously we would support open enrollment to the VA healthcare system. If veterans want to use the system and they are willing to bring their dollars to receive healthcare, we believe they should have that opportunity.

Very briefly on the capital asset realignment for enhancement of services, it was a systemwide process to do an assessment of VA infrastructure. In short, with regards to VA construction, AMVETS supported the CARES Commission process.

Regarding legislation on the English language, we believe that veterans earn benefits and services and are granted access to the system by virtue of qualifying military service. This should continue to be the overriding principle when discussing veterans' issues.

And for Congress to pass a law and mandate the Secretary to provide these services when, in fact, they are starting to do this internally would create division and separation among veterans that took an oath to uphold and defend the Constitution of the United States in English.

Mr. Chairman, with regards to chiropractor care, the program has been pretty successful at DoD. There was some resistance at VA initially getting the program started. We would like to see similar results within VA that appeared in DoD.

This concludes my testimony. I will be happy to answer any questions.

[The prepared statement of Mr. Hollingsworth appears on p. 77.]

Mr. MICHAUD. Thank you very much.

Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, on behalf of the 1.3 million members of the DAV and its auxiliary, I wish to express my appreciation for the opportunity to present our views on healthcare legislation before us today.

As a majority, the bills for consideration seek to address access to VA medical care whether it is time or distance that it takes a veteran to get to a facility or the time it takes a veteran to receive the care when needed.

The DAV is encouraged with this hearing and the number of bills introduced that Congress believes as we do that through their extraordinary sacrifices and contributions in military service, these veterans have earned the right to VA healthcare as a continuing cost of national defense.

Operating on a limited resource environment, there is a cost to improving access to VA care. And in addressing this issue, it is incumbent upon us to ensure that VA receives on time sufficient funding to plan and meet the growing need of enrolled veterans' healthcare including rural veterans' care as well as for VA to be held accountable for meeting the need in a timely manner.

Equally important that all of this be done without disrupting the delicate balance by the erosion of VA's patient resource base and eventually what has been recognized as America's best healthcare value.

For the sake of brevity, I will highlight some measures in my oral testimony and refer you to my written statement for greater detail on our position and commentary on any of these measures.

DAV opposes both House Resolution 92 and 339. Both contain, as my colleague mentioned, a trigger mechanism that would require VA to utilize its contracting care authority in the provision of medical care. This is in line with our organization's opposition to any initiative that would turn VA into a primary insurer rather than provider of healthcare to veterans.

In line with this, Mr. Chairman, our concern is this hard trigger, using limited resources, particularly without appropriate controls to protect from erosion the critical mass of VA patient over time as I had mentioned earlier.

House Resolution 463 would overturn the policy to close enrollment and deny access to Priority 8 veterans. DAV believes that the manner by which this is accomplished in this bill would eliminate accountability over the Secretary's responsibility to establish and operate a system of annual enrollment for VA healthcare.

Similarly, DAV opposes "Rural Veterans Healthcare Act," which would provide veterans access to VA care at the expense of worsening VA's financial situation. We urge the confidence in the VA healthcare system displayed in this measure to remain and be used within the VA healthcare system, not outside, not without.

Veterans' geographic inaccessibility of VA care is a direct result of limited VA resources. This bill would not improve this financial situation nor does it address the higher cost of rural care and in the end would not serve veterans well.

DAV members support the systemwide availability of chiropractic services within the VA as contemplated under House Resolution 1470. However, 1471 would establish chiropractic services' practitioners on the same level as VA medical doctors in the direct provision of primary care services.

DAV believes access to chiropractic services should be provided in consultation with VA primary care providers responsible for maintaining the overall health of patients assigned to them. Thus, we oppose House Resolution 1471.

As this Committee is aware, the cost of providing care in rural and remote areas is higher than in urban areas. In much of our deliberation on this issue, we struggle to find a way to fill the inde-

terminate gap between limited resources and the demand for rural healthcare.

Accordingly, we ask due consideration be given to the cost-effectiveness of the mobile vet center program in the draft bill titled "Veterans Rural Healthcare Act." This is a concern for such a program serving in rural areas and must be addressed accordingly.

Much of the content of this bill is consistent with the recommendations on the Independent Budget. Further, we believe this measure is a good first step in addressing the healthcare needs of rural veterans and a good complementary step to the Public Law passed late last year. Therefore, DAV fully supports the purposes of this bill.

Mr. Chairman, much of the content of the "Veterans Traumatic Brain Injury Act of 2007" is consistent with the recommendations of the IB. We have some recommendations in our testimony and refer you to them.

This concludes my testimony, Mr. Chairman. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 79.]

Mr. MICHAUD. Thank you.

We will have to recess at this time so we can get over and vote and we will recess until approximately 12:15 according to Mr. Tucker.

[Recess]

Mr. MICHAUD. I would like to reconvene the Committee. Sorry for the delay. The votes lasted longer than what Mr. Tucker originally thought they would last.

We left off with Carl Blake from Paralyzed Veterans of America. Carl.

STATEMENT OF CARL BLAKE

Mr. BLAKE. Mr. Chairman, thank you for the opportunity to testify today. It seems ironic that in the face of some criticism about the care being provided in VA facilities that demand has never been higher.

House Resolution 92 would establish standards of access to care within the VA healthcare system. Access is indeed a critical concern of PVA as with the other organizations. The number of veterans enrolled in the VA is approaching 8 million and the number of unique users is nearly 6 million. Unfortunately, funding for VA healthcare has not kept pace with the growing demand. Furthermore, Congress has failed to live up to its responsibility to provide adequate resources in a timely manner. As long as VA continues to receive funding months into its fiscal year, it will never be able to properly plan to meet this demand. To that end, access standards without sufficient funding provided by the start of the fiscal year are standards in name only.

PVA is concerned that contracting healthcare services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care.

We do think that these access standards are important, but we believe that the answer to providing timely care is in providing suf-

ficient funding in the first place in order to negate the impetus driving healthcare rationing.

Because House Resolution 315 and House Resolution 1527 principally address the same issue, I will outline our concerns with these proposed bills together.

PVA is fully aware of the challenges the VA faces every day to provide timely access to quality care for veterans who live in rural areas. However, we are concerned that in addressing the problem of access for these veterans, the long-term viability of the VA healthcare system may be threatened.

The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a large pool of veterans is sent into the private sector for healthcare, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately PVA has serious concern about the provisions of this legislation that would give VA additional leverage to broaden contracting out of healthcare services to veterans in geographically remote or rural areas thereby leading to privatization.

Privatization is simply a means for the Federal Government to shift its responsibility of caring for the men and women who have served and sacrificed.

Current law limits VA in contracting for private healthcare services to instances in which VA facilities are incapable of providing necessary care, when VA facilities are geographically inaccessible to a veteran for necessary care, when medical emergency prevents a veteran from receiving care in a VA facility, or to complete an episode of VA care, and for certain specialty examinations.

The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program. Due to the concerns that I have outlined and included in my written statement, PVA cannot support House Resolution 315 or House Resolution 1527.

PVA fully supports House Resolution 463. The provisions of this legislation are in accordance with the recommendations of the Independent Budget. However, we must emphasize that if this policy is overturned, additional adequate funding must be provided to meet this new demand. It would make no sense to make this change without providing that funding.

PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans in the VA healthcare system to leave the system and seek services elsewhere as House Resolution 1426 would do. While this legislation may be well-intentioned, the potential unintended consequences far outweigh any benefit that this bill might provide.

There would almost certainly be a diminution of established quality, safety, and continuity of VA care of veterans if they were to leave the system.

While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records, and medication verification program.

These unique VA features culminate in the highest-quality care available public or private. Also these safeguards that are generally not available in private-sector systems would equate to diminished oversight and coordination of care and ultimately may result in lower quality care for those who deserve it most.

Mr. Chairman, we recognize that the challenges the VA faces in the healthcare arena are difficult. However, we must reiterate that the VA will struggle to meet the ever-growing demand of veterans, particularly rural veterans, as long as it does not receive adequate resources in a timely manner.

It is unreasonable and, frankly, unacceptable to place expectations on the VA to meet certain types of demand if it is not given the resources and tools necessary.

I look forward to working with the Subcommittee to develop workable solutions that will allow veterans to get the best quality care available.

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

[The prepared statement of Mr. Blake appears on p. 84.]

Mr. MICHAUD. Thank you very much, Mr. Blake.

Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the men and women of the Veterans of Foreign Wars and auxiliaries, I want to thank you for including us in today's most important discussion.

First under discussion today was House Resolution 92, the "Veterans Timely Access to Healthcare Act." The VFW strongly supports the intent of this legislation, but we do have concerns about the contracting aspect as well as the adverse impact on overall VA funding.

Next under discussion is House Resolution 315, the "HEALTHY Vets Act." Again, the VFW supports the intent of this bill. We would express our concern, however, with the potential for over-use of contracting care as we did with House Resolution 92. But there are certainly areas where its use is proper.

We must be mindful, though, of a demonstration project VA is currently undergoing, Project HERO, Healthcare Effectiveness through Resources Optimization. We have been supportive of the Project HERO's aims and think it would be wise to see how effective this demonstration project is and what lessons can be learned from it before making a sweeping legislative change.

Next under discussion is House Resolution 339. Again the VFW supports the intent of this legislation, which is similar to House Resolution 92, in that it establishes standards of care for veterans waiting to receive care from VA.

Next I will address House Resolution 463. The VFW strongly supports this legislation which would end the 4-year freeze on the enrollment of Category 8 veterans. We also urge that Congress keep in mind that this would have to be properly funded.

Next the VFW will discuss House Resolution 542. The VFW supports this bill which would make mental health services available

for veterans with limited English proficiency. There can be no other area where clear communication is so important as with respect to the provision of mental health services.

Next I will address House Resolution 538. This bill calls for a study to determine whether contract care, construction of a VA medical facility, or sharing agreement with defense facility would fill the needs of veterans residing in far south Texas.

Current VFW Resolution 661 which was adopted by the voting delegates of our last national convention calls for a medical center in this region.

Next I will address House Resolution 1426. The VFW opposed this legislation which would allow any veteran to elect to receive contracted care whenever and wherever they choose. We have strong concerns about the viability of the VA healthcare system should this be enacted. Although this bill intends to expand coverage available to veterans, we believe it would only dilute the quality and quantity of service provided to new and existing veterans into the future.

Next under discussion is House Resolution 1470, the "Chiropractic Care Available to All Veterans Act." The VFW supports this bill.

Next under discussion is House Resolution 1471. The VFW opposes this legislation which would allow veterans to receive direct access to chiropractic services. It is important to remember that no other VA healthcare specialty allows for direct access to patients.

Next under discussion is House Resolution 1527. We also support the intent of this legislation, which, like House Resolution 315 as discussed, allows for contracting of care to veterans in rural areas. Again, we urge that the Committee consider the results of Project HERO before going further with this bill.

Also under discussion is House Resolution 1944. The VFW offers our strong support for this legislation which would require VA to implement screening programs for traumatic brain injuries which is the signature disability of this particular conflict, something with consequences going far into the future.

Last under discussion is the draft bill, the "Rural Veterans Healthcare Act." The VFW supports this bill which would make changes and improvements to the availability of veterans' rural healthcare. With over 44 percent of returning servicemembers living in rural areas access problems are all to clear and need to be addressed. We are happy to support this bill.

Mr. Chairman, this concludes my testimony.

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

Mr. MICHAUD. Thank you very much.

Mr. Weidman.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, Vietnam Veterans of America thanks you for this opportunity to present our views here today.

Quite a number of these bills that are under consideration really revolve around a funding issue and only point up the need for assured funding that is predictable, that is adequate to meet all the needs of veterans.

And I am sure you are familiar with this. The partnership, sir, which nine organizations including the six represented at this table have agreed upon and urge that the 110th Congress move to address this chronic problem and to do so before the end of the first session because it would obviate the need for many of these well-intentioned bills that just nibble around the edges.

In regard to the Priority 8 veterans, in January of 2003, the Executive Directors, and I am that for VVA, of the six organizations represented before you met with Secretary Principi and the then Under Secretary for Health and were told that they were going to limit, because of the short-term funding problem, we are going to temporarily suspend enrollment of Category 8's on the basis that it was a temporary suspension. We backed them at great political cost, I might add, within our organizations.

Five weeks later, I was in a briefing on the so-called CARES procedure and they flipped up a slide. I said stop, go back. The slide before projected 20 years out was a still freezing out Category 8 veterans. I said how did we go from a 1-year, temporary freeze to a permanent barment of veterans who are not indigent.

We resented that. I can assure you that I asked who authorized this and ended up on the 10th floor of VA saying I do not know how we can trust you all again because you sold us a pig in a poke. And this is not right. It is not right to do this on a permanent basis.

If, in fact, you all asked for enough money to serve the veterans whom you are legally obligated to serve correctly and they do not give it to you, shame on the Congress. But if you continue not to ask for that money, then shame on you. And it is time once again to address the funding issue.

Similarly to that, if I may suggest, and this also goes along with, VVA strongly supports the TBI bill, the screening bill, and at the same time would encourage you to add in that a requirement that as they are in the process now of redesigning the automated patient treatment record that VA be required, since they do not seem to be able to do it on their own, be required to take a complete military history and include it in the automated patient treatment record based on branch of service, when did you serve, where did you serve, what was your military occupational specialty, and what actually happened to you. And based on the answers to those five questions to automatically screen for things like traumatic brain injury as one example along with many other things such as post-traumatic stress disorder (PTSD). And it would be high time to do that.

Doing the look-back and the proper training on TBI throughout VA is absolutely essential. I would bring to the Committee's attention that 17 percent of the active-duty troops serving at Fort Carson in a survey that was completed 2 weeks ago done by the Army that were diagnosed, most of these people were not diagnosed as TBI; 17 percent of those active-duty troops who had been in Iraq were screened and found to have traumatic brain injury of one degree or another.

This is a huge problem. It is going to be a huge problem that unfortunately is moving from the military medical system, and not being adequately addressed there, into the VA healthcare system.

And VA needs to do its part and urge that Mr. Snyder and those folks on Armed Services ensure that military medical system carries more of its load.

On a number of the other bills, rural access to veterans and building a hospital in south Texas, VVA strongly favors that. It is a need that goes back very far and these veterans have been underserved for many, many years, and urge that the Committee move expeditiously on that and the Congress move expeditiously.

Once again, we agree with our distinguished colleagues from the VFW in the intent of the "Veterans Timely Access To Healthcare," "Richard Helm Access To Healthcare Options And Resources Act," and the "Rural Veterans Access To Care Act" are well-intentioned. However, we come back to the point that if you are not adequately funding the system to serve folks within the system, where are you going to get the money in order to contract out?

Mr. Snyder hit it right. At the moment, it is a zero sum game. And if you take away from that, then you are going to be taking away resources from within the system.

We are philosophically not opposed to contracting out where it is in the best interest of the veteran. However, we need adequate funding before you start taking money out of the system.

Because I am out of time, I will stop there. And the rest of the statement on the other bills, I think is contained therein. I would be happy to answer any questions, Mr. Chairman. Thank you.

[The prepared statement of Mr. Weidman appears on p. 92.]

Mr. MICHAUD. Well, once again, I would like to thank all the panelists for your testimony. It was very interesting. There are a lot of common themes throughout each of your statements.

I just have a few questions for VFW. You mentioned Project HERO. This might be a more appropriate question for the VA. When is that report due out? Do you have any idea?

Mr. CULLINAN. I talked with our health policy person and there seems to be some uncertainty as to when exactly it is going to come out. The only thing is it is, from our understanding, it is gathering very valuable information with respect to these kinds of projects. So it is something worth waiting for.

Mr. MICHAUD. Okay. Mr. Weidman.

Mr. WEIDMAN. If I may comment. Originally Project HERO was designed because there was a strong interest on the part of the Congress to standardize across Veterans Integrated Services Networks (VISNs) and between hospitals the cost of various goods and services. And this was a laudable goal on the part of the Congress, pointing out the fact that it was all over the map in terms of what we were paying for the same service or same good from hospital to hospital.

So Project HERO, inappropriately named as VVA would maintain, was supposed to standardize that. And, in fact, the first draft RFP was a fire sale on clinical care across the board to the private sector. We said time out. What do you all think you are doing. This is not what the Congress intended. They intended you to rationalize that which you were already contracting out. And it has scaled back several times.

But the problem with all of this contracting out right now is that you give them an inch, they take a mile. And until we can have

confidence that the intent of the Congress is not going to be distorted by the way in which it is actually implemented, VVA has no choice but to oppose it, sir.

Mr. MICHAUD. You mentioned support of the legislation dealing with the hospital in Texas. As you all know, VA went through an extensive process, the CARES process, and hopefully we will be able to move forward on that more aggressively than we have in the past.

Do you think the Texas hospital should be put before the CARES process or should we follow the CARES process first?

Mr. HOLLINGSWORTH. Mr. Chairman, AMVETS, as I indicated, did support the CARES process and there were some decisions. I think there was 18 studies. Some of those were going to require further analysis. To the best of my knowledge, the VA has not responded to some of those.

In addition, I would like to add that during the 108th Congress, there was a separate study that VA, I believe, was mandated to do with regards to that specific region and that report is still supposed to be forthcoming.

Mr. MICHAUD. Okay. Great.

Mr. WEIDMAN. Unlike our colleagues, Mr. Chairman, VVA does not support the CARES process in its current form. We would characterize it as an organized way of going wrong with confidence. It is based on a civilian medical formula for people who can afford HMOs and PPOs. They have adjusted somewhat for mental health and somewhat for blind and visual and for prosthetics, but they only adjusted a formula that is fatally flawed. It does not address veterans' healthcare and as a result is always going to underestimate the needs. Let me give you one example, if I may.

That formula is predicated on one to three presentations per individual who walks through the door. VA averages at their hospitals five to seven presentations per individual who comes through the front door. So the burn rate, if you will, of clinical resources is much higher among veterans than it is among the civilian population who are middle class, well fed who that formula is based on.

As a result of that, it is going to continually underestimate not only the amount of care needed but the shape of care needed. There is a dramatic difference between civilian medicine and veterans' healthcare medicine. And until we start to think of veterans' healthcare as a set of occupational healthcare entities or occupational health for a set of very dangerous occupations, we are going to continue to go wrong.

So we think that the need for the south Texas facility is self-evident and we should move on it immediately, sir.

Mr. MICHAUD. Thank you.

And my last question, and I will preface it with some comments, deals with access to healthcare. And I agree with the comments that you have all made. We have definitely got to adequately fund VA which is extremely important. And I think a lot of problems related to the bills that we have heard today and ones that we will be hearing hit on that core issue about not adequately funding VA.

However, even if VA was adequately funded, my concern still would be the access issue in rural areas. And I know in some of the comments, there was talk about it being more expensive and

less cost-effective. That is probably true, but when you look at veterans in rural areas, if they are going to get the services that they need, we might have to pay a little bit more for those services because I do not think it would be cost-effective to have clinics throughout all the rural areas.

So is that a fair assumption on all the VSOs that even if we do adequately fund the VA, which I think we definitely have to do, that there still will be a need for fee-for-service arrangements for veterans who live in rural areas?

Mr. CULLINAN. Mr. Chairman, speaking on behalf of the VFW, we certainly have no philosophical or other kind of objection to providing contract-based care. VA has existing authority to do that. We would urge that they do it more judiciously, perhaps more liberally.

The only thing we do not want to see is contract care suddenly supplanting the VA's own infrastructure. That is our concern and, of course the cost of all this.

Mr. MICHAUD. I agree with that comment.

Are any of the VSOs, following up on that same line of questioning, aware of any VISNs out there now that are abusing the fee-for-service contracting out services?

Mr. HOLLINGSWORTH. Mr. Chairman, AMVETS is not aware of that, but some of this delves into a territory I do not think we want to go today which has to do with the medical care cost collection funds and how we fund things.

I think overall, you know, AMVETS says, hey, we need to get the services that veterans are entitled to receive or that they are authorized to receive and we should provide those services.

I think our overriding concern with some of the legislation presented today is the simple fact that the Secretary does have this authorization and so there is no need for separate legislation to do this. If the needs are not being met, then let us get the VA to act within their existing authorizations.

Mr. ATIZADO. Mr. Chairman, if I may, with regards to the VISNs that make extensive use of contractor fee-basis care, I think if you look to the hearing with regards to Project HERO, it was mentioned in that hearing that the four VISNs that were chosen were chosen specifically for their high utilization rate of contracting fee care.

With regards to rural care, I think once we all agree with the fact that to provide this care is going to be higher than what we are all used to, then we would have to shift our idea of cost-effective care specifically for this population.

The concerns that all my colleagues have here on this side of the table is the idea that has been presented on how to deal with this issue. Much of them require VA, takes out flexibility, it is a hard trigger legislation, which, if I may say, we could probably look more toward a soft trigger, something that would allow us to be more aware of the situation, be more cognizant, and be more prudent as well as take incremental steps to really address this problem.

This is a very huge problem, particularly for the new veterans from OIF/OEF. And we really should take the time to take a look at this instead of coming up with this potentially, and I say this, potentially dangerous legislation with the way it is written.

Mr. WEIDMAN. VVA is not, as I mentioned before, philosophically opposed to contracting out as long as it is done judiciously and as long as the system is adequately funded.

I am keenly familiar with what you are talking about, Mr. Michaud. A decade following military service in Vietnam, I lived in northern New England and was 2½ hours if the roads were dry, which you cannot assume in northern New England, from White River Junction. And so I am familiar with the difficulty in receiving care from VA when you have those kinds of distances.

But the real issue here is if you have adequate funding for the overall system and using, as our good friends from the DAV put it, judicious use of the already contract fee provider mechanism, then we would have no objection whatsoever.

Mr. MICHAUD. Great. Well, once again, I would like to thank the panel for your testimony today. I look forward to working with you as we continue moving forward in this Congress to deal with issues important to veterans. Our door is always open. So, once again, thank you for your testimony.

Sorry for the delay. And I would ask the last panel to please come up. On the panel is Dr. Cross, who is the Acting Principal Deputy Under Secretary for Health. He is accompanied by Walter Hall who is the Assistant General Counsel for the Department of Veterans Affairs.

And, once again, I apologize for the lengthiness of the hearing on these pieces of legislation. Unfortunately, votes got in the way.

So without any further ado, Dr. Cross, once again, welcome and I look forward to your comments.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Good afternoon, Mr. Chairman and Members of the Subcommittee, and thank you for inviting me here today to present the Administration's views on several bills that would affect programs administered by the Department of Veterans Affairs in the provision of healthcare to veterans.

With me today is Walter Hall. He is the Assistant General Counsel.

The various bills under consideration address issues that include wait times, expanded access to healthcare in rural areas, the provision of chiropractic care, and multilingual outreach.

Mr. Chairman, knowing my time is limited, I will address these issues collectively by subject. And I would like to submit my written testimony which provides additional in-depth information for the record.

Mr. MICHAUD. Without objection, so ordered.

Dr. CROSS. House Resolution 92 deals with waiting times. Specifically House Resolution 92 addresses wait times for appointment scheduling as well as the issue of waiting room times. Both issues are important to VA and VA has no significant objection with respect to the 30-day standard for scheduling patients.

We would, however, ask the Committee to change the bill language to clarify that it would apply only to new patients. It is these patients who need to be tracked to understand that there are difficulties accessing the VA system.

Turning to waiting room times, we would like to submit to the Subcommittee results from our customer satisfaction survey which is independently done indicating nearly 80 percent of patients waiting for primary care services are seen within 20 minutes of their appointment time and more than 70 percent of veterans are seen within 20 minutes of their specialty care appointment time.

We feel that House Resolution 92 would not remedy the wait experience of the patient for a particular visit and further that the remedy is based on a flawed assumption that all private care in the community meets the proposed standards.

House Resolution 315 and House Resolution 1527 address expanded access to healthcare for veterans in rural and highly rural areas. VA is concerned that both of these bills would undermine further expansion of our system to facilities in rural areas.

VHA recently established the Office of Rural Health in accordance with Congress' mandate in the "Veterans Benefits Healthcare And Information Technology Act of 2006." This office will determine how we can continue to build on what we have already successfully accomplished and to expand on that expertise in caring for our rural and highly rural veterans who, in fact, rate their satisfaction of care higher than their urban veteran counterparts.

House Resolution 538 defines provisions of care for veterans in far south Texas. VA at the request of Senator Kay Bailey-Hutchinson has contracted to evaluate and to report on current needs in the south Texas region. The results from the study are due in July of this year.

VA respectfully requests that the Subcommittee await the results of this ongoing evaluation before considering whether to mandate a particular means for addressing the healthcare needs of veterans in that area.

House Resolution 1426 would provide enrolled veterans the option of receiving care outside the VA healthcare system. VA strongly opposes enactment of this bill. Not only could it lead to the undoing of a world-class VA healthcare system, but it would also fragment the care our veterans receive because they would no longer have a complete set of medical records reflecting their comprehensive care.

House Resolution 463 would terminate the administrative freeze on enrollment of veterans in Category 8. VA strongly opposes this bill. The bill would render meaningless the prioritized enrollment system mandated by Congress in 1996. VA would have to add capacity to absorb the increased workload this bill would entail. But in the interim, the quality and timeliness of VA healthcare would suffer.

House Resolution 1470 and 1471 deal with chiropractic care programs in the VA. VA does not oppose increasing the number of VA sites providing chiropractic care. However, at this time, we do not believe that chiropractic care at all VA medical centers is warranted. To date, 98 percent of our patients can receive chiropractic care within 30 days of their desired date.

And VA also strongly objects to extending the field of chiropractic care to the treatment of other medical conditions. We believe that it is in our patients' best interest to continue having their individual primary care providers remain in charge of managing their care, particularly since our aging population exhibits complex medical conditions requiring intensive and highly integrated clinical management skills that are better managed in a primary care setting.

House Resolution 542 would require VA services in a language other than English for veterans with limited English proficiency. We believe that we are already meeting the intent of this bill.

On February 12, 2007, VHA issued a new directive updating the guidance previously set forth regarding services to individuals with limited English proficiency. Similar documents have also been issued by the National Cemetery Administration (NCA) and by the Veterans Benefits Administration (VBA).

These action plans ensure that VA facilities and programs fully implement all such requirements.

Sir, this concludes my prepared statement. Mr. Chairman, we are still in the process of developing cost estimates for these bills and we will supply them for the record when they are cleared. And I would be pleased to answer any questions you have.

[The prepared statement of Dr. Cross appears on p. 94.]

Mr. MICHAUD. Thank you very much, Dr. Cross.

When do you think they will be cleared as far as the cost estimates?

Dr. CROSS. Well, I do not have a date in mind at this point, but this is of great interest and concern. And, sir, we will cooperate with you and do it as quickly as possible.

Mr. MICHAUD. Okay. Great. In your written testimony, you also said you will provide comments on H.R. 1944, the rural healthcare bill as well. When do you think you will have those?

Dr. CROSS. H.R. 1944 is a bill that we have just seen. It just came over, I believe, and so we looked at it. It concerns TBI. Obviously TBI is of intense interest to us and our system right now.

My view of it, and this is not official, is that the intent of the bill and many of the things in the bill are consistent with the direction that we are pursuing right now.

Mr. MICHAUD. But when will you have it? You said you would have written testimony on those two specific bills.

Dr. CROSS. Having just gotten it, I am sure that it will take a couple of weeks.

Mr. MICHAUD. Project HERO, when is that report due or when will it be ready?

Dr. CROSS. Actually, HERO is to some degree just being kicked off because it was announced in January and I believe the first RFPs just went out in, I believe, April. And so it is very, very early in the process.

We are using four sites, four VISNs. The focus is on the effectiveness of how we do our current contracting to make it more effective. And I will have to get you in writing, sir, the answer as to exactly when the date is for that to be turned in. It is a 5-year pilot project.

Mr. MICHAUD. And you heard from Vietnam Veterans of America about the enrollment ban on Priority 8 veterans, that originally that was put in place because of lack of funding within the VA and it was only supposed to be temporary. But it appears that the VA intends to make that permanent; is that correct?

Dr. CROSS. It is correct that we do not have any plans to change the current regulation at this time. And it is more than a funding issue. It is also a capacity issue and it will take time and funding substantially to incorporate that large bolus of an additional population.

Mr. MICHAUD. When you talked about waiting lists I believe you said that we ought to look at new patients, not existing veterans. Why is that?

Dr. CROSS. I wanted to explain that. I am really pleased that you asked because we deal with a chronic disease model of care given the nature of the patients that we see.

A patient who is coming in to us over a period of decades for their blood pressure control, for cardiac evaluation, for cholesterol, for PTSD, they do not necessarily need to be seen every month. And so we want to be careful. If you set a 30-day standard, we may be telling them they do not need to come back for 2 months or 3 months or 6 months.

So we use something called the desired date. And I have to explain that to you because that is a negotiation between the doctor, the scheduler, and the patient as to what is appropriate time for them to come in and what is convenient for them as well, what fits into their schedule.

And an arbitrary standard of simply 30 days measure does not account for that finesse within our system. The new patients, a hard number of 30 days is just fine, I think, because that person making that initial request, we want to get them in. There is no desired date issue. We assume that they want to be seen as soon as possible.

And so that is why I made that distinction, and we would support that.

Mr. MICHAUD. You also mentioned the Office of Rural Health. Have you already hired the individual?

Dr. CROSS. We have already established the office. We have assigned the duties to our Policy and Planning Chief, Pat Vandenberg, but our intent is to move forward with further development of that office. And I think we were given an end-point target date of the end of the summer or the end of the fiscal year. And we are working hard to meet that. We will meet that.

Mr. MICHAUD. And what are you looking for for an individual to run the Office of Rural Health?

Dr. CROSS. Well, I am not sure if I have the criteria all in mind, sir, but I would be happy to share those with you. We want someone who is committed in the same way that you are to moving this forward for our rural veterans.

And may I please say, you know, we had the rural health hearing just a short time ago. This is a strategic direction for us. We are moving out with more and more Community-Based Outpatient Clinics. We are moving out with more telemedicine, telemental health. We want to reach out into those communities.

But there is a new technique that we want to add in, which we are already doing to some degree, outreach clinics. We always put the CBOCs on the map and that is a big deal. But we want to have also clinics that are CBOCs that are part time, that do not really count as a full CBOC. We call them outreach clinics. We have about a dozen of those so far.

And those serve that need of that very small population going into perhaps leased space in the community part time, 1 day a week, 2 days a week, half day a week where we can meet those veterans' needs so they do not have to leave that community, can get their prescription refilled, can get their blood test done, and so forth. And that is one of our strategic directions.

Mr. MICHAUD. You heard the testimony from my colleagues on both sides of the aisle this morning and unfortunately a lot of it relates to funding issues, and it is not only the Administration's lack of looking at what we need for the VA, but it is also Congress' lack of taking the initiative to provide the appropriate funding.

I think if we do have appropriate funding, whether it is assured or mandatory funding, that a lot of these problems, a lot of the legislation we are having today, would not necessarily be here. Funding is a big issue, as is funding for rural healthcare when you look at the men and women who are currently serving in our military today in rural areas.

My only concern, and hopefully you will keep this in mind, is even though rural healthcare might be important for some over at VA, I do not think that is necessarily true for all. And that is where a lot of us who represent rural regions are concerned.

As for the CARES process, had that process been moving along a lot quicker than it has, I think a lot of these problems would not be here.

But, again, it boils down to funding issues. A good example, is Maine. During the CARES process, VISN 1 had recommendations for a CBOC, and I believe five clinics. Yet, when we talked with the region one VISN Director, they never even requested a business plan.

That does not give me a good feeling that the interests, particularly as you have heard earlier this morning from other Members of Congress, that if you have a VISN Director who sits in a metropolitan area, that they really understand what is happening out there with our men and women who served this country in rural areas. And I think it is very important that we do have a focus on taking care of veterans regardless of where they live.

I look forward to working with you, Doctor, as we move forward in this Congress on a lot of the issues that we have to deal with. And I look forward to working with my colleagues on both sides of the aisle because, as I stated over and over again, veterans' issues are not Democratic or Republican issues. They are American issues.

The situation at Walter Reed, the situation with Bob Woodruff, some of the articles that have come out as far as taking care of our men and women who are serving and who have served our Nation, have not been good. But the bottom line is good, particularly when you look at the budget that was passed about a month ago as it relates to VA.

And we have to make sure that we continue onward in this area, and I appreciate all the work that you are doing, Doctor and Mr. Hall, within the VA system and I look forward to working with both of you as we move forward along with the VSOs.

At this time, I would actually ask, since Mr. Miller was unable to make it back, if Counsel on either side might have any questions?

Ms. DUNN. No.

Mr. TUCKER. I do have two quick questions.

Mr. MICHAUD. Okay. Yes, Mr. Tucker.

Mr. TUCKER. Thank you.

Dr. Cross, just two quick questions. One a little more philosophical than the other.

You state that you are looking at outreach clinics as providing some of the primary care in rural areas. Is this similar to what HHS is doing and is there any overlap between what you are doing or trying to do and what HHS is currently doing?

Dr. CROSS. I think there is a very important distinction on a couple of aspects of that. The outreach clinics that we have, like our CBOCs, are tied into our system. For instance, they are tied in by our electronic health record system. That promotes a level of safety, for instance, in prescribing that, you know, I think is different from the civilian community that uses paper prescriptions.

The same screening criteria, and we are very proud of this, this is so important as was mentioned by one of the VSOs, that this is a unique thing that we must do for our veterans. So we screen them for PTSD. We screen them now for TBI, all of the OIF and OEF that we see. We screen them for alcoholism and so forth.

We are focused on those issues. And it is hard to explain sometimes what that distinction is, but I think that distinction is very important.

Mr. TUCKER. And my last one is more philosophical. As we are trying to address rural healthcare needs and trying to figure out the best mix of VA services and possibly other services and how to provide that care, how do you see the VA providing healthcare in the next decade or next two decades? Is it going to be based on the system that we have today with a VA medical center and a hub and spoke system with Community-Based Outpatient Clinics? Are we going to be looking at building more and more Community-Based Outpatient Clinics in rural areas to provide primary care and other services or how is the VA approaching what healthcare will be like in the next decade or so?

Dr. CROSS. Dr. Kussman just led a summit meeting where we looked at the future of VA healthcare as a group with our VISN Directors and Program Chiefs. VA healthcare is going to look very different in a lot of respects. We are going to become less institutionalized.

The idea that the patient has to leave home to get medical care is not necessarily the way that we want to go. We think that much more can be done in the community and at home. Let me give you a couple of examples.

Information, we have the My Health*e*Vet Web site so that they can get the information that is wholesome and reliable in their own home for those who have a computer and Internet access. We let

them refill their prescriptions sitting at their desk at home and just log in and take care of that.

We will download their medical records to the individual electronically. So if by chance we do send them off somewhere, we do fee-basis care in the rural environment and other places, they can print off and take the relevant materials with them to that institution that does not have electronic records.

I think that we are going to have less focus on grand, large, giant institutions and much more on meeting the needs in other ways. We are doing that with nursing homes, moving away from the standard model to a less restrictive model. We are doing home-based primary care where we send people out to visit in the home. We are spending $175 million on 2008 budget for home-based permanent care.

I think that is the direction, and I think it will look different. I think it will be innovative and I think it will meet the needs of our patients actually better.

Mr. MICHAUD. Just one last question. I know money is an issue and it will help. I am also concerned that we make sure that we provide adequate healthcare but in a manner that is cost-effective. And this just is a rough idea I am throwing out to get your thoughts.

When you look at what we have for a system in State Veterans Homes, have you looked at trying to partner with the State Veterans Homes, for instance, if they have a Veterans Home to take care of our veterans long term but also saying, well, maybe that might be an area where the Veterans Home might be able to build a CBOC or a clinic and have a community, veterans' community there by utilizing another entity as far as partnerships? Is that something that you are looking at?

Dr. CROSS. I think we are very open to that idea. I think that is a good idea. I think we are actually doing that in some locations already where we have a little campus, not necessarily the traditional VA campus, but elsewhere where we put a number of services collocated, regional office, VBA services, and State Veterans Homes, those kind of things.

A number of State Veterans Homes, I believe, and I am not sure of the number, are located actually on campuses with the VA. So that works in the other direction as well.

Mr. MICHAUD. Okay. Great. Once again, I want to thank both you, Dr. Cross, and Mr. Hall, for your testimony as well as all the other previous panels, and look forward to working with you as we move forward in this Congress. Once again, thank you very much.

With no further questions, the hearing is adjourned.

[Whereupon, at 1:23 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud
Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

Today's legislative hearing will be the first of many this Subcommittee plans on holding to provide Members of Congress, veterans, the VA and other interested parties with the opportunity to discuss legislation within the Subcommittee's jurisdiction in a clear and orderly process.

I don't necessarily agree or disagree with the bills before us today, but I believe that this is an important process that will encourage frank discussions and new ideas.

We have 11 bills before us and one discussion draft.

The discussion draft represents some of my ideas to improve the quality of care available to our rural veterans and the ability to access that care such as:

- Establishing mobile vet centers, improving information technology and technology sharing between VA and non-VA providers;
- Establishing a Rural Veterans Advisory Committee;
- Creating Centers of Excellence to encourage research and innovative healthcare to address the needs of rural veterans; and
- Encourage more healthcare professionals to work in rural areas.

I look forward to hearing the views of our witnesses on this discussion draft and the other bills before us.

I also look forward to working with everyone here to improve the quality of care available to our veterans.

Prepared Statement of Hon. Jeff Miller
Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this legislative hearing today and welcome the opportunity to discuss the 12 different legislative proposals before us focusing on providing better healthcare access for veterans.

There has been an unprecedented demand for the Department of Veterans Affairs (VA) healthcare. Since 2003, the number of patients VA is treating has grown from 4.8 million to an expected 5.8 million in FY 2008. In 2008, VA anticipates treating 263,000 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, 25.8 percent more than the 2007 level. This surge in demand for healthcare is expected to continue and creates new challenges for VA's capacity to deliver both primary and specialty care.

Two of the bills we will consider today, H.R. 92, the Veterans Timely Access to Healthcare Act, and H.R. 339, the Veterans Outpatient Care Access Act of 2007, would require VA to contract for care for veterans who are unable to be seen in a VA facility in a timely manner. Since 2004, VA has reported a substantial improvement in the percent of veterans who receive appointments within 30 days of a patient's desired date, stating they are meeting their established 30 day goal for 96 percent of primary care and 94 percent of specialty care patients. However, statistics mean nothing to a veteran who is delayed care because they are placed on a waiting list. If VA cannot meet its own established standard for any veteran, that patient should be given the choice to receive care in a non-VA facility.

Last week, this Subcommittee held a hearing on veterans' access to care that highlighted our concern that veterans in rural areas face additional challenges to receiving healthcare as these areas are traditionally underserved. In the Pensacola area of Florida, in my district, the nearest inpatient VA facility is located approximately 125 miles away in Biloxi, Mississippi.

Several of the bills we will examine would specifically address the needs of veterans living in rural or geographically remote areas. One of the bills, H.R. 1527, the Rural Veterans Access to Care Act, introduced by our fellow Subcommittee Member, Jerry Moran, would allow a highly rural veteran enrolled in VA healthcare to receive services through a local provider if that veteran chooses to receive non-Department care. It would also allow VA pharmacies to fill prescriptions written by non-Department providers for these veterans.

In March, this Subcommittee held a hearing to assess the rehabilitation needs and care of our injured servicemembers with Traumatic Brain Injury (TBI). These injured servicemembers and their families are relying on VA to provide a full continuum of first class care and support for their complete recovery—from inpatient services at the Polytrauma Rehabilitation Centers, to outpatient rehabilitation to long-term care services in their home communities. At this hearing we will consider H.R. 1944, the Veterans Traumatic Brain Injury Treatment Act of 2007. This bill would among other requirements, establish a comprehensive program of long-term care for post-acute TBI in four geographic regions.

Additionally, we will discuss legislation to improve the provision of chiropractic care through VA medical centers. According to a November 2006 VA study, musculoskeletal ailments are among the top health problems of veterans returning from Iraq and Afghanistan.

We will also consider H.R. 463, the Honor Our Commitment to Veterans Act. This legislation would change the law to require the Secretary of Veterans Affairs to administer the VA healthcare enrollment system as to enroll any eligible veteran who applies. The President's Task Force to Improve Healthcare Delivery For Our Nation's Veterans, in their 2003 Final Report, issued a recommendation that "The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem."

In closing, I want to thank the Members who have brought these bills before us and all of our witnesses appearing here today. I look forward to engaging in a productive discussion about legislation that will help us provide the best care for our veterans, whether it is through contract care, or requiring more VA medical centers to provide chiropractic services.

Thank you, Mr. Chairman, I yield back.

Prepared Statement of Hon. Steve Pearce, a Representative in Congress from the State of New Mexico

I would like to thank Chairman Filner, Ranking Member Buyer, Subcommittee on Health Chairman Michaud and Ranking Member Miller for the opportunity to discuss this issue that is critical to the veterans of the State of New Mexico. Today I am calling on you and Members of the Veterans Affairs Committee to support my legislation, H.R. 315, the Help Establish Access to Local Timely Healthcare for Your (HEALTHY) Vets Act.

In New Mexico's rural communities, many of our veterans are deprived of accessible medical facilities and face the high cost of gasoline to travel and to obtain care. My legislation would require the Secretary of Veterans Affairs to contract with local doctors and hospitals on a case-by-case basis to provide medical services, including primary care, for those veterans who live far away from VA medical facilities. This would expand the ability of our local health providers in southern New Mexico to provide more convenient, efficient medical services for veterans who live in areas that are far away from established VA facilities.

Currently, veterans residing in southeast New Mexico must drive between 400 and 500 miles roundtrip to receive care at New Mexico's ***only*** VA Hospital located in Albuquerque. I consistently hear stories from my constituents about the detrimental impact this long-distance drive has on their ability to access timely care and overall health. One Marine veteran amputee began having uncontrollable drainage from his "good" foot and was making 2 to 3 trips a week to the Albuquerque VA hospital. This equates to 18 hours of drive time a week. After 4 months, he finally lost his foot. Several local civilian healthcare experts feel the unfortunate travel "marathon" contributed to the failure to save his foot.

Another 87-year-old Bataan veteran developed a serious bladder infection and was directed to make the 6 hour roundtrip drive along with his 85-year-old wife. Halfway through his treatments prostate cancer was found and additional trips had to be made for chemotherapy. After 7 months of trips, he died and his wife's health was seriously damaged after the strain of such long-distance care.

Today, I know you will hear from several National Veterans Service Organizations who may not support my bill and others under consideration today. That is because many of these groups have committed themselves to the goal of "keeping VA dollars inside the VA." I understand this concept and believe at first glance it sounds like a commonsense approach to VA budgeting. But following this logic, the only way to get more localized access to care for veterans in my district would be to build new facilities in areas closer to their homes.

I believe there is a need for a full-service Veterans Health Center in southern New Mexico and would love to see that come to fruition. However, I am a realistic man as are the veterans living in rural New Mexico. With the tight budgetary constraints our Nation faces, and the smaller population in States like New Mexico, that idea is much easier said than done. This is a reality veterans living in rural areas have been forced to accept.

Since that solution is not realistic at this time, we must work to find other solutions to this problem that is hurting our veterans with every 6–8 hour roundtrip journey to the hospital. Unfortunately, the idea of expanded contracting authority raises flags with certain Veterans Service Organizations that see it as a step toward privatization. They characterize this as the Federal Government brushing aside its commitment to care for the men and women who have served our Country.

Well I will tell you that the Federal Government and the VA are not adequately living up to their commitment and serving my constituents under the current system. John Taylor, a life member of the Military Order of the Purple Heart and life member of the Disabled American Veterans, lives in Roswell, NM which is approximately 200 miles away from Albuquerque. In a letter John wrote to me:

> "Rural veterans in New Mexico are dying and losing body parts because of a 6 hour, roundtrip drive to the nearest VA hospital in this State. . . . Our VSO legislative representatives from the DAV, etc. have no experience or live in contact with this issue, as they are from large urban areas with massive facilities and infrastructure for support. The classic response to invitations requesting visits to our rural areas has historically been, 'we'll try, but it takes time to get out there, and we have a very busy schedule.' I submit the same time that is an inconvenience to executives is the same time killing my fellow veterans or at the very least, causing serious exacerbation of their medical problems."

U.S. Army Retired LTC Charlie Revie, a member of the Uniformed Services Disabled Retirees, noted that the drive from Las Cruces to our only major VA facility is a 250 mile one way trip—from Hobbs, the distance is 320 miles.

The notion that providing contracted care to veterans through local doctors at non-VA facilities is somehow a way to finagle out of caring for them is absurd. Under my legislation, the VA will clearly still pay for the care veterans obtain at non-VA facilities. Veterans in my district and across rural America have been hearing politicians talk about increasing access for years. It is simply imperative Congress take these issues seriously this year.

After the reports regarding conditions at Walter Reed Army Medical Center, the House passed the Wounded Warrior Assistance Act, which takes steps to shed light on the bureaucratic process that plagues the VA. It improves communications amongst DoD, VA and Congress and strengthens the process for returning soldiers transitioning into the VA healthcare system. All these measures are extremely important and I hope the Senate works to pass similar legislation. But we must not just be a reactionary Congress that only finds time to fix issues in light of displeasing media reports. Without any changes to allow veterans more localized access to care, many soldiers returning from Iraq and Afghanistan who return home to their families in southern New Mexico will face the extensive 400+ mile trek to the VA medical center in Albuquerque.

I appreciate the opportunity to present my legislation to the Committee and speak on this issue which deserves the attention of Congress. Our veterans in rural America deserve no less.

Prepared Statement of Hon. Ginny Brown-Waite, a Representative in Congress from the State of Florida

Thank you for allowing me to appear before the Subcommittee today.

I appreciate the opportunity to testify on my legislation, H.R. 92, the *Veterans Timely Access to Healthcare Act*.

When I first came to Congress in 2003, I introduced this measure after hearing of the long wait times facing some veterans in need of healthcare at the VA. Frank-

ly, the stories many of us have heard about these delays are unacceptable. These holdups can worsen the veteran's health and impose a greater financial hardship on everyone involved. In some situations, these wait times can be the difference between life and death.

Events in Iraq and Afghanistan also remind us of the urgent matter at hand. With thousands of soldiers returning from the front lines, many of whom will require immediate healthcare, VA medical facilities face a difficult task. Unless Congress takes action, wait times will only continue to grow.

My legislation would help ensure that our Nation's veterans receive timely healthcare. For veterans seeking primary care from the VA, my bill would establish a 30-day timeframe as the standard for access to medical services. This standard would cover from the time an individual schedules a visit until they actually see a medical provider. In the event this standard is unachievable, the VA would have authorization to contract for care from a private provider. At the same time, my bill also grants the VA some flexibility in meeting this standard. For those facilities in geographic areas that have a 90 percent or greater rate of complying with this requirement, the contracting provisions would not be necessary. Finally, this legislation would establish comprehensive reporting requirements on wait times for individuals seeking care at VA medical facilities.

As Members of Congress, we have an extraordinary responsibility to veterans. These brave men and women answered the call in our time of need; it is only fitting that we take care of them in their own. I look forward to working with my colleagues on the critical issue of wait times. I would be happy to take any questions regarding my legislation.

Thank you.

Prepared Statement of Hon. Solomon Ortiz, a Representative in Congress from the State of Texas

Mr. Chairman, thank you for this opportunity to speak on behalf of south Texas veterans and help this Subcommittee understand the urgent need for a veterans' hospital for the men and women who fought for us.

Here with me today are members of the Veterans Alliance of the Rio Grande Valley—so you can see the faces of the south Texans affected by the lack of a hospital . . . the Rio Grande Valley is the southernmost tip of my district.

Here with me are: Jose Maria Vasquez, Ruben Cordoba, and Max Balamaris, Polo Uresti, Frank Albiar, and Mr. Felix Rodriguez.

My legislation gives the government flexibility in establishing a way to deal with hospital services in south Texas . . . but the only real solution for the area is a hospital.

Bottom line: veterans' inpatient healthcare must be available where the veterans live, not several hours away.

These guys have fought, bled and sacrificed for this Nation—they need something that belongs to them . . . a hospital that get's them the care they need where they live—not 5 hours away.

We know the VA plays the numbers game—but the numbers do not reflect the need . . . particularly in the Rio Grande Valley.

When the VA commissioned their CARES study they recognized the far south Texas area was in need of acute inpatient care.

They decided to meet this demand through contracting or leasing beds in local communities, an approach simply not working.

Veterans are still traveling in large numbers to Audie Murphy in San Antonio for care, and for many who are treated for emergencies at area hospitals, the bills go unpaid by VA.

Many veterans are so disgusted by the level of VA health services, they simply do not sign up for VA healthcare.

You have heard me describe the conditions of south Texas vets; today I want to show you experiences of veterans themselves . . . veterans who shed blood for our Nation . . . veterans whose healthcare is utterly inferior.

South Texas veterans regularly travel 5 hours there and back to a 15 minute appointment that took months to get.

Sometimes they need to stay overnight in San Antonio . . . sometimes, veterans find after the strenuous trip, their appointment has been canceled.

We've scrubbed the names to prevent any retaliation for truth telling. . . . And my time will run out before I'm done, but I want you to hear the stories I hear. . . .

A 21-year-old Iraq war veteran came home badly wounded in his spine.

He's now at Audie Murphy in San Antonio.

He was being moved by hospital staff from the bed to a wheelchair—but they moved too quickly and damaged his spine even more.

He has a lifetime of going back and forth to San Antonio for treatment . . . and his family has a lifetime of committing to take him there regularly.

One veteran underwent emergency heart surgery; his wife called the local clinic and she was directed to call 911; he was admitted for the emergency surgery locally.

His benefits coordinator told him to follow up with a local cardiologist to chart his progress since there wasn't a cardiologist at the clinic.

He did, but VA did not pay and on the 3rd visit, the cardiologist's office told him to pay upfront for all services.

The VA clinic then told him he should have gone to a cardiologist in San Antonio.

By now, his sutures were infected and leaking.

Eventually, he got an appointment to see a VA cardiologist 5 weeks later.

The stress from all this prompted his psychiatrist to increase the dosage on his meds.

When he got to San Antonio, the cardiologist was surprised to learn he had surgery.

He was prescribed more high blood pressure medication.

That made him faint from low blood pressure, panicking his wife . . . she called a home health nurse who suggested stopping all meds and going immediately to the hospital.

He did not want to go to the hospital because they had not been paid and he might be refused.

He was poor—so the nurse recommended that he drink a Coca-Cola with crackers, which helped temporarily.

Due to a faulty medical records system, he was prescribed too much medication.

Since then, he travels to San Antonio to monitor his heart.

He travels 5 hours, has a 10 minute procedure done, and once was told to return in 48 hours.

He did not qualify for lodging so he returned to the Valley. After 2 days he returned for a procedure that took under 5 minutes.

That equals 2 trips to San Antonio in 2 days . . . traveling about 25 hours . . . to be seen a total of 15 minutes.

A retired disabled veteran is in the midst of several surgeries to correct service injuries, in numerous visits to San Antonio, the nearest VA hospital to the Valley.

When he had shoulder surgery, he spent the night in his car so the anesthesia could wear off . . . and he didn't take any pain medication so he could make the 4 hour drive back home. . . .

He had to stop several times along the way to vomit from the pain.

He also had to sleep once in his car in San Antonio to make an early appointment because by the time he arrived in San Antonio all the rooms available for veterans had been taken.

A constituent's brother had a triple bypass done in San Antonio Audie Murphy Veterans Hospital in 2005.

During the course of his recovery at home, he developed complications that needed to be monitored closely.

The VA medical provider told him that he needed to be monitored closely; then later that day, he got a call from the VA clinic that he needed to go to the nearest hospital taking veterans.

Once there, he was moved by ambulance to another area hospital, where he was admitted after advising the hospital he was a veteran and showing his ID card.

The hospital got the clearance from San Antonio VA and admitted him.

His medical bills there have not been paid because the VA is claiming that "VA facilities were feasibly available to provide the care."

The VA said his brother could have traveled to San Antonio under the dangerous medical problems he was having.

His brother does not want to "rock the boat" because of his heart condition and other medical problems.

In a sense, he is held hostage by our government.

A family member said this: Congress should also hear about the hardship that the vet's family must also endure.

She has a full-time job but must miss work, taking leave, to take a loved one to San Antonio.

She cannot let him go by himself whenever they do procedures that require anesthesia or manipulation of his neck or spine.

He is usually in so much pain and/or drowsy with medication that he cannot drive.

He has a hard time sitting for long periods, and San Antonio is 5 hours away.

They must also make arrangements for the kids if they are not getting back before school's out.

A couple of times he's had to go alone because she couldn't leave work or find another driver.

Then she is so worried about him driving that she cannot function at work, going out several times to call to make sure he is OK.

She also notes the travel pay is woefully insufficient, given gas prices.

They have to fill up twice to get there and back, plus pay for meals.

She notes that hospitalized vets would be better off near friends and family to keep them in good spirits.

A Vietnam vet still being treated for post-traumatic stress disorder; has two sons, both active-duty military, who have served multiple tours in Iraq.

After a late-night phone call from a son saying that he'd been hurt in an IED explosion, his post-traumatic stress surfaced . . . when he called to see the psychiatrist, he was told the soonest appointment was in 6 months.

The district director for the Veterans of Foreign Wars in the Valley says VA provides good medical care.

The doctors and staff do the best they can with what they have.

The problem is getting into the system to get the care.

He says, "We believe we've earned the right to see a doctor where we live."

Veteran and State Rep. Aaron Peña says what isn't spoken is the sense that they are being ignored despite the long history of Hispanics' service to the U.S. military.

We've fought in almost every American war . . . and we're still being ignored.

The disabilities of a Port Isabel veteran who served two tours in Vietnam are made worse by a round trip on a crowded van, and an overnight stay in a dirty hotel.

Fourteen months ago he went to a private emergency room, which then sent him by ambulance to San Antonio to treat a kidney infection.

VA still has not paid for the emergency visit—ironically today, April 26, is his deadline to pay the local hospital $10,000 since VA won't pay.

An Iraq veteran is haunted by some of the terrible things he saw in combat leading to depression and thoughts of suicide.

His friend got him to go to the VA office . . . where he was referred to the VA hospital in Waco for evaluation for post-traumatic stress.

He was told he needed to begin regular sessions, and he'd get an appointment in the mail.

Three weeks later, he got a letter from VA that he could see the doctor in 8 months.

Another veteran notes: "It's hard to hold a job when you have to miss work four or five times a month to travel to San Antonio for medical appointments."

One veteran has utilized the VA healthcare systems in Reno, Nevada and Fargo, North Dakota, and he reports both were very good.

Conversely, his experience with the clinics in Harlingen and McAllen are "ongoing nightmares."

Lately he's been trying to get an appointment with the psychiatrist in Harlingen.

Every time he calls, he's put on hold and eventually hangs up after waiting and waiting.

He was not alone among veterans who suspect some manner of "Federal racism" when our Nation is only anxious to send border patrol agents, but no hospital to treat military veterans who live here.

A daughter who misses her dad says her father served in the U.S. Army and came home needing psychological care catered to what a veteran experiences—and taking into consideration the stigma a Hispanic man feels with depression.

She lost her father to suicide and wishes that care was available.

Another veteran learned the VA now accepted that Agent Orange could have affected sailors in the Tonkin Gulf.

The VA did not respond to him since he was not a "wounded veteran."

He also has diabetes for which they will not treat him.

He believes they want to wait until he cannot care for himself at all rather than helping him prevent the devastation of diabetes while he can.

A former military wife said her ex-husband and daughter now live in San Antonio and her son has plans of retiring there too—merely to be closer to military medical facilities.

Veterans are forced to choose between living near home and family, or living near healthcare.

Another veteran notes many soldiers from the Valley can not afford the trip, much less the expense it takes to visit these facilities.

He notes many veterans have died never getting the medical attention they needed.

He calls the VA health system in south Texas a "disastrous situation."

A former sergeant says: The cruel irony of extra stress on various disabilities caused by traveling 5 hours to a VA hospital makes conditions even worse.

And like several others I heard from, he issued an invitation for any of my colleagues here today to join them on the 5 hour ride to San Antonio in the van.

A retired major notes local access would promote early diagnosis and early cure for ailments that would otherwise generate higher treatment costs if left untreated.

He also has the novel suggestion of using hospital ships as a veteran's hospital.

A retired Air Force sergeant—who is covered by TRICARE benefits—knows he is lucky to have access to local medical facilities.

Always a soldier, he volunteered to drive the van to San Antonio.

He would drive from Raymondville to Brownsville to pick up veterans at 6 a.m. then to San Benito then Harlingen and then back to Raymondville, where the actual trip to San Antonio commenced.

He reiterated what many people said: It's not a straight 5½ hour trip since they had to stop various times for restroom breaks.

And he was prohibited from helping the vets in and out of the van out of liability concerns.

Most veterans he drove had to wait hours to be seen for just a 15 minute visit, then they began the long trek back.

The widow of a Vietnam-era vet said he died 9 years ago of a heart attack and almost certainly from a lung problem associated with his exposure to Agent Orange.

He never pursued a diagnosis because the San Antonio facility was too far and he was not able to make the trip.

The one time he did for hearing loss from a mortar concussion while in Vietnam, he found that the number of people they were trying to serve was too great for quality care.

He never went back again.

A captain with the 1st Cavalry in Iraq was wounded in 2003 by an IED that ruptured both ear drums and left his right side littered with pieces of shrapnel, many still remain.

He plans to retire in the next 4 years.

He said he's gotten good treatment while on active duty, but worries about the time when he retires, with no local VA hospital in the area.

He talks regularly with local veterans that can not afford to make the drive to San Antonio because they can't afford the gas or can't drive or have no one to take them.

Another veteran echoes many voices in saying south Texas veterans should be treated by local medical resources.

He lives in Corpus Christi, but worries about what the cost of transportation does to an aging veteran's population with higher poverty rates in the Rio Grande Valley.

Extended trips place unnecessary physical stress on veterans, it places a financial burden on Valley veterans and their families as well.

He sustained a head injury, which resulted in a visible dent in the skull.

After headaches and memory issues, the VA physician sent him to Audie Murphy for a CT scan; and he had no option but to drive the 300 mile round trip to the VA facility.

That trip not only put him at risk, but the safety of other drivers as well.

Another veteran invites all of us to come experience the long and painful ride from south Texas to San Antonio to visit a doctor.

A south Texan speaks on behalf of friends married to veterans; she is incensed that for healthcare they must be inconvenienced financially (gas, food, overnight stays for vets and families) and time-wise, which interferes with their jobs.

The brother of a constituent is medically retired from the Air Force and must travel to San Antonio every month for his medical treatments.

It takes a day out of his life and requires a long ride back and forth.

Another retired veteran chooses the expense of private care over the time it takes waiting at the local clinic or taking the time to travel to San Antonio.

Another veteran also speaks to the trouble and time consuming nature of going so far for procedures.

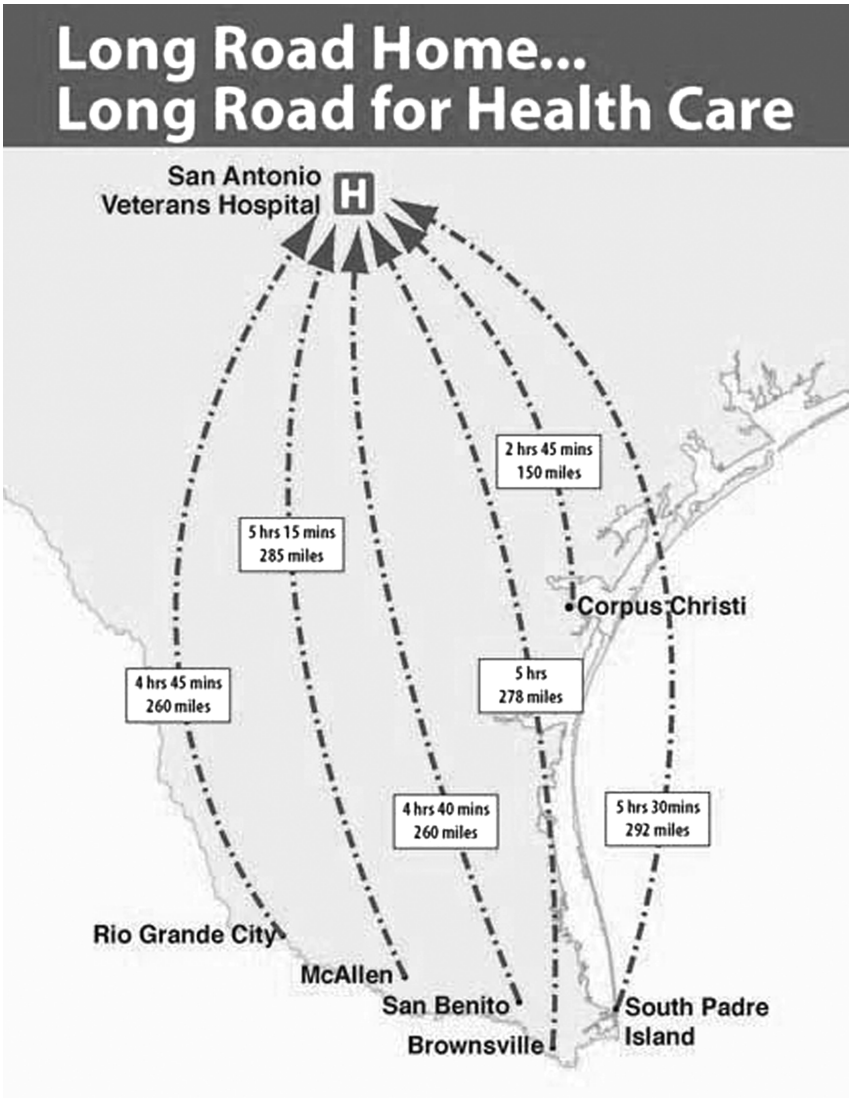
He knows that by the time you arrive your problems just seem to increase.

A Corpus Christi veteran laid out the context of getting treatment in San Antonio: She said it is a 12 hour ordeal to get to San Antonio, get tended to at Audie Murphy, and return home.

It costs two tanks of gas and a whole day of work. The $26.00 for travel does not cover nearly the cost.

Placido Salazar, State Veterans' Affairs Officer of The American GI Forum of Texas, tells me that some veterans from the Valley were recently in San Antonio for 3 days of appointments; they told him that a manager at the associated hotel would not release a room to them until 6:00 p.m., (using very abusive language); with one of the veterans not getting a meal in more than 24 hours.

[PETITIONS SUBMITTED BY REPRESENTATIVE ORTIZ ARE BEING RETAINED IN THE PERMANENT COMMITTEE HEARING FILES AND ARE NOT BEING PRINTED.]



ADDENDA—LETTERS AND STORIES OF SOUTH TEXAS VETERANS

Last week, some veterans from the Valley that were in San Antonio for 3 days of appointments at Audie Murphy called me to inform me that one of the managers at the Oak Hill Hotel on Wurzbach Road had given them a hard time, in not releasing a room to them until 6:00 p.m., (using very abusive language) with one of the veterans not getting a meal in more than 24 hours.

THAT is totally unacceptable, but I believe we got the situation corrected. If anybody else should have trouble at that hotel or any other type of problem, I will be glad to try to assist. Just call me, any day—any time (210) 658–9756.

Placido Salazar
State Veterans' Affairs Officer of The American GI Forum of Texas (210) 658–9756

My father served in the U.S. Army and came home to marry the girl next door, raise a family consisting of four kids, but never truly felt at peace because he suffered from what he was exposed to while he was in the Army.

He needed psychological care catered to what a veteran experiences taking into consideration the stigma a Hispanic man must deal with for feeling depressed.

He ended up committing suicide years later leaving us all behind to miss him dearly. Please build a complete veterans hospital in the Valley, our veterans deserve and need it.

Thank you,

Army Veterans Daughter

I am a veteran here in south Texas and would be willing to go to Washington next week, in order to prepare the Congressman for his testimony.

I live on a fixed income but will drive if I have to be there.

I am sure I can get at least two other vets from here to go with me. Please call me ASAP to speak of this.

Thanks,

Lydia

Congressman Ortiz,

It is with great pleasure and honor that I congratulate you for your efforts to bring a veterans hospital to south Texas. While south Texas is one of the homes of many heroes who have given their lives in foreign wars for the sake of freedom in America, south Texas remains one of the poorest areas in the Nation where veterans have difficulties finding jobs and medical care. As a Navy veteran of the Vietnam War, I served on a destroyer for several months in the Tonkin Gulf and also on an expedition to the Sea of Japan during the USS Pueblo incident where the North Koreans boarded one of our ships and took our men prisoners.

At some point in my life I became diabetic while no one in my immediate family (father, mother, or grandparents), were diabetic. For 10 years I have addressed diabetes on my own. One day a Vietnam vet friend told me that I could have been affected by Agent Orange even though I was aboard a destroyer and that the VA was now accepting that Agent Orange could have affected sailors in the Tonkin Gulf. I reported to the VA clinic in Corpus Christi and basically they did not respond to my request for nothing more than diabetic medication which is extremely expensive.

I am one of those individuals that will address health issues with or without VA assistance. However, my DD 214 clearly states that I served in the Tonkin Gulf and shows my veterans status, but somehow no one seemed to know what I was talking about when I visited the VA clinic in Corpus Christi. They told me they needed more documentation and that I was not a wounded veteran. Nevertheless, I was not looking for any kind of monetary compensation, but rather for help with medication for my diabetes only.

The thought occurred to me that one day I will probably need assistance from the VA hospital in San Antonio, but will not get it because I am not a wounded veteran, but have been afflicted with diabetes that may have occurred in the Tonkin Gulf. The VA made available benefits for veterans of the Tonkin Gulf, but no one at the VA clinic seems to know that.

While I have assisted many veterans by taking them for medical service at Audie Murphy, many were not wounded veterans. I suppose that they want to wait until I am unable to care for myself entirely to provide service, if any, instead of helping me now prevent the devastation of diabetes while I can. I have seen many veterans struggle with transportation to San Antonio for service and as you well know I provided services for many senior citizens from Kleberg for many years that needed to go to Audie Murphy. Now I am one of them and a veteran who volunteered during the Vietnam War.

I know that many vets struggle getting to San Antonio from the coastal bend to receive services. A hospital closer to us would be appreciated by all veterans and in fact every region across America should have one more so we need to spend money on expanding economic efforts rather than basically serving special interests like oil and uranium mining. I for one am disappointed with the reception I received at the Corpus Christi VA and surely I am not going to beg for their attention to my need and get kicked in the face every time I ask.

Hopefully, you will be successful in your bid for a VA hospital for veterans that is long overdue and maybe a revamping of existing VA clinics and services so that vets like myself who need assistance are not turned down because someone there does not understand what being aboard a destroyer in the Tonkin Gulf means.

I remain your friend and supporter of many years,

Ben Figueroa, BA, MA, LCDC, CPS, CPM

Dear Congressman Ortiz,

Thank you so very much in you support of our veterans and their welfare. Though I am not a veteran, my daughter, son and ex-husband are veterans along with other family members.

I feel that a veteran's hospital is greatly needed in the Valley. My ex-husband along with my daughter are now living in San Antonio and my son has plans of retiring there too. Why? You guessed it. . . . Military medical facilities.

My ex-husband was diagnosed with cancer along with other Vietnam medical issues and has had to leave his immediate family and move to San Antonio in order to be closer to medical assistance.

Thank you so much, again, for taking on this task. My prayers are with you.

Sincerely,

Beatrice Weaver

To whom it may concern:

My name is Jim Hodges, Jr., a Vietnam veteran from Brownsville, Texas. I am the proud Past-Commander of America's Last Patrol Inc., Post 2. I am also the son and nephew of a couple WWII veterans. I am also involved in trying to get a veterans hospital in the Rio Grande Valley.

My relatives served in WWII, Korea, Vietnam and every conflict our wonderful country has ever been involved in. They have had and have an extremely hard time getting the medical attention that they earned. Many of my relatives and friends can not go to the VA hospitals in Houston, San Antonio and/or Fort Bliss. Most of these soldiers are "POOR" and can not afford the trip much less the expense it takes to visit these facilities.

Many have past away never getting the medical attention they needed. I am blessed that I can go to the VA here in the Houston area where I live. BUT, there are many in this area who can not.

That is why there is a "shuttle" to help those veterans who can not afford it and/or are not able to drive. How can we expect our veterans to make that 300 to 500 mile trip to a veterans hospital? Thank you for your help and attention to this "disastrous situation."

In service to our country,

Mr. Jim Hodges, Jr.
832–228–2758

To whom it may concern!

My problem with VA healthcare is the extra stress on our disabilities caused by traveling 5 hours to a VA hospital. That is one way only. Also, 24/7 medical care that is needed by service-connected veterans. Let the Veterans' Affairs Committee come to the Rio Grande Valley and travel to VA on a van?

Sgt. James Krummel

April 21, 2007

Congressman Solomon Ortiz
3649 Leopard Street
Corpus Christi, Texas 7841

Subject: VA Hospital in South Texas

Dear Congressman Ortiz:

It is most encouraging to hear of your fight to provide the veterans of south Texas with a VA hospital. Please allow me to offer some suggestions that may help. Among the most salient reasons for locating such a facility in this area are the following points:

1. Local access would enhance participation by some veterans who are discouraged by the travel distance to out-of-town VA facilities. This in turn would pro-

mote early diagnosis and early cure for ailments that would otherwise generate higher treatment costs if left untreated. Equally, it would also benefit those who are too seriously ill to tolerate the commuting stress. All of this would lead to more efficient expenditure of VA healthcare dollars.

2. With the Port of Corpus Christi's expanded terminal now able to handle large volume military hardware shipping, it lends itself to accept hospital ships that have become a major factor in saving military lives. At a time when America's freedoms are challenged in all parts of the globe, the ability to have a hospital facility that could accept large numbers of military patients from a waterborne hospital vehicle, would be strategically and economically prudent. It makes little sense to dock such a vehicle in outer ports and then air-transport the patients to inland hospitals. Corpus Christi could service all of that need in one location, and could easily provide contingency plans for expansion in national emergencies. Also, the government could save by incorporating the ancillary services such as lab, X-ray, and pharmacy, in a location that could handle both active and retired military personnel. This would provide economy of scale in areas of high cost medical technology, which is a primary reason for escalating health costs.
3. A large VA hospital facility would help mend the region's physician shortage. Logically, some VA physicians serving the region would elect to remain here in private practice. This would provide relief in Medicare services, such as rheumatology (among other specialties), that are heavily skewed to a narrow panel of physicians who accept and treat Medicare patients in this region. Again, this would deliver Medicare budget economies by early diagnosis and treatment.

The above three points are only a sample of the issues that stress a need for a VA hospital in this region. I truly hope you are successful in your effort. If I can be of further assistance, please do not hesitate to call upon me. I can be reached at 361–993–6905.

With best personal regards,

John D. Falcon
Major, USA (Ret.)

Dear Congressman Ortiz,

I myself a veteran retired of 20 years serving in the U.S. Air Force do not need to travel the long distance being I have TRICARE benefits to visit local medical facilities. I was a volunteer driver for 8 months and at one time I drove twice a week for 2 months being there wasn't other drivers. The trip was to leave on Sunday and return on Monday. The other to leave on Wednesday and return on Thursday.

I would drive from Raymondville to Brownsville, Texas to pick up veterans early in the morning, 6 a.m., to return to San Benito then Harlingen and then back to Raymondville. After picking up the remaining vets at Raymondville we started the longer trip to the VA hospital in San Antonio, TX.

The trip was not a straight 5½ hours, we had to stop various times due to some of the vets needing to use the restrooms due to medical problems such as prostate illnesses and others needing to stretch out, as you know or can visualize a WWII veteran sitting on such a long trip and of course also climbing on and off a 15 passenger van. We as driver were not, repeat not, able to help him on or off the van due to liability. The veterans had to be ambulatory.

Upon arrival, the veterans would be dropped off at the entrance and from then on they were on their own, able to walk on their own or not he or she needed to walk to report to their appointment for the same day or the next. Most of the veterans had to wait hours to be seen for just a 15 minute visit and be released for the rest of the day and wait to return on the 5½ hour trip.

Before departing back to the Valley, Raymondville, Harlingen, San Benito and Brownsville, the veterans needed to be located from wherever their appointment was at, which wasn't very simple due to the other "many" veterans who had similar appointments.

Yours truly,

Tsgt. Rafel M. Cisneros III
U.S. Air Force, Retired

My name is CPT Martin Albert Longoria and I am currently serving with the 1st Cavalry Division which is in Iraq.

I was wounded in November 2003 by an IED that ruptured both of my ear drums and left the right side of my body littered with pieces of shrapnel that are affecting me today. I have pieces that are in my hands which I am having trouble with as we speak to include my calf and thigh.

The pieces that were left in me for the last 3 years are working their way out and some have already been removed. In the next 4 years I plan on retiring, but I will still have pieces of shrapnel that will eventually work their way out too. While being on active duty I have received good treatment. When a piece of shrapnel needs to be removed it is.

However, the day will come when I retire and having a local VA hospital in the area would make a difference to those that are not as financially stable as others. I have talked with local veterans that can not afford to make the drive to San Antonio because they can't afford the gas and can't drive for some health reason or have no one to take them.

We as local veterans have served our country when called upon to PROTECT IT and DEFEND IT no matter what and some have died doing it. I have served with many local soldiers from the south Texas area in war and peace, but who is going to take care of this generation of veterans. We as a country seem to make the same mistakes from past conflicts in not providing adequate healthcare for our past veterans.

When its budget time you will not hesitate to give yourself a raise, but when it comes to us the veteran it seems we are put on the back burner for political jargon. I hope what I have expressed helps with this cause that is taking place and I hope it helps the veterans that have served as proudly as I have. Please remember this when you are sitting at home or in your office. We have served being away from loved ones and doing what is asked of us.

Thank you for the opportunity to provide comments on the availability of veterans' healthcare in south Texas. It is common knowledge to everyone in the region that south Texas veterans' are underserved as far as veterans' healthcare is concerned.

The problem didn't occur overnight and has been a gradual process. No blame is being assessed. The time has come, however, to rectify the problem for both current and future veterans.

The south Texas veteran population is spread over a large area with many veterans living in rural environments. Many south Texas counties have no significant metro type area and consequently are limited in any medical resources, much less those for the veteran populations.

This particular concern could be addressed in Congressman Ortiz's bill which in part provides south Texas veterans be treated by local medical resources. That would insure that every veteran would have access to appropriate medical care in a timely manner. Often, it can take months for a veteran to get scheduled for what would otherwise be a routine medical visit. That needs to be changed.

The Veterans' Health Administration (VHA) is well known for its quality care especially preventive medicine. In some cases veterans have to go to extraordinary lengths to receive the preventative care. First hand experience may illustrate some of these inequities.

This veteran suffers from Chronic Obstructive Pulmonary Disease (COPD). It's a progressive lung disease with no known cure. Competent medical practices contend a COPD patient take a pulmonary function test (PFT) twice a year or at a minimum of once a year. A complete PFT takes around 45 minutes.

COPD is typically diagnosed in patients at around middle age thereby suggesting that the COPD population is older than the rest of the veteran population. The pulmonary function lab at Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas is the only PFT resource available to south Texas veterans enrolled in the VHA system. There are, however, facilities in Corpus Christi as well as in the Rio Grande Valley where the test can be taken.

The round trip for this writer is about 300 miles or maybe a bit more than 5 hours driving time. Therefore, it takes nearly 6 hours to get the test. Of those 6 hours, more than 5 are driving time. For older patients that becomes a real issue.

For veterans in the Rio Grande Valley, the distance and drive time is slightly more than doubled. That would mean a veteran and probably a veteran getting up in years would be required to drive 10 or 11 hours for a 45-minute test. That is problematic and raises a legitimate issue about the burden and travel stresses on an older veteran with a disease, which will probably end his or her life.

Another issue is the cost of transportation be it by private accommodation or some commercial means. The Valley has an aging veterans population according to the last census data. It also has higher poverty rates. In addition to an extended trip placing unnecessary physical stresses on veterans, it places a financial burden on Valley veterans and their families as well. That needs to be remedied.

There are other routine procedures, which necessitate a trip to Audie Murphy. This veteran had sustained a head injury, which resulted in a visible dent in the skull. After discussing ongoing headaches and memory issues, the VA physician said a skull series or CT scan was necessary.

That routine procedure necessitated a trip to Audie Murphy. The veteran had no option but to drive the 300 mile round trip to the VA facility. The safety of that endeavor is questionable at best. Not only was the veteran put at risk, but the safety of other drivers as well.

There was about a 10-minute wait for the X-ray procedure and the scan itself took 6 or 7 minutes. A cup of coffee left in the car was still hot for the return drive home. Out of 5 hours and 15 minutes for the CT scan, 5 hours was driving. The same imaging could have been done locally or in the Valley.

It was later learned that the injury triggered two strokes as well as a bifrontal hygroma. The hygroma is dead brain tissue that has filled with fluid. The wisdom of having a patient make that kind of drive is indeed questionable. Consider the patient, made maybe more frail making that trip from Brownsville, Texas. An argument could be made that such a trip would simply be reckless.

One other trip to Audie Murphy is especially haunting. This veteran needed to go to the cardiac lab in San Antonio for a thallium stress test. That's a routine procedure for evaluation of the heart. The procedure was scheduled for morning.

In order to make the appointment, it was necessary to leave Corpus Christi before daylight. It was soon learned that the veteran's night vision had deteriorated to the point of making the trip dangerous. That is now a new concern for Valley veterans. The thallium stress test is available nearly everywhere and in most communities with a hospital.

The test itself is a simple procedure with an 8-minute protocol on a treadmill. At the end of the treadmill a nuclear dye is injected. Next, the patient waits for a period of time measured in hours for the dye to circulate. Then multiple images of the heart are taken.

While waiting for the imaging in the lobby of Audie Murphy, an elderly man was encountered. We visited for a while. He said that he caught a ride in a VA van in Cameron County, Texas. He continued that he got on the van way before daybreak for the ride to San Antonio.

Although the purpose of his visit is not recalled, he said only 15 to 20 minutes of his time was needed at the hospital. Then he had to wait hours until 3:00 p.m. to catch the van back to Cameron County. He said it would probably be dark when he got back.

He was clearly tired. He had family in Corpus Christi. We talked about his staying with them and then going back to Cameron County the day after. We called his family who thought that it was a great idea. He rode to Corpus Christi with this veteran.

Ever since, there has been a concern about other Valley residents who have had to endure the same travel stresses. That man should have never been put into that position. Whatever services he needed should have been obtainable in or near Cameron County.

While having to make a trip to Audie L. Murphy may be an inconvenience to this veteran, to Valley veterans it is a more serious matter. First the trip is onerous, especially on the older or frailer veterans. Secondly, the cost of the trip in some cases could conceivably cause veterans to avoid necessary medical care, simply because they couldn't afford the transportation.

The current delivery of veterans' health is inadequate and in many cases not being made reasonably available. A case for making what would be customarily considered outpatient services available through existing private sector resources should be relatively easy to see and make. A veteran should be able to get procedures as those discussed above near his or her home town.

A matter not clear in the bill is that of emergency room care. An uninsured visit to an emergency room can be financially catastrophic. Today, if a veteran calls facilities as the Corpus Christi Outpatient Clinic or even Audie L. Murphy Memorial Veterans' Hospital, the caller will hear a recording to the effect that if the call is an emergency, call 911.

Any such medical care is at the veteran's expense. On the other hand, should there be a VHA hospital nearby or an ER that contracts with the VHA, the veteran

is covered. Acute medical care should be available to any veteran wherever they are situated.

Within the last several years, a sibling sustained a head injury in a fall. Although the sibling died after a few days, the emergency room and intensive care bill was around $70,000. Such could be devastating to a veteran's survivors.

With or without a new hospital many of the routine medical services such as stress tests, pulmonary function tests and numerous radiological procedures can be done competently, cost effectively, and with fewer burdens on the veteran.

As far as inpatient care is concerned, this veteran would prefer to get to a real veterans' hospital if able. It would make no difference if the facility were located in either the Valley or San Antonio. If it were an acute matter, the preference would be the first facility contracted with VHA if a VHA facility were not nearby.

The ability to provide routine medical procedures as well as acute or emergency room care should be available in nearly every community in south Texas. That would necessarily contemplate the public-private component of the bill or some combination of the other provisions.

Your consideration of these remarks is appreciated.

Claude V. D'Unger

To whom it may concern:

I'm a decorated veteran who served two tours in Vietnam, 1967 through 1969. I'm a 100% permanent disabled veteran. The 5-hour trips I have to make to San Antonio for any special needs the clinics can't perform is making my disabilities worse. The round trip is made on a crowded van, and the overnight stay in a dirty hotel is a hardship. I'm too sick to drive myself. If you are in a wheelchair you can't ride the vans. I'm saddened to see the old WWII veteran of 90 years old suffer this way as well. I went to an emergency room at a private hospital 14 months ago and then was sent up by ambulance to the Audie Murphy veterans hospital in San Antonio Texas for a kidney infection. To this day I'm still waiting for so-called due process. I've talked to three different people in fee-basis with the most recent being the supervisor. They all told me it would be 45 days with the last contact on April 3rd. Well guess what, nothing yet. I'm currently being threatened and I have until April 26, 2007 before bill collectors are given the job to collect $10,000 from me, for what I shouldn't have to be concerned about. My credit is at risk because fee-basis is backlogged, so they keep saying. This is a big mess with a lot of stress. I truly have lost faith in this VA nightmare. Give the veterans what they deserve or tear down this VA system and close the doors and let us use our cards like (Medicare) and pick and choose our own doctors and hospitals. I'm not too proud being a veteran because there's too much disgrace and shortcomings from a broken-down system. Another disgruntled veteran? Maybe so but it shouldn't be this way. This substandard treatment for veterans in the Rio Grande Valley is unacceptable as it is anywhere in the U.S.A. Please let our voice be heard, we the people. Veterans don't want our new veterans to endure these shortcomings. Do what's right—PROVIDE FOR ALL WHO DESERVE.

Dan Kerkow,
Port Isabel Texas

Honorable Sir:

I do not know if you have heard from any of the family members of the disabled veterans from the Rio Grande Valley that require travel to San Antonio for appointments, but I believe that Congress should also hear about the hardship that the vet's family must also endure. I have a full-time job at one of the area hospitals. When my fiancée needs to go to San Antonio for certain procedures, I have to take time off from work to accompany him. It causes me to lose work time, and the only way I can make up that money is to use my vacation days. I cannot let him go by himself whenever they do procedures that require anesthesia or manipulation of his neck or spine. He is usually in so much pain and/or drowsy with medication that he cannot drive. He has a hard time sitting for long periods, and San Antonio is 4 hours away, and sometimes longer when we have to stop so that he can stretch to relieve the pain. A couple of times he has had to go on his own because I cannot take off from work and we cannot find anyone else to go with him. He has had to lie to the staff that he has a driver. Then I am so worried about him driving that I cannot even function at work, and am having to go out several times to call him to make sure he is OK. We also have to make arrangements for our kids if we are not getting back before they get home from school. We have had to go to San Anto-

nio just to get a result of an X-ray or CT scan. This requires at least 8 hours of driving for an appointment that lasts 10 minutes. Where is the justice in that?

I know several veterans that have to go to San Antonio for treatments or procedures; some do not have family members that can drive them to San Antonio or reliable vehicles or they are taking care of small children at home. What are they supposed to do? The van that is supposed to be available to these vets is not really available; it only runs on certain days and with limited space and with no handicap accommodations. Sometimes some procedures have to be scheduled for the weekend; like my fiancée's MRI that's scheduled for a Sunday; he also has another appointment scheduled for Monday for a spinal procedure. I cannot even make that appointment with him because I cannot take the time off. This means we have to call around and see who can go with him. What happens to those vets that have no one to take them and no bus available? Rescheduling appointments can take up to 6 months or more.

I have heard several horror stories from these vets and I think it is a shame that our vets are having to sleep in their cars overnight because there is no room available at the designated hotel and they have to be there for an early morning appointment. And travel pay?? You have got to be kidding; with gas prices the way they are, we barely get enough for one tank full of gas. We have to fill up twice to get there and back, plus pay for meals. How about when these vets are hospitalized up there? Isn't it better for them to be near friends and family that can visit and keep him/her in good spirits? Isn't this supposed to be better for them, rather than being all alone away from everyone?

The Valley has several thousand vets already and will have more when these young men and women return home from our current conflicts. Are they going to have to suffer the same hardships?

Congress needs to stop turning a deaf ear and a blind eye to our situation in the Rio Grande Valley. Our veterans have willingly given their service to the United States. It is time to return that service. How can Congress appropriate money for every other cause except this one, when it means taking care of our own? These men and women deserve better; we all owe it to them.

Sincerely,

Anabeth Molina

I am a strong supporter of establishing a veterans hospital in south Texas as soon as possible. Veterans who have to visit a hospital have to travel all the way to San Antonio, TX to take care of their medical needs. I venture to say that the majority of the personnel voting against this issue have never been in the military. I will ask these opponents of the medical facility in south Texas to please take a trip all the way from south Texas to San Antonio to visit a doctor.

But take this trip when he/she/they are in pain or sit in a wheelchair for the trip and see how they like it. I dare any one of those opponents to try taking this trip! If he/she/they decide to do so please let me know so I can get the news media to cover this trip. You may quote me on any or all of the above statements.

Lino Trevino,
305 Beverly Dr.,
Schertz, TX 78154

I HAVE SEVERAL CLOSE FRIENDS WHO'S HUSBANDS ARE VETERANS AND THEY TELL ME, AND I CAN ALSO SEE, WHAT THEY HAVE TO GO THROUGH EVERY TIME THEY HAVE TO LEAVE FOR SAN ANTONIO. IT IS SUCH AN INCONVENIENCE FOR THEM AND THEIR FAMILY, PLUS THE COST FOR THEM AS WELL, SINCE THE COST OF GAS HAS GONE UP AND THEN THE COST OF A HOTEL IF THEY HAVE TO STAY PLUS FOOD ETC. . . .

COULD WE NOT USE THE HOSPITAL AT THE CORPUS CHRISTI ARMY DEPOT ON BASE, BUILD IT UP AND MAKE IT BIGGER, HIRE THE DOCTORS AND NURSES NEEDED TO MAKE LIFE A LITTLE EASIER FOR ALL OUR DESERVING VETERANS.

I AM DEFINITELY FOR A VETERAN'S HOSPITAL IN THE SOUTH TEXAS AREA.

YOURS TRULY,

OLGA RODRIGUEZ

Olga V. Rodriguez, CCISD Office of Food Services, 4922 Westway, Corpus Christi, TX 78408, (361) 844–0222, Fax: (361) 844–0226.

The Honorable Congressman Ortiz,

My husband is a Vietnam War veteran and my father is a World War II veteran. Both had injuries due to the war and both have to make trips to San Antonio at the Audie Murphy Hospital. My father is in his mid 80's and it is getting harder and harder for him to make trips to San Antonio. My husband also has had problems getting to San Antonio. . . . I feel they both served their country and gave their all while doing so and they need to have you be their voice to tell Congress that there is a great need here in south Texas to have a veteran's hospital. Thank you for what you are trying to do for our loved ones that have served their country because they believe in our traditions and also served with honor.

Many blessings to you.

Sincerely,

Elizabeth Jasso,
Food Service Coordinator,
Corpus Christi ISD

Dear Congressman Solomon P. Ortiz:

I have a brother who is medically retired from the U.S. Air Force. He must travel to San Antonio every month for his medical treatments. It takes a day out of his life and requires a long ride back and forth. I am also a retired veteran but choose to see my own doctors rather than spend a long time waiting at the local clinic or taking the time to travel to San Antonio. It would be a blessing to many of us veterans if we had a hospital here in Corpus Christi or nearby.

I would like for you to know that I am a registered Republican but I started voting for you when you ran and was elected sheriff of Nueces County. You may remember I was an active member of Associated Clubs of Texas (ACT). I have voted for you each time you ran for Congress. I am confident that you can get the veterans hospital for us.

Respectfully,

Richard D. Hanson

Dear Sir:

I appreciate this opportunity to give my opinion on veteran's care in south Texas. I have been a part of the VA healthcare systems in Reno, Nevada and Fargo, North Dakota. Both Reno and Fargo were very good. These were medical hospitals, not clinics. My experience with the clinics in both Harlingen and McAllen are ongoing nightmares. Lately I have been trying to simply get an appointment with my psychiatrist in Harlingen. Every time I call I get put on hold and eventually I hang up after waiting and waiting. I finally gave up but I will try again soon. This is just one example. I dread trying to do anything with the veterans care facilities here. I have tried to figure out why it is that an area that seems to have more veterans per capita than any other area of the Nation has the poorest healthcare for them. I suspect a type of Federal racism. I can't understand what else it might be. The employees in both clinics are overworked way beyond the point of laughability. The thought that maybe we don't need a VA hospital in this area is so ridiculous I feel embarrassed for whoever might be thinking this. Many veterans won't use the facilities here. They self-diagnose and then pick up meds in Mexico.

I am Douglas R. Brown. My phone is 956–579–4441. I will reveal any other personal information about myself if you need it. I am available to talk to anyone.

Congressman Ortiz:

We need a Veterans Administration hospital in the Rio Grande Valley so that we do not have to travel to San Antonio for acute care. I have had a couple of near-death experiences dealing with the bureaucracy of the Veterans Administration as it provides healthcare to us veterans.

I underwent bypass heart surgery under an emergency basis as a result of a heart attack. My wife called our local clinic and she was directed to call 911 and that if I was service-connected the VA would cover. I in fact did have the surgery. I had no problem being admitted, but after my release from the hospital everything changed. Upon release we provided the VA clinic with the hospital doctors' recommended post surgery instructions. I was placed under new medication.

Unfortunately, the nurse which received those medical instructions did not input them into my computer medical records. I was at home without medication and had to turn to a private pharmacist to obtain them. No one at the VA had requested the new medication. I went to the benefits coordinator and told him that I needed to follow up with a cardiologist to chart my progress. He told me since there wasn't a cardiologist at the clinic that he saw no problem if I followed up with the local cardiologist. I did and VA did not pay. I was taking Coumadin and had to be monitored weekly.

After three visits, the cardiologist's office advised me of the problem with the VA and requested that I pay up front for all services. I called the clinic and was told that the VA says that I should have gone to a cardiologist in San Antonio. By this time, my sutures had become infected and I was leaking fluids. I went to the clinic and was told that they would assign a home health nurse to monitor the sutures. She was given very specific instructions and was limited on what she could do.

I then attempted to get an appointment to see a VA cardiologist which had been seeing me, but was told at the local VA that they did not do that and I should call San Antonio directly. I did and was able to get an appointment 5 weeks after my release. By this time I was all stressed out and had to see my psychiatrist. He doubled my dosage on my medication in order to help me. When I arrived in San Antonio, the cardiologist did not know that I had had surgery.

She was surprised because she thought that I was coming up to San Antonio for a heart catheterization. She thought that I had a valve problem and was surprised that they had found two arteries that were clogged. She was irritated because she did not have my up to date medical records. I showed her my sutures and she was visibly irritated because they were infected.

She tried calling the local VA clinic but could not get the line. She immediately called the surgeon's office and made arrangements that I be seen immediately. She reviewed all my medications and made changes. The surgeon cleansed my sutures and told me to return to the surgeon that had done my surgery so that he could follow up locally. I returned home and continued with problems with my sutures.

I was also prescribed more high blood pressure medication. I was taking so much medication that my blood pressure fell down almost to the point that I was fainting. There was no way to reach the VA because it happened on a weekend, not even the toll-free nurses number. My wife panicked and called the home health nurse which suggested that I quit taking the medications and go immediately to the hospital. I did not want to go because the hospital had not been paid and I might be refused.

The nurse recommended that I drink a Coca-Cola with crackers, which I did. Thank God that the home remedy that the nurse recommended worked. On Monday I called San Antonio and told them what had happened and they took me off some medication and I was told that I was taking too much medication. (The reason for this is the faulty medical records system.) I returned to the surgeon that performed the surgery and I told him that the VA had sent me back to him.

His office called the VA and I assumed it had been approved. He saw my sutures and was very concerned and wondered what the VA was doing. He immediately ordered wound therapy and I was given a 3 times a week regimen for about 2 months. Since then, I have had to travel to San Antonio to have a halter placed to monitor my heart. I traveled 5 hours. When I arrived I had the procedure done, which took about two (2) minutes. I was told to return in 48 hours. I did not qualify for lodging so I returned to the Valley. After 2 days I returned to have it removed. Again I traveled 5 hours to get there. The procedure to remove it took 45 seconds to a minute. I had to make two (2) trips to San Antonio to be seen a total of 2½ to 3 minutes. Why? Because this procedure could not be done at the local clinic?

On my last visit to my medical provider at the clinic I was assigned a new doctor. When I was being triaged, the nurse asked me if I had any past surgeries. I told her, hell yes, I just had a bypass, isn't it in the records. I told her that I even had to go to San Antonio to have a halter to monitor my heart. She wondered out loud as to why they had sent me to San Antonio for a procedure that could have been done locally. The doctor and I reviewed my medical and I was surprised that some of the medication that I had been ordered to stop was still on the active list. I told him that I had not refilled those prescriptions. He deleted them from my record. I had to update him on what had happened since my surgery.

The hospital and the doctors that did the surgery have not been paid and I am getting medical billings from them. The fee service people at the VA told me that I could have gone to San Antonio for the medical services. They did not have any records in their files indicating that a VA doctor had approved the medical. I told him that the hospital had called and that they were given the okay or they would not have allowed the services. I told him that I had no choice but to go to a local

hospital because it was an "emergency." And since the clinic had not provided post surgery care, I had had to follow up with the doctors.

I am doing fine now. I am gradually recovering from the surgery. But while I was suffering with the infection to my surgery and the delicacy of the operation I had to make two (2) trips to San Antonio, a total of almost 20 hours in a car. The pain and discomfort that I suffered made me think, why in the hell did I choose the VA for my medical.

I have gone to San Antonio on previous occasions to see the cardiologists only to find out that the echograms and ekg's done at a local hospital were not available. They were not sent up there because the VA had not paid. The cardiologist was visibly disturbed by this and she ordered new ones done since I was in San Antonio already. She showed concern that I had traveled all the way from the Valley and that I would not be seen due to the lack of the medical being sent to her.

I have had to go to San Antonio for other minor exams that took 15 to 20 minutes. The stress test could have been done locally, the allergy tests could have been done locally, the breathing test could have been done locally, and my skin rash exams could easily have been done locally. But I had to travel to San Antonio for them because the Rio Grande Valley does not have acute care to provide healthcare for us.

Sincerely,

Arturo Treto Garza

Honorable Solomon Ortiz,

Thank you for getting our needs in the Rio Grande Valley heard. Yes, we do need a hospital for us. Having to travel to San Antonio is just so much trouble and time consuming. Sometimes it just does not help, by the time you arrive your problems just seem to increase. We need all the help we can muster.

Respectfully,

Jose Benavides,
334 McDavitt Blvd.,
Brownsville, Texas 78521

Dear Congressman Ortiz:

My brother had a triple bypass done in San Antonio Audie Murphy Veterans Hospital in 2005. He returned after a 2 week stay at Audie Murphy and continued with his post-surgery care. During the course of his recovery, he developed complications with a blood thinning medication called Coumadin. That medication had to be monitored closely. On one occasion he went to the Harlingen Outpatient Clinic with problems.

His VA medical provider told him that he needed to be monitored closely for his PT INR and that he needed to take vitamin K. He sent him home while he ordered his new dosage of medication.

He told my brother that maybe the pharmacy in McAllen might deliver the medication later that day. As soon as my brother arrived at his home, he received a call from the VA clinic that he needed to go to the nearest hospital immediately and was told that Dolly Vinsant Memorial Hospital in San Benito was taking veterans.

My sister-in-law drove him right away to DVMH. At DVMH he was told that he was very sick and he was immediately transferred to Valley Baptist Medical Center in Harlingen, TX by ambulance. He was admitted because he advised the hospital that he was a veteran and showed his ID card. The hospital got the clearance from San Antonio VA and admitted him. He was given two pints of blood and was required to stay for 4 days to recover.

His medical billings have not been paid because the VA is claiming that "VA facilities were feasibly available to provide the care." In other words, the VA felt that my brother could have traveled to San Antonio under the dangerous medical problems he was having.

He barely made it to the local hospital let alone to San Antonio which is 4 to 5 hours away by car. The VA clinic did not tell him that they would provide an ambulance for him to take him to San Antonio, they know better. There is no such thing. What his VA medical provider did do and under an abundance of caution was referred him to the nearest local hospital.

If the VA feels that our veterans can immediately fly or magically transfer themselves to San Antonio for medical care under emergency conditions, then I wish they would let us in on the secret.

Once again the VA is using the excuse that medical VA facilities were feasibly available. The local VA clinic does not even have a cardiologist. VA facilities are not "feasibly available" for veterans with emergencies and or acute care problems.

This is another reason why we need a VA hospital for the Rio Grande Valley. My brother does not want to rock the boat because of his heart condition and other medical problems which have developed. He does not want to jeopardize the healthcare that he does receive from the VA. In other words, he is in a sense held hostage by our government.

Sincerely,

Arturo Garza

Dear Congressman Ortiz,

My husband, Alfonso X. Soto, an army veteran of the Vietnam War died 9 years ago. I believe that at the time of his heart attack he was also suffering from a problem with his lungs possibly due to his exposure to Agent Orange while in Vietnam. He never persued a diagnosis mainly because the San Antonio facility was too far and he was not able to make the trip. The one time he did go due to hearing loss from a mortar concussion also while in Vietnam, he found that the number of people they were trying to serve was too great for quality care. He never went back again.

My husband is gone, but for the sake of other veterans who deserve our support and in light of the number of young men and women from our area serving in Iraq, who will need physical and psychological support when they return, I ask that you actively pursue a facility in the south Texas area. Each time I drive by the old Valley Regional facility just sitting there with no purpose, I wonder at the possibility of a veteran's hospital in Brownsville, Texas. Congressman, I know you are a man of vision. Please do what you can.

Sincerely,

Neida Ruth Soto

Mr. Ortiz:

I am a 54-year-old black female veteran and I retired and live in Corpus Christi, Texas. I have 60% service-connected disability and find it ridiculous and cumbersome to have to travel to San Antonio for visits to Audie Murphy. I have to take off from work for a day as opposed to 1 to 2 hours to have a mammogram, an X-ray, consults which take all day waiting, and 10 minutes to get done.

I usually have appointments at 12 p.m. which means I must go to bed early enough, to get up around 6 a.m. leave Corpus no later than 7:30 to make sure I get to Audie 30 minutes prior to my appointment. Once I am checked in; and I will take my last appointments for instance, I wait for 1 hour to be called, and another 2 hours before I am seen. They reimburse me $26.00 for the appointment and we know that does not even fill a tank.

I must miss a day of work of course because it is a full day evolution to get this completed. I work on the military base located at NASCC. It has a large hospital that is being used as a clinic. I do not know why the government is underutilizing the facility and requiring veterans from our surrounding cities as well as those here in Corpus to travel miles for services that can be provided right here. This will show the appreciation for the veterans, employ qualified physicians, get adequate services and probably allow the people that have fought for our country the availability to convenience in knowing what some of our brothers and sisters died for was not in vain.

The last visit to San Antonio I was in a room with several other veterans. We all realized through conversation that we were all from either Corpus, Robstown, Brownsville, and other surrounding areas of Corpus. This was ridiculous because some had been there since 8 a.m. and it was already 11 a.m. and they had not been serviced. My appointment was 11 a.m. and I was seen at 1 p.m. and left at 4 p.m. This was a full day of work and not counting me driving up there and returning home, which by the way I arrived at 7 p.m.

So basically from beginning to end it took me 12 hours to get to San Antonio, get serviced at Audie Murphy, caused me to fill my tank twice, going and coming, I took off a whole day of work and got 26 dollars for my troubles and all of this could have cost nothing but probably 4 hours of time if I could have used the hospital already in Corpus or some facility that is comparable.

I sincerely appreciate you fighting this battle for us because it is becoming increasing difficult to travel those miles for treatment that can be completed in Cor-

pus Christi. I cannot say enough that finally someone is noticing that we veterans do not ask for much but when we do it is because we feel we need it, deserve it and it is a doable request.

Thanks for the time and energy put forth for this cause.

Billie P. Harvey, USN–Ret.

I favorably support the proposal(s) concerning the establishment of a VA hospital in the Rio Grande Valley, not just "south Texas."

Even though I am a retired and VA-disabled U.S. Army Vietnam War veteran, I have not used VA facilities, other than the Disabled Veteran license plate benefit. Perhaps I will need their services in the future.

I do, however, recognize and support the efforts of you, and our VA-eligible brothers and sisters, to gain relatively local access to VA care, other than crowded, overloaded VA clinics.

This effort needs to be sustained to fruition even though this may not be the year for success.

Carry on, sir.

Most respectfully yours,

John M. Lawrence,
1SG, U.S. Army (Ret.),
26 Winterhaven Lane,
Brownsville, TX 78526

We need all the support from you to make this recommendation become a reality. For several years I have seen and helped other veterans travel to San Antonio for their medical problems.

It is time to open their eyes, that we do need a hospital here in the Valley. The Harlingen area will be getting a new outpatient clinic within the next few months but this will not help because we still need to travel to San Antonio.

It's great but we need a hospital here. There's too many of us veterans who need a hospital. It's very difficulty for us to travel because of our illnesses and no support for our families when we are there. I have advised those veterans that they need to speak out so that our congressmen hear us.

Our vote means a lot and if we get together we can have a great impact in our coming elections. Once again, thank you for your support and I hope that you can convince the VA Committee.

Miguel Rangel

My opinion on this matter is that in the Rio Grande Valley, there is a serious need of a VA hospital.

There are many vets that because of the drive to San Antonio most of them would rather just not worry about being seen at the VA. For those who make that 4-hour drive it is not as easy at it seems.

It is very tiring and the fuel cost, lodging, and food is very costly for those that depend on a family member to take them to their appointments. The travel pay assistance that one receives is not enough to cover these expenses.

Having a hospital in the Valley would benefit the vets that have supported this Nation and now it is time for the Nation to step up to the plate and assist our south Texas veterans. I am a Navy vet and hearing their stories of war and their sacrifice that they face each and every day is something I do not wish on anyone.

Mr. Ortiz, we in south Texas are behind you 100% and do appreciate everything you have done for us. We stand next to you in this battle and I pray that those who make this decision will hear our cries for help.

God Bless,

Joseph D. Ramos

Dear Rep. Ortiz:

I'm a Vietnam veteran with several service-related health problems. I've made about 8 trips to Audie Murphy in San Antonio this past year and am scheduled to make several more in the next month or so. My health is still well enough where

I can make the trips OK. As my conditions worsen I know it will get harder and harder to make the 5-hour trip each way.

I see a lot of veterans from the Valley every time I go there. There are a lot of veterans who cannot make the trip on their own. They make the trip by bus or take relatives who I'm sure have to make sacrifices missing work, caring for children and other parents to make the trip. It is a real hardship for most veterans and their families to have to go all the way to San Antonio for medical care.

Americans from the Rio Grande Valley have always responded with great patriotism when our country had called. PLEASE HELP THE MANY, MANY VETERANS FROM THE VALLEY GET A VA HOSPITAL IN THE VALLEY.

Filiberto Conde,
Rancho Viejo, Texas

April 24, 2007

Dear Congressman Ortiz:

I'm a disabled vet from WWII who used to drive 357 miles to San Antonio for treatment but I can't do that anymore. I now visit the Harlingen outpatient clinic and the McAllen outpatient clinic for podiatry. They do the best they can with limited space and equipment and time.

This Valley is in dire need of a hospital or more inpatient clinics to deal with the thousands of vets from the previous war era and now the Iraq War.

Congressman Ortiz, I know you will do your best to remedy this situation, anything you do will be appreciated.

Sincerely,

Bernard Reyes
Staff Sergeant
99th Infantry Division
1st and 3rd Army
World War II

Mr. Ortiz:

First of all I'm not a veteran but I do work with them. I was a scout leader and I teach all my kids the importance of honoring a vet (a warrior). Here in the Valley our warriors have given up 3% of all deaths compared to 1% in any community in all the Nation in all wars and are the most highly decorated in the Nation. Just on that alone our Valley warriors deserve more than what they are getting.

Epifanio Valdez III

Respectable Congressman Ortiz:

You have our support and encouragement. Do us well. And, thank you in advance. Tomorrow, my husband and I will get up at 4:30 a.m. to get ready and be on our way to San Antonio by 6:00 a.m. My husband has an appointment with the cardiologist. He has a heart condition and we have to make that trip periodically. Our trip is not any longer than the veterans that come from Brownsville, McAllen and all those other small towns. Many of our veterans can not afford private supplemental insurance. If we have a medical emergency after the hours of operation of our local VA clinic or during the weekend that requires hospitalization we are encouraged to go to our local emergency room, but that leaves us with the total expenses. The other alternative is to drive to the VA hospital in San Antonio at whatever time and with a near-death condition. The services and attention in Audie Murphy are excellent, but Audie Murphy is overextended. It is a problem to find a parking space due to the number of patients they see daily. Every time we go we see the increase in patients and it will only get worse especially with soldiers coming from the war. Also, because south Texas is the temporary home for many veterans that come for the winter. Yes, we need a veterans' hospital in south Texas.

Sincerely,

Miltan Martiz

Rudolph Salinas, Sr.
Korean War Veteran

Vets fight for hospital in Valley
They endure long trips, long waits, lots of red tape to get healthcare
12:37 AM CDT on Sunday, April 22, 2007

By DAVID McLEMORE / The Dallas Morning News
Brad Doherty / Special Contributor

Veteran Steve Dunn of Harlingen must travel hundreds of miles to receive treatment at the VA hospital in San Antonio

WESLACO—Every Sunday and Wednesday morning, small groups of military veterans, some in their faded camouflage shirts, stand patiently at designated locations in the Rio Grande Valley, waiting for the "vet van."

Veteran Steve Dunn of Harlingen must travel hundreds of miles to receive treatment at the VA hospital in San Antonio. Eventually, two government-leased, 15-passenger vans will weave their way to the stops between McAllen and Brownsville, picking up the passengers for the 240-mile drive to the Audie Murphy Veterans Memorial Hospital in San Antonio.

They'll travel 5 hours to an appointment that took months to get. Sometimes, it's for a specialized X-ray that takes 15 minutes. Sometimes it's for a procedure that requires an overnight stay in San Antonio. And sometimes, veterans find, their appointment has been canceled.

On most days, the vans leave behind people who reserved a place weeks in advance or waited in line in the hope that someone would miss the van, veterans say.

"It's a long trip. But it's the only way to get to the hospital," said Ruben Cordova, a Navy veteran with Persian Gulf service. "The buses aren't handicapped accessible and you have to tell the driver if you need to go to the bathroom. People bring their breakfast tacos and pain meds and hope for the best."

For years, veterans in the VA system in south Texas—which at last count numbered more than 107,000 for the 60-county service area—have been asking for their own VA hospital. They're tired of traveling hundreds of miles, enduring long waits for care and putting up with bureaucratic snarls.

And with their numbers on the rise, they want the hospital now. The patient load at the south Texas VA facilities has grown 31 percent since 2001.

"We've never said VA doesn't provide good medical care," said Felix Rodriguez, district director for the Veterans of Foreign Wars in the Valley. "The doctors and staff do the best they can with what they have. The problem is getting into the system to get the care. There are too many barriers to eligibility."

There is also a sense of promises not kept, Mr. Rodriguez added.

Their complaints come at a time when VA facilities are coming under attack following reports of inadequate care at Walter Reed Army Medical Center in Washington, D.C.

"We did what we were asked by this country and we don't believe there is any excuse, any reason for VA to refuse to build a veterans hospital here," he said. "We believe we've earned the right to see a doctor where we live."

The Department of Veterans Affairs operates two routine healthcare clinics in the Valley—one in McAllen, the other in Harlingen. The clinics are part of the south Texas Veterans Healthcare System, which also includes the Audie Murphy hospital in San Antonio, a smaller facility at Kerrville, and outpatient clinics in Corpus Christi, San Antonio and the Valley.

For the more complicated procedures, veterans have no choice but to drive to San Antonio.

The VA takes the veterans' concerns seriously, said Amjed Baghdadi, spokesman for the San Antonio-based south Texas health system.

It's launched a feasibility study for either a hospital or expanded outpatient services in the Valley. And in 2003, the VA received approval for an outpatient clinic at Harlingen as a temporary measure pending construction of a primary care clinic scheduled for completion later this year, Mr. Baghdadi said.

The new clinic will provide expanded audiology, dental and pharmacy services, as well as physical therapy, mental health and social work services not now available.

Veterans groups are glad for the new clinic. But they believe a fully staffed hospital would better fit their needs.

Unprecedented growth

Nationally, VA's medical system has experienced unprecedented growth, ballooning 22 percent since 2001 when it had 4.1 million veterans registered. It now has 5.3 million, including 1.7 million in Texas. And while the largest single group is Vietnam-era vets, the number of Iraq and Afghanistan vets is growing.

The Texas Veterans Commission reports it has received about 2,000 discharge documents a month since 2001.

"Iraq and Afghanistan veterans are a rapidly growing component of VA care," said Terry Jemison, VA spokesman. "Just a year ago, they made up 2 percent of our caseload. With the war continuing, we anticipate their numbers will continue to rise."

In south Texas, about 3 percent of the patient load is veterans of Iraq and Afghanistan.

Yet VA projections about 3 years ago showed veterans requiring VA services diminishing. A report by a special commission appointed to study Valley veteran health needs, said only 10 beds were needed for both the Lower Rio Grande Valley and the Coastal Bend area near Corpus Christi.

Homer Gallegos, a Vietnam vet and a member of VFW Post 8788 in McAllen, fears returning modern vets will soon face the same inadequate reception at VA that veterans of his war did.

"When I returned home after Vietnam, there were few resources here for veterans and VA wasn't equipped to handle the number of veterans coming back," he said. "Now, we're seeing some of the same things with the Iraqi vets. I'm really afraid these guys are going to fall through the cracks."

Young vets are dealing with a host of different problems, Mr. Gallegos said, from an increasing number of head and brain injuries and amputations to emotional problems resulting from the combat they saw and the strain of multiple deployments to the war zones.

"Right now, the younger guys don't feel comfortable with the VA system and they don't relate much to the concerns of the older vets," Mr. Gallegos said.

The younger vets are more worried about "getting jobs, getting married and aren't too concerned with long-term health issues," he said. "I just don't want them to get lost."

More sad than angry

State Rep. Aaron Peña, D–Edinburg, who represents part of Hidalgo County and is also a military veteran, has joined the call for construction of a VA hospital in the Valley.

"What the veterans in my district tell me is that health services to vets is lacking, distant and bureaucratic," he said. "There is more sadness than anger when they talk about this. They want to believe the system will respond to their needs. They gave so much and they feel forgotten.

"But what isn't spoken is the sense that they are being ignored despite the long history of Hispanics' service to the U.S. military," he said. "We've fought in almost every American war and we feel we've suffered disproportionately in the current war. And we're still being ignored."

Approximately 10 percent of the 320 Texans killed in Iraq and Afghanistan are from south Texas. According to Defense Department data, 100,000 Hispanics currently on active duty make up about 9 percent of the military.

Mike Escobedo, 38, returned home to the Valley in 1982 after a 4-year hitch in the Marines. But it wasn't until 17 years later that he learned he could get his hearing loss—a result of working around aircraft—treated at a VA clinic.

To go to the audiologist, he must still periodically travel to San Antonio.

"It's not so bad for me, but we have a lot of older vets and people without arms or legs who need more care," he said. "They shouldn't have to spend 5 hours in a van to see the doctor."

Seeking help

Jesus Bocanegra, 25, a veteran of Iraq, came home to Progresso nearly 3 years ago. After he was discharged, memories of some of the terrible things he saw in combat led to severe depression and thoughts of suicide.

A friend talked him into going to the VA office in McAllen. He was subsequently referred to the VA hospital in Waco for evaluation for post-traumatic stress disorder and intensive treatment.

Caseworkers there told him he needed to begin regular sessions with a therapist once he returned to the Valley.

"They told me I'd get an appointment in the mail," Mr. Bocanegra said. "Three weeks later, I got a letter from VA that I could see the doctor in 8 months. I had heard about red tape, but I didn't realize how bad it was."

Currently, there are five full-time VA psychological counselors and two part-timers for the entire Valley, a VA spokesman said.

Mr. Bocanegra said only three are available at any given time. The veteran clinics in Harlingen and McAllen are closed on the weekends. The PTSD hotline is available from 8 a.m. to 5 p.m., he said.

"There's a lot of people not getting the help they need and they're falling off a cliff and there's no net," Mr. Bocanegra said. "The Viet vets have been dealing with this kind of stuff for 30 years. But there's a lot of Iraq vets coming back, and we're not going to wait that long to get someone's attention."

In late 2005, Mr. Bocanegra and two dozen other veterans participated in a 5-day march from the Valley to San Antonio to promote the need for a VA hospital. Shortly thereafter, the VA commissioned the study to determine whether a VA-staffed hospital in south Texas is warranted.

"Let's face it. This is a largely Hispanic area that the feds routinely ignore unless they want to send more Border Patrol agents," he said. "But Hispanics have a lot of pride and they're proud to serve our country. In return, we get a lot of promises, but no one does anything about it."

VA officials said the study, later expanded to include evaluation for specialty outpatient care, should be completed this summer.

In the meantime, the outpatient clinic expansion in Harlingen will result in increased mental health services, as well as improved access to some of the services now available only in San Antonio, Mr. Baghdadi said. "The south Texas Veterans Healthcare System is actively working to increase access to services throughout the system," he said.

U.S. Sen. Kay Bailey-Hutchison, a Ranking Member of the Veterans Affairs Appropriations Subcommittee, recently pushed VA Secretary Jim Nicholson on the delay of the report.

"Secretary Nicholson assured me that the study I requested in February 2006 to determine the need to establish a veterans hospital in the Valley will be completed by July," Ms. Hutchison said. "This study has taken an awfully long time and I am anxious to learn the results. Our veterans in the Valley deserve accessible, quality care."

Twenty-five year effort

U.S. Rep. Solomon Ortiz, whose district covers much of the Valley, said he's tried for 25 years to get a VA hospital in south Texas. Time and again, VA officials said there weren't enough veterans or enough in the budget.

"Congressman Ortiz has been at this so long, it's gotten to the point he's boiled the argument down to its essence out of frustration," said Cathy Travis, the congressman's spokeswoman. "We want south Texas veterans to get the healthcare they need where they live. However it gets done, let's do it."

Veterans in the Valley have no shortage of stories about treatment delayed, appointments scheduled months in advance, long waits, and piles and piles of paperwork to receive medical treatment.

Mr. Cordova received a referral for an MRI for persistent shoulder pain. It took the VA 3 weeks to notify him that he would have an appointment in San Antonio 4 months later. After a 5-hour drive, the procedure took 15 minutes.

"You can't afford not to make an appointment," he said. "If you miss an appointment or have to reschedule, everything starts back at ground zero and it's many more months before you see a doctor."

Mr. Cordova is 90 percent disabled. Like many Valley veterans, he finds that the difficulties in getting appointments and traveling to meet them make it hard to maintain a sense of normalcy.

"It's hard to hold a job when you have to miss work four or five times a month to travel to San Antonio for medical appointments."

Apolonio Uresti is a Vietnam veteran still being treated for post-traumatic stress disorder. His father is a World War II veteran. His two sons, both active-duty military, have served multiple tours in Iraq.

Recently, a late-night phone call from one of his sons saying that he'd been hurt in an IED explosion dredged up memories of Mr. Uresti's own war experiences.

He called the clinic in Harlingen about seeing the psychiatrist. He was told the soonest appointment was in 6 months.

"You get tired of waiting," he said. "When my sons leave active duty, I'll have to tell them that they will have to fight to make the government keep its end of the bargain. I've seen it in my Dad's life and in mine."

Ortiz wants to hear from south Texas veterans ahead of key hearing
20 April 2007
Steve Taylor, *Rio Grande Guardian*

WASHINGTON—U.S. Rep. Solomon Ortiz wants to hear from south Texas veterans about the healthcare they are receiving and the efforts they have to make to get it. And he wants it in a hurry.

Ortiz, D–Corpus Christi, is set to testify at a hearing of the House Veterans' Affairs Subcommittee on Health regarding his legislation to establish a veterans hospital in south Texas next Thursday.

Ortiz said he wants south Texas veterans to send him messages, stories, petitions—anything that will help the Veterans' Affairs Subcommittee on Health understand the context of the difficulties south Texas veterans face.

"I know the time is short, but our veterans need to 'surge' now to help me characterize for Congress the everyday difficulties they encounter in terms of healthcare," said Ortiz, a veteran himself. "I want to tell these guys the personal stories of south Texas veterans."

In January, Ortiz introduced the South Texas Veterans Access to Care Act, which requires the VA to advise Congress in 180 days how they will tend to the acute healthcare needs for south Texans.

Ortiz introduced the same bill last year in an attempt to get the Administration to deal realistically with the massive number of wounded veterans in south Texas.

Ortiz has asked in for the construction of a veterans' hospital for south Texas in each Congress that he has served. "Each year, the bill is rebuffed, mostly for financial reasons," he said. "Testifying before the Health Subcommittee next week will be a step forward for this legislation."

Perhaps one of the Rio Grande Valley veterans the House Veterans' Affairs Subcommittee on Health would like to hear from is Ruben Cordova, a USN retired disabled veteran.

Cordova is waiting to have several surgeries to correct injuries he had sustained while in the service. That means numerous visits to the Audie Murphy hospital in San Antonio, the nearest VA hospital to the Valley.

"The worst case was when I had shoulder surgery and I spent the night in my car so that the anesthesia would wear off. I didn't take any pain medication so that I could make the 4-hour drive back home," Cordova said.

"The pain was unbearable and I had to make several stops along the way to vomit from the pain. But that was what I had to do because it is the only place for veterans to have surgery."

Cordova said he had also slept in his car in San Antonio to make an early appointment.

"By the time I arrived in San Antonio all the rooms available for veterans had been issued out," he said.

Cordova said he knew of many veterans that cannot sit for very long periods and have to lay down while in transit to San Antonio. "Their family has to make ar-

rangements to transport their loved ones in these conditions to make their appointments," he said. "If a veteran doesn't make their appointment they sometimes have to wait until there is an available appointment—usually another 6 months."

Cordova said people who don't have to live these ordeals don't know what veterans and their families have to endure.

"I wish you would live through a trip with a veteran and see what it takes to have medical attention," Cordova told the Guardian.

"Veterans don't want a handout they want what is rightfully theirs. We want service from our government without questions just like we served without questioning what was asked of us. We were ready to do or die for our country. Now it's time to receive."

Ortiz said his legislation gives the government three different options in establishing a method to better provide acute healthcare services for veterans in south Texas.

"They can either establish a public-private venture to provide inpatient services; or they can build a hospital there; or they can utilize an existing military treatment facility with a sharing agreement," Ortiz said. "The end result is that veterans' inpatient healthcare are attended to, near where the veterans live, not several hours away."

Ortiz said veterans should email their stories to: ortizvets@mail.house.gov or hand-deliver them to his Brownsville office by noon Wednesday, April 25.

Prepared Statement of Hon. Steven R. Rothman, a Representative in Congress from the State of New Jersey

Let me begin by thanking the Committee on Veterans' Affairs for allowing me to testify. I want to especially recognize the leadership of Chairman Bob Filner and Ranking Member Steve Buyer. Under your stewardship, this Committee is continuing its important work in looking after our veterans.

Mr. Chairman and Members of the Committee, I am here today to testify about the moral responsibility and practical obligation of the Federal Government to honor its commitment to *all* of our veterans—namely, the commitment to provide them with quality, affordable healthcare.

It is a moral responsibility because the American Government makes a promise to every veteran. We say that because you have volunteered to put your lives on the line for freedom—because you are willing to sacrifice yourself for the good of all Americans—because of this courage, we will take care of you when you leave the service.

We don't make that promise with our fingers crossed. We don't tack on fine print or attach a bunch of strings to the promise. We make that promise freely because our veterans gave freely of themselves in the service.

It is a practical obligation because how on Earth can a young soldier fight with all of his willpower on behalf of a government if he meets a 60-year-old veteran who is battling cancer without any healthcare because he has been banned by his own President from enrolling in the healthcare service for veterans?

It's outrageous. Yet, as the representative for more than 156,000 veterans, I have heard story after story from veterans in Bergen, Hudson, and Passaic Counties who tell me that their government has broken its promise to them.

That's because in January 2003, the Bush Administration decided to cut costs by telling veterans designated as "Priority 8" that they are banned from enrolling in the VA health system and will no longer have access to VA hospitals, clinics and medications.

The Administration defended its decision by saying that Priority 8 veterans make too much money to be worth the added expense. I say that's hogwash.

Hogwash because a veteran is a veteran is a veteran. Hogwash because we made a promise to those men and women to take care of them and there is absolutely no justification whatsoever for breaking that word. And hogwash because those veterans often live in areas where the cost of living eats up all of the income that the Bush Administration seems to think they have.

In fact, the national income threshold for Priority 8 veterans is $26,902. I don't know of any town in America where that qualifies as Bill Gates-style wealth. And in towns where the amount is slightly higher, it is still much too low to account for the high cost of living. Bergen County—which I represent—has the second largest concentration of veterans in the State of New Jersey and the largest number of Priority 8 veterans. All in all, it is estimated that nearly 5,000 veterans in New

Jersey alone have been turned away from the VA healthcare system. Nationwide, the number of veterans turned away is over 273,000.

Turned away—listen to those words. I don't have to tell the good Members of this Committee how terrible a message we send to young soldiers when we "turn away" 273,000 veterans from the VA healthcare system.

We "turned away" hundreds of thousands of brave servicemembers who said they were willing to die for the freedom of all Americans when they are at their most vulnerable.

The fact is that "turned away" is another way of saying we broke our promise. We broke our promise to 273,000 veterans. We broke our promise to people who said they were willing to die for the freedom of all Americans and we broke our promise when they were at their most vulnerable.

Imagine: You have a loved one who is 60 years old. He served bravely for 10 years as a young man and afterward worked hard as a civilian for decades, raised a family. But suddenly, he is diagnosed with cancer. He doesn't have health insurance. He can't afford private health insurance. So he turns to the Veterans Administration to save his life. But our VA says to him: 'Sorry, Charlie. You should've come to us before January 2003. We can't care for you. You're out of luck.'

Can you imagine? Can you imagine what that does to the faith of all our veterans in their government? Can you imagine what that does to the morale and trust of our current soldiers serving in Iraq and Afghanistan?

It's not right and I believe this Committee must ensure that we stop breaking our promise.

That's why I have introduced the Honor Our Commitment to Veterans Act, which tells the Bush Administration that it can't just promise to care for our veterans, but has to actually *care* for them. I strongly urge the good Members of this Committee to consider and move on this legislation.

Republicans and Democrats will never agree on everything, but we should all agree on the importance of keeping our promises to veterans.

As I said earlier, those promises weren't made with our fingers crossed behind our backs. They were promises made in earnest and they are promises that we must keep—for the good of our veterans and of our country. I will submit my full remarks for the record.

Once again, I thank the Committee, Chairman Filner, and Ranking Member Buyer for your time and consideration of the Honor Our Commitment to Veterans Act and the very important issue of providing healthcare to all of our veterans.

Prepared Statement of Hon. Tom Latham, a Representative in Congress from the State of Iowa

Mr. Chairman and Members of the Subcommittee, I am honored to have the opportunity to testify before you today regarding H.R. 1426, the Veterans' Access to Local Healthcare Options and Resources Act, known as the VALOR Act.

I introduced this legislation in response to growing concern expressed by veterans in my district regarding access to VA healthcare. Veterans who live in rural parts of my district must travel long distances to VA medical facilities to receive the healthcare promised to them. Oftentimes they have to wait months for an appointment. They are frequently forced to give up a full day, sometimes in fragile condition, to travel for care. Despite the remarkable improvement in the quality of VA healthcare during the past decade, the fact remains that not all America's veterans have equal access to these services.

One example of this inequity is the story of a Vietnam Army veteran from Fort Dodge, Iowa. This recipient of the Bronze Star is service-disabled, and he estimates that he has made the 4-hour round trip from Fort Dodge to the VA medical center in Des Moines more than 100 times over the last 3 years. Because he cannot drive, he relies, like many veterans, on a shuttle graciously provided by one of the Veterans' Service Organizations, which takes up to 10 or more veterans to Des Moines at a time. Since they have to wait until the last appointment to return, the trip takes an entire day, starting at 5:00 a.m. and returning late in the evening.

Countless similar cases have been reported to me by veterans in my district. This situation leads me to ask the question, "Can we really say that we are providing 'top quality' care for our veterans when so many have limited access to it?" Out of nearly 8 million veterans enrolled in the VA healthcare system last year only 5 million veterans actually used VA healthcare. Recent reports show that the VA healthcare system continues to match or outrank private-sector healthcare in overall quality and consumer satisfaction. Out-of-pocket costs are extremely low, particularly for

service-connected veterans. So why are less than two-thirds of the veterans enrolled in the system actually using it? I believe that access problems account for a great deal of this disparity. For millions of veterans, VA healthcare is simply not readily accessible, especially in rural areas.

VA-funded research conducted by Dr. William Weeks and his colleagues from the VA Outcomes Group highlights the urgent need for action to increase healthcare access for our rural veterans. This research supports the conclusion that, compared with their urban counterparts, rural veterans have a higher prevalence of mental and physical health problems, but the least access to VA healthcare.

I am concerned that this disparity will continue to grow over time unless we do something to stop it. First, rural residents are overrepresented among veterans. The VA Outcomes Group found that 22% of veterans are rural, compared with 14% among the general population. Furthermore, rural veterans are overrepresented among those serving in Iraq and Afghanistan, due to increased use of the National Guard and Reserve units. These units are often dispersed in rural areas, far from large urban centers or concentrations of veterans where VA facilities tend to be located. As I previously mentioned, rural veterans are already more likely to experience health problems. With large numbers of these veterans returning from combat, the need for VA healthcare in rural areas will increase dramatically in coming years.

The VALOR Act aims at meeting this need by providing veterans with an option to receive care they would otherwise be eligible to receive in a VA facility, at a local hospital or physician's office. To provide this option the legislation builds on the existing VA system for contracting with non-VA providers known as fee-basis care. The VA already has specific statutory authority to contract with non-VA facilities for medical care, but it is subject to a number of restrictions that limit its use.

The VALOR Act would require an expansion of fee-basis care to allow greater access to VA-funded healthcare in local communities. Under the bill, covered services include hospital care, medical services, rehabilitative services and preventative health services that a veteran would be eligible to receive at a VA facility. It also clarifies that VA drugs can be obtained with prescriptions written by contracted providers.

In region 23, which includes Iowa, the VA already spends roughly 10 percent of its regional healthcare budget on fee-basis care. The fee-basis system is already in place, and I believe expanding this system would be a very practical way to address the rural access problem. I understand that some are concerned about ensuring quality of care for veterans in expanding fee-basis. I would answer that access to care is a key component of quality, which is currently lacking for many rural veterans.

I also understand there are concerns about the integrity of VA medical records for veterans moving between VA and non-VA providers. This is one of the issues being addressed in the VA's Project HERO demonstration programs. It is not an insurmountable problem, and I applaud the Chairman for including in his draft rural health bill a provision specifically establishing a health information technology pilot program to examine ways to improve quality of care for veterans who use fee-basis care.

I know that many of my colleagues representing rural districts share my concerns about access to care for veterans. I applaud Jerry Moran and Steven Pearce for also bringing legislation forward that would allow veterans to get care closer to home. I ask Members of the Subcommittee to carefully consider H.R. 1426 and I look forward to working with you to improve access to healthcare for our rural veterans.

Prepared Statement of Hon. Jason Altmire, a Representative in Congress from the State of Pennsylvania

I would like to thank Chairman Michaud, Ranking Member Miller and Members of the Committee for the opportunity to testify today about H.R. 1944, the Veterans Traumatic Brain Injury Act of 2007, bipartisan legislation that I introduced to increase the screening and treatment of traumatic brain injuries (TBI) for our Nation's veterans.

Mr. Chairman, we are facing an impending crisis in this country. Our brave men and women are returning from Iraq and Afghanistan with TBI at an alarming rate. Of those treated at Walter Reed Army Medical Center, 65 percent have been diagnosed with TBI as a primary or co-morbid diagnosis. Many now consider TBI to be the signature injury of the wars in Iraq and Afghanistan.

I am concerned that the Veterans Affairs Administration may not be properly identifying and treating TBI among the Nation's veterans. It is estimated that more than half of all combat casualties have associated brain injuries. Most of them include mild TBI, which is often missed in initial exams as physicians attend to other more apparent injuries.

The Veterans Traumatic Brain Injury Act improves the coordination of TBI care for our Nation's veterans by requiring the Veterans Affairs Administration to screen veterans for symptoms, develop and operate a comprehensive program of long-term care for post-acute TBI rehabilitation, establish TBI transition offices at all polytrauma network sites, and create and maintain a TBI veteran health registry.

In our first 4 months, the 110th Congress has taken enormous strides in meeting its commitment to veterans. We have provided more than $11 billion in increased funding for veterans' healthcare and passed the Wounded Warrior Assistance Act to improve the management of their medical care.

I believe that we owe no greater debt than to our veterans and, while we have made some progress, we can do more to improve their healthcare. To this end, the bipartisan Veterans Traumatic Brain Injury Act will allow us to properly screen America's returning heroes for TBI and improve their treatment.

Thank you for the opportunity to speak today. I would be pleased to answer any questions that you may have.

Prepared Statement of Hon. Bob Filner
Chairman, Committee on Veterans' Affairs

I appreciate the opportunity to speak on two bills of importance to veterans, especially to the veterans returning from the wars in Iraq and Afghanistan.

Right now, a special opportunity presents itself!! Forty-two percent of the medical problems in the returning servicemembers from Iraq and Afghanistan are musculoskeletal, and many can undoubtedly benefit from chiropractic care. I am one American who has benefited from chiropractic care, so I can promote it in absolute good faith.

H.R. 1470, which former Congressman Jeb Bradley introduced last session, is the *Chiropractic Care Available to All Veterans Act*. It requires that chiropractors are phased into the VA, with not fewer than 75 medical centers by the end of December 2009 and all by the end of 2011.

H.R. 1471, re-introduced from my bill (H.R. 917) in the last session, is the *BACK Our Veterans Health Act (The **B**etter **A**ccess to **C**hiropractors to **K**eep Our Veterans Healthy Act.)* It requires that veterans have *direct access* to chiropractic care at VA hospitals and clinics, so that veterans do not have to go through a general practitioner, or "gatekeeper" as this doctor is sometimes called.

We must remember that since the creation of the VA healthcare system, the Nation's doctors of chiropractic have been kept outside and all but prevented from providing proven, cost-effective, and much-needed care to veterans. So we are grateful that access is becoming greater.

The support for VA chiropractic care is bipartisan in nature. You may recall that former Secretary Anthony Principi released a policy directive before his departure regarding the true and full integration of chiropractic care in the VA.

Now, Secretary Nicholson and I have developed a truly working relationship, so chiropractic is an area that I will be working on with him. Both Republican and Democratic VA Committee Members have supported the inclusion of chiropractic care in the VA.

I have worked closely with chiropractic patients, particularly our veterans, on these two bills, as well as with the American Chiropractic Association. Hopefully, the two bills I have introduced might not even be necessary, because the VA will continue on its own to do what is right.

But as insurance, it is important to pass H.R. 1470 and H.R. 1471.

Prepared Statement of Shannon Middleton, Deputy Director for Health
Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's view on the several pieces of legislation being considered by the Subcommittee today. In recent years, The American Legion conducted a program, "I Am Not a Number," that identified many of the access problems identified in these bills. In addition, The Amer-

ican Legion's series, A System Worth Saving, has also validated many of the issues addressed. Research conducted by the Department of Veterans Affairs (VA) indicated that veterans residing in rural areas are in poorer health than their urban counterparts. Providing quality healthcare in a rural setting has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. The American Legion commends the Subcommittee for holding a hearing to discuss these very important and timely issues.

Improving Timeliness of Healthcare

H.R. 92, Veterans Timely Access to Healthcare Act, seeks to establish standards of access to healthcare provided by the Department of Veteran Affairs (VA). Although timeliness of care is not a challenge unique to rural areas, veterans who reside in rural areas face an additional challenge to accessing care. Setting standards for timeliness in the delivery of healthcare and requiring VA to report on how these standards were executed will provide a realistic illustration of the ongoing challenges of rural veterans in gaining timely access to care. It will allow VA and lawmakers to determine the best ways to improve timely access for rural veterans. The American Legion supports this endeavor.

H.R. 315, Help Establish Access to Local Timely Healthcare for Your Vets (HEALTHY Vets), would require the VA to contract with community healthcare providers to improve access to healthcare for veterans in highly rural areas. The American Legion believes that, where there is very limited access to VA healthcare, it is in the best interest of veterans residing in highly rural areas that local care be made available to them. Some of these veterans have physical limitations or suffer from conditions that make extensive travel dangerous. Many veterans have expressed concerns to The American Legion about their limited financial resources prohibiting travel, citing the rising cost of gas, the limitations of the mileage reimbursement rate, and the need to pay for overnight accommodations, as huge obstacles. Providing contracted care in highly rural communities—when VA healthcare services are not possible—would alleviate the unwarranted hardships these veterans encounter when seeking access to VA healthcare.

H.R. 339, Veterans Outpatient Care Access Act of 2007, would improve access at outpatient clinics with exceptionally long waiting periods by allowing veterans to utilize non-VA providers. The American Legion has no official position on this issue, but believes that more focus should be placed on remedying the causes of the long wait periods to ensure timeliness of care. Doing otherwise would perpetuate the problem.

Improving Eligibility for Healthcare

H.R. 463, Honor Our Commitment to Veterans Act, discusses lifting the healthcare enrollment restriction on Priority Group 8 veterans. A total of 378,495 Priority Group 8 veterans have been denied enrollment from the time the restriction was instituted in January 2003. The American Legion believes that a more effective method of ensuring that VA can continue to provide quality care to veterans would be to ensure that VA is sufficiently funded to care for their needs, not limiting access for those who have incomes that fall above means tests thresholds. These veterans are required to make copayments, in addition to identifying their third-party health insurance that will reimburse VA for reasonable charges. Many of these Priority Group 8 veterans may very well be VA employees, Medicare beneficiaries, TRICARE or TRICARE for Life beneficiaries, or enrolled in the Federal Employees Health Benefits Program. The American Legion supports the lifting of the current prohibition on healthcare enrollment restriction for Priority Group 8 and exploring effective means to improve third-party reimbursement collections.

Improving Access to Healthcare

H.R. 538, South Texas Veterans Access to Care Act of 2007, addresses the healthcare needs of those who reside in south Texas. Although The American Legion has no official position on this proposal, we believe that VA should do everything in its power to improve access to its healthcare system for those residing in rural areas.

H.R. 542, bill to Require the Department of Veterans Affairs to Provide Mental Health Services in Languages other than English, seeks to make mental health services available in languages other than English for those who have limited English proficiency. The American Legion strongly supports English as the official language of the United States. However, The American Legion believes that VA needs to remove any hindrance that prevents veterans from obtaining the care they have earned through their military service. This is an extremely important issue for family members who may be required, by law, to make medical procedure decisions on behalf of a veteran.

H.R. 1426, the Richard Helm Veterans' Access to Local Healthcare Options Resources Act, would provide veterans enrolled in the VA healthcare system the option of receiving covered health services through non-VA facilities. It also would allow VA to fill prescriptions obtained from non-VA doctors. The American Legion believes that VA is a Federal healthcare provider not a Federal health insurer like the Department of Health and Human Services (Centers for Medicare and Medicare Services). Clearly, there will be unique situations in which VA should and must reimburse other healthcare providers, but this should be the exception to the rule, not a standard practice. Veterans should not have to travel hundreds of miles for healthcare or rehabilitation.

The American Legion believes veterans should not be penalized or forced to travel long distances to access quality healthcare because of where they choose to live. It is more important that VA is adequately funded at a level that would allow it to service the needs of veterans and to improve access to quality primary and specialty healthcare services, using all available means at their disposal, for veterans living in rural and highly rural areas.

The American Legion also supports VA pharmacy benefits for enrolled veterans when prescribed by an authorized VA physician or provider in the course of providing medical care.

Improving Healthcare and Treatment

H.R. 1470, the Chiropractic Care Available to All Veterans Act, seeks to make chiropractic care available at all VA medical centers. The American Legion has no official position on this issue.

H.R. 1471, Better Access to Chiropractors to Keep Our Veterans Healthy Act (BACK Our Veterans Health Act), would allow eligible veterans direct access to chiropractic care. The American Legion has no official position on this issue.

H.R. 1527, the Rural Veterans Access to Care Act, would allow highly rural veterans who are enrolled in the VA healthcare system to receive covered healthcare services through non-VA providers. It would also allow VA to fill non-VA prescriptions for highly rural veterans. As stated previously, The American Legion believes that, when there is no other acceptable VA healthcare option, veterans residing in highly rural and rural areas should be able to receive healthcare services through non-VA providers.

The American Legion supports VA pharmacy benefits for enrolled veterans when prescribed by an authorized VA physician or provider in the course of providing medical care.

Draft Discussion, Rural Veterans Healthcare Act of 2007, discusses a pilot program utilizing mobile vet centers in rural areas for a period of 5 years. The provisions in this bill are essential in addressing the challenges to providing quality care for rural veterans:

Section 2 establishes mobile vet centers. The mobile vet centers would provide a glimpse of health issues affecting rural veterans, while providing care to mitigate the problem of inaccessibility.

Section 3 establishes a health information technology program. The health information technology program would ensure that rural veterans receive continuum of care.

Section 4 describes the establishment and duties of an Advisory Committee. The Advisory Committee on Rural Veterans would regularly assess the needs of rural veterans and identify gaps in policy and care.

Section 5 addresses research and training. Rural health research, education and clinical care centers would afford VA the opportunity to build strategies to improve its system of care for rural veterans, as well as educate and train healthcare professionals on health issues prevalent in specific rural veteran populations. It also mandates the designation of centers for rural health research, education and clinical activities.

Section 6 addresses homelessness. It identifies that homeless veterans in rural areas have more challenges in obtaining local resources.

Section 7 discusses rotations and medical residents in rural areas, establishing programs to enhance education/training/recruitment and retention of nurses and allied health professionals in rural areas. Since VA has had challenges with finding providers who can furnish the types of services needed by veterans in rural areas, this section offers a remedy that would result in the ability of VA to provide quality care to rural veterans in their communities.

H.R. 1944, Veterans Traumatic Brain Injury Treatment Act of 2007, seeks to have certain veterans screened for symptoms of traumatic brain injury. It also discusses the creation of a comprehensive program for long-term care and rehabilitation that includes residential, community and home-based components. The Amer-

ican Legion believes that the provisions in this bill are both necessary and timely. Symptoms of traumatic brain injury may not be obvious and may be dismissed or may occur over time. Screening those who were known to have been subjected to blast trauma in theater—even if they have no visible physical wounds—would aid in diagnosing injuries more quickly. Early diagnosis would also help to mitigate the effects of the trauma and improve the chances of a successful rehabilitation.

Mr. Chairman, a critical element in screening veterans from traumatic brain injury will begin with the quality of the military health records. The Department of Defense (DoD) and VA must work in close harmony on this newest identified medical condition. DoD healthcare providers must work to identify and document "blast injuries," especially non-penetrating traumatic brain injury. DoD and VA established the Defense and Veterans Brain Injury Center. However, there remains little expertise to formulate an effective definition, clinical guidelines, and treatment for returning Operation Enduring Freedom and Operation Iraqi Freedom veterans.

In most cases, not only is the diagnoses of the less visible injuries of war difficult, physical wounds may "mask" the accurate diagnosis and treatment of traumatic brain injury. Blast impacts may not be properly documented and consequently the patient may have potential brain injuries that may very well go undetected until much later after behavioral changes become more evident.

Currently, DoD does not measure individual cognitive ability upon enlistment or pre-deployment; therefore, it is much more difficult to measure any decrease in cognitive ability after deployment that is due to military service. This clearly complicates diagnosis, treatment, and service-connection determinations.

Again, thank you, Mr. Chairman, for giving The American Legion this opportunity to present its views on such an important issue. The hearing is very timely and we look forward to working with the Subcommittee to bring an end to the disparities that exist in access to quality healthcare in rural areas.

Prepared Statement of Kimo S. Hollingsworth
National Legislative Director, American Veterans (AMVETS)

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear today to offer testimony on behalf of American Veterans (AMVETS) related to pending Department of Veterans Affairs (VA) healthcare bills before this Subcommittee.

The VA healthcare system has evolved into one of the best healthcare systems in the Nation. The Veterans Health Administration (VHA) is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected injuries. The VHA provides a wide array of specialized services to veterans and this type of care is extremely expensive. It is absolutely critical that the VA healthcare system be fully funded.

The central problem for veterans with regards to the VA healthcare system is how to access the system in a timely fashion. Over the years VA has become increasingly efficient in providing timely care, though problems still remain.

As this Committee is aware, AMVETS hosted the "National Symposium for the Needs of Young Veterans" in Chicago, Illinois last year. More than 500 veterans, active duty and National Guard and Reserve personnel, family members, and others who care for veterans examined the growing needs of our returning veterans. Some of the issues relevant to today's hearing identified at the Symposium include timely access to VA healthcare and funding for the Department. AMVETS believes these issues are inextricably linked.

Regarding the 12 bills that this hearing is supposed to cover, AMVETS will discuss the nature of the overriding issue(s) of these proposals and some of our recommended solutions. Overall, AMVETS is concerned about the "wave" of legislative proposals to mandate the Secretary of the VA to contract out medical and other services. AMVETS recognizes that many of these bills are well intentioned and our organization supports veterans being able to access the benefits and healthcare they are legally authorized to receive.

Mr. Chairman, veterans enrolled in the VA are already allowed to elect coverage in a non-VA facility. Veterans are free to choose when and where they receive medical care. One of the common themes for all of these proposals is allowing veterans to receive care at non-VA facilities and providers and having the Secretary of Veterans Affairs be responsible for the cost of coverage.

AMVETS reaffirms its commitment that service-disabled veterans should have the highest priority access to VA healthcare services and these services should be of the highest quality. AMVETS believes that service-connected veterans currently have

that level of access and quality in VA today. VA's current policy statement on this issue clearly affirms this priority, as follows:

> "VA is committed to providing priority care for non-emergent outpatient medical services and inpatient hospital care for any veteran seeking treatment of his or her service-connected disability. It is VA's policy to provide priority access to outpatient medical care and elective inpatient hospital care for any veteran who requires non-emergent care for a service-connected disability. . . . For veterans who are 50 percent service-connected or higher, VA's policy is to provide priority access to medical services and inpatient care, regardless if treatment is needed for their service-connected disability."

Many of today's proposals risk some potential unintended consequences to include quality control and safety, and potential adverse impact on the statutory requirement by VA to maintain the capacity of specialized medical programs in Public Law 104–262. Overall, these proposals would seem to move VA toward higher costs. The escalating costs of healthcare in the private sector are well documented and VA has done an excellent job of holding down costs compared to the private healthcare industry.

AMVETS believes the central question to all of these "contract" proposals is whether or not Members of Congress believe the VA healthcare system is a national asset worth preserving or a system that should be abandoned. AMVETS believes the problem with VA continues to be access to the system. This in turn is reliant on appropriate levels of funding to hire staff, operate facilities and clinics and provide unique and specialized services. Appropriate levels of funding would also allow VA to open outpatient clinics and provide other contractual arrangements to provide VA sanctioned healthcare.

As we are all well aware, the Secretary of VA already has the authority to enter into contracts for medical services. Many of these proposals have some "triggering" mechanism that would mandate the Secretary to contract care. These "triggering" mechanisms appear to be a "one-time" event that authorizes veterans to "opt out of the system" and have VA pick up the costs. For lack of a better word, these bills appear to authorize a "vouchering system."

Sections 212 and 213 of Public Law 109–461 are specifically targeted at advancing the healthcare needs of veterans living in rural areas. VA is mandated to establish an Office of Rural Health within the Veterans Health Administration (VHA). The office is charged with improving VA healthcare for veterans living in rural and remote areas. Among other provisions, the law requires an extensive assessment of the existing VA fee-basis system of private healthcare, and eventual development of a VA plan to improve access and quality of care for enrolled veterans who live in rural areas. AMVETS would encourage Congress to fully fund the Office of Rural Health and allow VA to conduct the mandated assessment.

Regarding the overall issue of VA providing timely access to care, the Government Performance and Results Act, Public Law 103–62, requires that agencies develop measurable performance goals and report results against these goals. In the President's Fiscal Year 2008 budget request, VA focuses on the Secretary of Veterans Affairs priority of providing timely and accessible healthcare that sets a national standard of excellence for the healthcare industry. VA generally tracks the timeliness of care in two broad areas—primary and specialty clinic appointments. Over the next year, the percent of appointments scheduled within 30 days of the desired date is expected to reach 96 percent for primary care appointments and 95 percent for specialty care appointments.

In July 2005, the VA Office of Inspector General reported that VHA's scheduling procedures needed to be improved and issued eight recommendations. As of September 2006, five of the eight recommendations for improvement remained open and AMVETS would encourage the Department to implement the remaining recommendations.

The issue of nonservice-connected veterans accessing VA healthcare is not new. Since colonial times, this country has pledged its continued support for medical care and other benefits for those who served in the military. During the 1920s, three Federal agencies—the Veterans Bureau, the Bureau of Pensions in the Interior Department, and the National Home for Disabled Volunteer Soldiers—administered various benefits for the Nation's veterans. The Congress, in 1924, gave wartime veterans with nonservice-connected conditions access to Veterans' Bureau hospitals. With the establishment of the Veterans Administration (VA) in 1930, previously fragmented care for veterans was consolidated under one agency. Over the years, Congress expanded eligibility for hospital care and it was gradually extended to

wartime veterans with low incomes; then, in 1973, to peacetime veterans with low incomes; and finally, in 1986, to higher-income veterans.

In 1996, Congress passed and the President signed H.R. 3118, the Veterans' Healthcare Eligibility Reform Act. This veterans' healthcare bill updated and simplified many of the outdated and existing eligibility rules in effect at that time. Most importantly, the bill established a "medical need" as the sole test for veterans who enroll for care with VA. In short, veterans have generally always had access to the VA healthcare system and they should not now be denied access because of a lack of funding; especially if they are willing to pay for these healthcare services.

The Capital Asset Realignment for Enhanced Services (CARES) was supposed to be a systemwide process to prepare the VA for meeting the current and future healthcare needs of veterans. CARES addressed the appropriate clinical role of small facilities, vacant space, the potential for enhanced use leases and the consolidation of services and campuses. To date, it is the most comprehensive analysis of VA's healthcare infrastructure conducted.

In May 2004, the VA issued a Decision Document that was supposed to serve as VA's guide for capital planning decisions. Annual updates with new forecasts of future demand were supposed to be incorporated in VA's strategic planning process. The May 2004 Decision Document identified 18 sites for additional analysis and studies. Overall AMVETS supported the CARES Commission process.

As a veteran and patriotic organization, AMVETS also associates itself for the purpose "to help unify divergent groups in the overall interest of American democracy." Veterans earn benefits and services, and are granted access to the system by virtue of their qualifying military service. This should continue to be the overriding principle when discussing veterans' issues. Mandating the Secretary to provide services in other than the English language only serves to create division and separation among veterans that took an oath to uphold and defend the Constitution of the United States in English.

Mr. Chairman, Public Law 107–135 mandated the VA to require implementation of a nationwide chiropractic care program. VA was less than enthusiastic about this endeavor and it took the Department until June 2004 to actually make these services available. Overall, chiropractic care is a complementary and alternative healthcare profession with the purpose of diagnosing and treating mechanical disorders of the spine and musculoskeletal system with the intention of affecting the nervous system and improving health. A similar program was mandated on the Department of Defense (DoD) around the same timeframe and DOD. It is AMVETS understanding that the DoD program has been highly successful and we would like to see similar results at the VA.

VA's approach to Post-Traumatic Stress Disorder (PTSD) is to promote early recognition of this condition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments available early to prevent chronicity and lasting impairment. The same must be done for Traumatic Brain Injury (TBI). However, there is no medical diagnostic code specific to TBI—a patient may carry more than one diagnostic code (fracture of facial bones, concussions, and/or brain injury of an unspecified nature, etc.). AMVETS is asking Congress to increase funding for PTSD and TBI, with an emphasis on developing improved screening techniques and assigning a new medical code specifically for TBI.

Mr. Chairman, this concludes my testimony.

Prepared Statement of Adrian M. Atizado
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

On behalf of the more than 1.3 million members of the Disabled American Veterans (DAV) and its auxiliary, I wish to express my appreciation for this opportunity to present the views of our organization on healthcare legislation before the Subcommittee.

The DAV is an organization devoted to advancing the interests of service-connected disabled veterans, their dependents and survivors. For the past 8 decades, the DAV has been devoted to one single purpose: building better lives for our Nation's disabled veterans and their families.

The measures before the Subcommittee today cover a range of issues important to DAV, to veterans and their families. My testimony includes a synopsis of each of the bills you are considering, along with DAV's position or other commentary. We

ordered our testimony numerically by bill in the same way you listed the bills in your letter inviting our testimony.

We have previously testified that through their extraordinary sacrifices and contributions in military service, veterans have *earned* the right to the Department of Veterans Affairs (VA) healthcare as a continuing cost of national defense. Moreover, we adamantly believe America's free citizens, as beneficiaries of veterans' service and sacrifices throughout our history, desire that the government fully honor its moral obligation to provide quality and timely healthcare services to wartime service-connected disabled veterans.

This Subcommittee is aware the DAV is opposed to any initiative that would turn VA into a primary insurer rather than a provider of healthcare to veterans. We believe VA must use its resources to maintain the base of its healthcare services, which is provided through and by VA healthcare facilities and healthcare providers. This current form of VA healthcare has served well to the benefit of all veterans, offers an uninterrupted flow of services to veterans in need, and ensures the quality of those services. VA is well recognized as America's best healthcare value, with the lowest error rates, highest satisfaction rate and lowest cost. Why would Congress want to contract out some of those services, at higher error rates, lower satisfaction, and higher cost?

Notably, VA currently spends $2 billion or more each year on contract healthcare services, from all sources. Unfortunately, as VA's contract workloads have grown significantly, it has not been able to monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA healthcare system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

The DAV is deeply concerned that any bill seeking to contract for care outside VA without addressing these concerns would essentially shift medical resources and veterans from VA to the private sector to the detriment of the VA healthcare system and eventually sick and disabled veterans themselves. Any proposal to contract for care with non-Department facilities and providers would encourage VA to refer patients, and thereby spend dollars for their care outside a system that is specifically created for veterans. Such a proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans. It would erode Veterans Health Administration's (VHA) patient resource base, undermine VHA's ability to maintain its specialized service programs, and endanger the well-being of veteran patients under care within the system.

This Subcommittee is well aware of the funding crisis VA healthcare is experiencing and its impact on sick and disabled veterans who depend on VA's specialized programs. In the years since open enrollment was terminated, VA has been forced to do more with less. Even though over the past two budget cycles, Congress has provided increased discretionary appropriations for veterans' healthcare, the funding levels have not kept pace with VA's current services costs and the steady and significant increases in demand for services from enrolled veterans. If given sufficient funding on time to meet the growing need of all enrolled veterans' healthcare, including rural veterans, VA should be held accountable for meeting demand in a timely manner. Only as a last resort would we want care to be contracted out. Moreover, if VA timely receives adequate appropriations, it should be expected to plan for the appropriate number of staff, infrastructure, and other resources necessary to provide veterans medical care in a cost-effective manner.

H.R. 92

The stated goal of this bill is to provide timely access to VA healthcare. To accomplish this, a 30-day standard would be established as the maximum length of time that a veteran would have to wait to receive an appointment for primary care in a VA facility. It would also direct VA to establish a standard for the maximum length of time that a veteran would have to wait to actually see a provider on the day of a scheduled appointment. Under the bill, if the Secretary found that any particular VA geographic service area failed to substantially comply with the time

standards, facilities in that area would be required to contract for the care of a veteran in each instance in which facilities would be unable to meet those standards. The contracting requirement would be mandatory for veterans who are classified within enrollment Priority Groups 1 through 7, and discretionary for those within Priority Group 8.

The bill would require the Secretary to carry out a one-time examination of waiting time data for the entire system, stratified by geographic service area. The Secretary would be required to issue a determination regarding compliance with the standard in each geographic service area. If the compliance rate for any area were below 90 percent, then facilities located in that area would be subject to the requirement that they contract for care whenever they are unable to meet those standards. The bill would also require that the Department of Veterans Affairs (VA) submit a variety of reports to the Committees on Veterans' Affairs concerning the purposes of the bill.

In addition, the bill's language pertaining to the payment mechanism VA would use for outpatient services provided under the terms of the bill is unclear. Specifically, if VA's reimbursement rate were linked to current policy under Part B of the Medicare Program, VA would be required to pay private providers 80 percent of the scheduler fee amount for which Medicare is ordinarily responsible. Under Medicare, beneficiaries must meet an annual Part B deductible for all outpatient services. Participating physicians under the Part B program can only receive equitable reimbursement for services rendered by invoicing Medicare beneficiaries the remaining 20 percent of the scheduler amount, and collect deductibles for given services or procedures.

DAV has a longstanding legislative resolution stating our firm opposition to copayments in VA healthcare. Under this measure, if a non-Department facility or provider were to receive the standard 80 percent of the fee schedule amount for which Medicare pays for a particular service, and they are forbidden to bill the veteran for any difference between the billed charges and the amount paid by VA, then, we believe this may act as a strong disincentive for private healthcare providers to accept and treat veterans under this authority, frustrating the very purposes of the bill.

Mr. Chairman, this Subcommittee held a thoroughgoing legislative hearing on September 30, 2003 (Serial No. 108–24) to consider an earlier version of this same bill. Among the statements made at that hearing was the following, by the then-Under Secretary for Health, Dr. Robert Roswell:

> *"My concern is that in the long run, I believe veterans are better served if we build a system of care that will address their needs, not leave it up to geographic location or a particular clinic that they might choose to use to determine what their healthcare benefit is on any particular day or any particular month. Ultimately, I think we have to build the system that addresses those needs. And purchasing care, because we are frustrated with waiting times, may not be the best way to do it. It might be, I don't know. I think we have to explore that in greater detail. I do believe there are a number of things that this Committee could do to enhance veterans' access to care. And I appreciate the leadership of the Committee in seeking those issues."*

The Subcommittee apparently agreed with Under Secretary Roswell. After considering all the views of witnesses and Members, and reviewing a series of policy issues raised by that bill, the Subcommittee took no further action on that bill for the duration of that Congress. We do not believe circumstances have changed since that time that would warrant this Subcommittee to take any action on the bill now. While we appreciate that on its surface this bill would seem helpful in the short run to some veterans, its probable but unintended destructive consequences demand that we oppose it.

H.R. 315

This bill would expand VA's existing authority to contract for private healthcare by redefining "geographic inaccessibility" through the use of population density markers and highway mileage distance from VA facilities. Under the bill, if a veteran's home of residence met a given inaccessibility standard, the Secretary would be required to permit that veteran to receive private healthcare for primary care, acute or chronic symptom management and for "nontherapeutic medical services." Most likely the Congressional Budget Office would conclude this bill constitutes mandatory spending under the PAYGO policy of the House.

As indicated in many other forums including this one, DAV supports passage of mandatory, guaranteed or assured VA funding to ensure sick and disabled veterans receive adequate VA healthcare, but we do not support mandatory funding for private providers to care for veterans via a VA insurance function. Thus, similar to H.R. 92, we do not support this bill.

H.R. 339

This bill would require the Secretary, in the case of a VA facility with a waiting list of 6 months or greater, to provide for any veteran so informed of that waiting period, contract services by private providers under the same terms and conditions as those services would be provided in a VA facility.

DAV opposes this bill for the same reasons we are concerned about the two earlier bills dealing with access. Insufficient resources is a primary cause of delayed access to care. This can be surmounted with new resources. This measure, like the others similarly aimed, would exacerbate VA's problems by stripping it of what limited resources it possesses to care for the patients now in the VA system, making its rationing and waiting lists even worse.

H.R. 463

This bill would legislatively moot Title 38, section 1705, thereby rescinding the Secretary's authority to establish and operate a system of annual enrollments for VA healthcare, and it would make every American veteran entitled to enrollment for VA healthcare on request. Over 1,000,000 veterans have unsuccessfully attempted to enroll in VA healthcare since the cut-off of enrollments for Priority 8 veterans occurred in 2003. While we certainly support the proponent's premise that every veteran who wants it should be able to enroll in VA healthcare, without a major infusion of new funding, enactment of this bill would worsen VA's financial situation, not improve it, and would not serve veterans well. We recommend the Subcommittee defer action on this bill until after Congress enacts mandatory, guaranteed or assured funding for VA healthcare.

H.R. 538

This bill would establish a requirement for a special study of the needs of veterans in 24 counties of "far south Texas," with the goal of establishing either a public-private venture, a full service VA facility, or a shared VA-military facility to meet their healthcare needs.

In accordance with our Constitution and Bylaws, the DAV's legislative agenda is determined by mandates formed by resolutions adopted by our membership. We have no resolution specific to the provisions of this measure. While we have some concerns about whether this bill would contravene the results of the recent Capital Assets Realignment for Enhanced Services (CARES) process in one particular geographic area, to the exception of all others, we take no official position on its passage.

H.R. 542

This bill would require VA mental health counseling to be provided in languages other than English when veterans are not English-proficient. The bill would also require the VA Secretary to ensure the purposes of Executive Order 13166, dealing with English as a second language among Federal beneficiaries, are carried out.

Again, we have no resolution relevant to the provisions of this measure; however, its purposes appear beneficial and therefore DAV would not oppose passage of this measure.

H.R. 1426

This bill would empower an enrolled veteran to elect to receive VA healthcare from private sources. Under its terms, the Secretary would have no discretion to deny such an election once it was made. The bill would also provide a medication benefit to all enrolled veterans for the dispensing of VA pharmaceuticals based on prescriptions written by private physicians. For similar reasons supporting our opposition to H.R. 92, H.R. 315 and H.R. 339, we oppose this bill.

H.R. 1470 and H.R. 1471

H.R. 1470 would expand VA chiropractic care by requiring such services to be available in at least 75 VA medical centers before the end of 2009 and available at

all medical centers by the end of 2011. VA was authorized to offer chiropractic care and services under the provisions of section 204 of Public Law 107–135, the Department of Veterans Affairs Healthcare Programs Enhancement Act of 2001. We believe chiropractic care offers a valuable healthcare service to veterans and DAV members support the systemwide availability of chiropractic services within the VA healthcare system.

While we support broader availability of chiropractic in VA facilities that would be brought about by enactment of H.R. 1470, the purpose of H.R. 1471 raises concerns. This bill would establish chiropractic service practitioners on the same level as VA medical doctors in the direct provision of primary care services. Each veteran receiving care in VA is assigned a single primary care provider, a medical doctor. A VA primary care provider is part of a primary care team charged with the responsibility for addressing the healthcare needs of the veterans assigned to that team. Accordingly, we believe in the VA healthcare system, access to chiropractic services should be provided in consultation with VA primary care providers responsible for maintaining the overall health of patients assigned to them. Thus, we oppose H.R. 1471.

H.R. 1527

Similar to H.R. 315, reviewed above in this testimony, this bill would grant election to veterans living at considerable distances from VA facilities to choose private care instead of care in VA facilities. The Secretary would not be able to deny this election, and VA would be required to pay associated costs. Furthermore, this measure would provide a pharmaceutical service similar to that of H.R. 1426. DAV opposes this bill for the same reasons as we oppose the earlier measures.

Draft Bill—Veterans' Rural Healthcare

The bill would require the Secretary to establish a mobile "vet center" pilot program in rural areas, and a pilot program for health information exchange with rural clinics, critical access hospitals and community health centers in rural areas. It would create an Advisory Committee on Rural Veterans and specify its membership and mission. The bill would establish at least four VA rural health research, education and clinical activities centers in VA medical centers in rural areas. It would amend section 2061 of Chapter 20, Title 38, United States Code, by adding the term "rural" as one of several groups defined with special needs to be addressed through VA's homeless assistance programs. The bill would expand VA's graduate medical educational mission into rural areas and enhance the education, training, recruitment and retention of nurses in rural areas. Finally, the bill would require a series of reports from the VA Secretary dealing with several of the matters contained in the bill.

As this Committee is aware, the cost of providing care in rural and remote areas is higher than in urban settings. In much of our deliberation on this issue, we struggle to find a way to fill the indeterminate gap between limited resources and the demand for rural healthcare. We are hopeful the creation of an Advisory Committee on Rural Veterans and the Rural Health Research, Education and Clinical Care Centers will strive to strike the balance we seek when providing better outreach and high quality VA medical care to veterans residing in rural and remote areas. Moreover, when striving for good stewardship of taxpayer dollars we ask due consideration be given to the cost effectiveness of the mobile vet center program, which is a concern for such a program serving rural areas. Much of the content of this bill is consistent with recommendations of the *Independent Budget*. Further, we believe this measure is a good first step in addressing the healthcare needs of rural veterans, thus; DAV fully supports its purposes.

H.R. 1944

The Veterans Traumatic Brain Injury Act of 2007 would require the VA to establish a screening program for all veterans of Operations Iraqi and Enduring Freedom, of the Persian Gulf War and earlier conflicts dating from 1998. The bill would require the Secretary to report the results of such screening to Congress on an annual basis. The bill would require the Secretary to establish comprehensive traumatic brain injury (TBI) rehabilitation programs in four geographically dispersed polytrauma network sites (presently centered in Richmond, Minneapolis, Tampa and Palo Alto VA medical centers), and to report that establishment within 1 year of enactment, with additional information about the veterans so served. The bill would establish a TBI transition office within each polytrauma network to coordinate healthcare delivery and other services. The bill would require VA to establish cooperative agreements with other entities capable of providing appropriate services to

veterans with TBI. Finally, the bill would establish a TBI registry to identify, track and communicate with, veterans suffering from TBI.

Mr. Chairman, much of the content of this bill is consistent with our review of TBI and our recommendations in the *Independent Budget* for fiscal year 2008. Clearly, TBI is going to remain a major focus of VA healthcare for the next several decades. Press reports indicate that over 12,000 improvised explosive devices (IEDs) have been detonated in the current OIF/OEF campaigns. This means the average soldier or marine has been exposed to concussion, possibly multiple times. VA needs to prepare for this coming healthcare challenge, particularly for those veterans whose exposure may be classified as "mild," or "moderate" in nature and when no head wound resulted from that exposure. We believe this is going to be one of VA's greatest healthcare challenges in the near term. This bill will aid VA in making those preparations; thus, we fully support its enactment.

In previous testimony, the DAV has raised concerns regarding the lack of effective screening and clinical assessment tools for mild to moderate TBI. While we applaud the Committee for considering this bill, and we support it, we note that VA issued a directive in the past 2 weeks (VHA Directive 2007–013), implementing a TBI initiative that features a screening "pop up" within the VistA clinical software system. The directive also makes reference to a screening protocol and the mandatory continuing education requirement for specialized training in TBI. The directive makes no mention of the clinical assessment tool, which was the subject of a vigorous discussion at the Committee's hearing on September 28, 2006. We understand that earlier this year, VA established a clinical task group to develop that clinical assessment tool, and we urge the Subcommittee to closely monitor this development to ensure that tool is put into the hands of VA practitioners at the earliest possible time.

Furthermore, we recommend greater flexibility be afforded to the Secretary regarding the number of locations for which the comprehensive program for long-term traumatic brain injury rehabilitation shall be carried out, such that if the need arises to expand the program, the current language limits VA's ability to meet that need. Also, the legislative language for eligibility of a veteran to receive care under this program may preclude veterans suffering from service-connected TBI. Finally, a provision of this measure encourages the Secretary to provide the comprehensive program for long-term traumatic brain injury rehabilitation through cooperative agreements with appropriate public or private entities. We are cognizant of the opportunities a cooperative agreement may offer but left undefined as currently written, we are concerned that this provision may overtime erode VA's special emphasis program of TBI care.

Mr. Chairman, this concludes my testimony. I and other members of the DAV Legislative Staff will be pleased to make ourselves available to you and your staffs for further discussion of our positions on any of these issues, in hopes of working toward compromise on measures that we can eventually support. Thank you for asking DAV to testify today. I will be pleased to respond to any of your or other Committee Members' questions.

Prepared Statement of Carl Blake
National Legislative Director, Paralyzed Veterans of America

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today regarding the proposed legislation. We recognize that the Department of Veterans Affairs (VA) faces serious challenges as it continues to face rapidly growing demand on its healthcare system. It seems ironic that in the face of some criticism about the care being provided in VA facilities that the demand on the system has never been higher.

H.R. 92, THE "VETERANS TIMELY ACCESS TO HEALTHCARE ACT"

H.R. 92, the "Veterans Timely Access to Healthcare Act," would establish standards of access to care within the VA healthcare system. Under the provisions of this legislation, the VA will be required to provide a primary care appointment to veterans seeking healthcare within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard for a veteran, then the VA must make an appointment for that veteran with a non-VA provider, thereby contracting out the healthcare service. The legislation also requires the Secretary of the VA to report to Congress each quarter of a fiscal year on the efforts of the VA healthcare system to meet this 30-day access standard.

Access is indeed a critical concern of PVA. The number of veterans enrolled in the VA is approaching 8 million and the number of unique users is nearly 6 million. Despite the ongoing policy to deny enrollment to Category 8 veterans, the numbers of enrolled veterans will continue to increase, particularly as more and more veterans of the Global War on Terror take advantage of the services in VA.

Unfortunately, funding for VA healthcare has not kept pace with the growing demand. Furthermore, Congress has failed to live up to its responsibility to provide adequate funding in a timely manner. Despite a positive funding outlook for this year, we remain skeptical. As long as VA continues to receive funding months into its fiscal year, it will never be able to properly plan to meet demand. To that end, access standards without sufficient funding provided by the start of the fiscal year are standards in name only.

PVA is concerned that contracting healthcare services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care. Contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality healthcare. We do think that access standards are important, but we believe that the answer to providing timely care is in providing sufficient funding in the first place in order to negate the impetus driving healthcare rationing. For these reasons, PVA cannot support H.R. 92.

H.R. 315, THE "HELP ESTABLISH ACCESS TO TIMELY HEALTHCARE FOR YOUR VETS (HEALTHY VETS) ACT"

H.R. 1527, THE "RURAL VETERANS ACCESS TO CARE ACT"

Because these two bills principally address the same issue, I will outline our concerns with the proposed bills in one statement. PVA is fully aware of the challenges the VA faces every day to provide timely access to quality healthcare for veterans who live in rural areas of the country. However, we are concerned that in addressing the problem of access for these veterans, the long-term viability of the VA healthcare system may be threatened. PVA members rely on the direct services provided by VA healthcare facilities recognizing the fact that they do not always live close to the facility. The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans is sent into the private sector for healthcare, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately, PVA has serious concerns about the provisions of this legislation that would give VA additional leverage to broaden contracting out of healthcare services to veterans in geographically remote or rural areas. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. We believe that this pilot program would set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the Federal Government to shift its responsibility of caring for the men and women who served.

Current law limits VA in contracting for private healthcare services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

In the end, we believe that in order for the VA to best meet this demand, adequate funding needs to be provided for VA healthcare in a timely manner. As we previously stated, placing the VA in the position it has dealt with for many years because Congress continues to wrangle over Federal budgets, does not prepare the VA to properly meet demand, including demand in rural areas.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. This legislation attempts to do so by stating defining "geographically inaccessible" in terms of a population density as it relates to a distance from a VA facility. However, this is very much a subjective idea. Access to VA healthcare is subject not only to population density or distance, but time as well. The difficulty in addressing this subject is apparent just by comparing the methods that the proposed bills take to define rural accessibility. However, due to the concerns that we have outlined, PVA cannot support H.R. 315 or H.R. 1527.

H.R. 339, THE "VETERANS OUTPATIENT CARE ACCESS ACT"

PVA opposes H.R. 339, the "Veterans Outpatient Care Access Act." As with the previous bills discussed, this bill would simply encourage broader contracting out of healthcare services without attempting to fix the problems that exist as a result of insufficient funding. With adequate resources and staffing, the challenges faced by outpatient clinics could be minimized. However, with the passage of this legislation, the VA would be discouraged from doing the right thing. For example, if a local clinic loses a particular specialty doctor, that clinic would likely turn to a contract provider without trying to refill that position.

Legislation such as this, once again, allows the Federal Government to absolve itself from the responsibility to care for the men and women who have served and sacrificed for this country. It is time for Congress to stop trying to pass the buck and provide the resources it will take the VA to provide this critical care. It makes no sense to continue to consider legislation that would lead veterans away from the best healthcare system in America.

H.R. 463, THE "HONOR OUR COMMITMENT TO VETERANS ACT"

PVA fully supports H.R. 463, the "Honor Our Commitment to Veterans Act." The provisions of this legislation are in accordance with the recommendations of *The Independent Budget*. We have continued to advocate for this policy to be overturned since it was put into place. It is unacceptable that these veterans are being denied access to healthcare simply because the Administration and Congress have been unwilling to provide the necessary funding to reopen the VA healthcare system to them. We believe this policy should be overturned and that adequate resources should be provided to overturn this policy decision.

VA estimates that more than 1.5 million Category 8 veterans will have been denied enrollment in the VA healthcare system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million in discretionary dollars.

H.R. 538, THE "SOUTH TEXAS VETERANS ACCESS TO CARE ACT"

PVA has no official position on this legislation. We believe that this is a local access issue. If a demonstrated need is there, then the VA must develop a solution to meet the needs of the men and women in this region.

H.R. 542

PVA has no opposition to the provisions of H.R. 542. Overall, we are pleased with the direction that VA has taken and the progress it has made with respect to its mental health programs. A great deal of time and resources have been invested in the VA's mental health programs in recent years to meet the growing demand of new veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). The War Supplemental currently being debated even includes significant additional resources to meet the mental health needs of OEF/OIF veterans. Many of the servicemembers who have served in OEF/OIF have experienced mild to severe mental health problems. Our only concern is that the VA does not invest considerable resources into the requirements of this legislation if the demand for such services is not really there. However, given that we do not have specifics about this type of demand, we would simply urge the VA to proceed with caution.

H.R. 1426, THE "RICHARD HELM VETERANS' ACCESS TO LOCAL HEALTHCARE OPTIONS AND RESOURCES ACT"

PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans in the VA healthcare system to leave that system and seek services elsewhere, as this proposed legislation would do. Over the past year we have read, as I am sure every Member of Congress has, all of the accolades given to VA healthcare by independent observers, newsweeklies and other publications. While we believe VA represents the best available care, oversight is needed to provide an additional guarantee that VA-provided services are of the highest quality for all veterans who use VA, especially for those with service-connected disabilities.

While this legislation may be well intentioned, the potential unintended consequences far outweigh any benefit that this bill might provide. There would almost certainly be a diminution of established quality, safety and continuity of VA care if veterans were to leave the system. It is important to note that VA's specialized healthcare programs, authorized by Congress and designed expressly to meet the

needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA's medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA healthcare. Additionally, Title 38, United States Code, section 1706(b)1 requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104–262 was enacted.

While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

With regards to the prescription drug provisions included in the legislation, P.L. 108–199, the "Consolidated Appropriations Act of 2004" provided the Secretary of VA the authority to dispense prescription drugs from Veterans Health Administration (VHA) facilities to enrolled veterans with prescriptions written by private physicians. Included in the public law, and further explained in the Conference Report H. Rpt. 108–401, was the requirement that the VA would incur no additional cost in providing such a benefit.

VA physicians, by being the sole source of care, have been fully able to monitor patients for potentially contra-indicative prescriptions. PVA is concerned that if VA is to accept non-VA physician written prescriptions, veteran patients may be put at risk with this loss of monitoring should the patient seek treatment both inside and outside the VA healthcare system.

H.R. 1470, THE "CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT"

PVA has no opposition to H.R. 1470, the "Chiropractic Care Available to All Veterans Act." Chiropractic care is another medical service that could benefit many veterans and disabled veterans who face spinal and musculoskeletal difficulties. Currently, the VA provides chiropractic care in selected sites in accordance with P.L. 107–135, the "Department of Veterans Affairs Healthcare Programs Enhancement Act of 2001." We see no problem with expanding this specialty care to the broader VA healthcare system; however, we must emphasize that adequate resources must be appropriated to allow VA to provide this care.

H.R. 1471, THE "BETTER ACCESS TO CHIROPRACTORS TO KEEP OUR VETERANS HEALTHY ACT"

As we previously stated, PVA has no objection to the provision of chiropractic care within the VA healthcare system. However, we do not support section 3 of this legislation which would elevate chiropractors to the status of a primary care physician in the VA. The primary care provider is responsible for assessment of illness and injury and triage to the appropriate specialty care. The primary care provider also provides basic care far beyond the scope of musculoskeletal conditions and the interaction with the nervous system—the principal focus of chiropractors. We believe that chiropractic care should be provided in consultation with the primary care provider responsible for the total healthcare needs of the veteran.

H.R. 1944, THE "VETERANS TRAUMATIC BRAIN INJURY TREATMENT ACT"

PVA supports H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act." It is fair to say that traumatic brain injury (TBI) is considered the signature health crisis for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. We believe that the provisions of this legislation will enhance the ability of the VA to provide comprehensive care for veterans with TBI; however, we also have a couple of concerns with the legislation.

Proper screening for this newest generation of veterans is critical to their immediate and long-term care. Unofficial statistics suggest that many OEF/OIF veterans

have suffered mild brain injuries that have gone undiagnosed. In many cases, symptoms have manifested themselves after the veterans have returned home. The Department of Defense (DoD) admits that it lacks a systemwide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI. It is only appropriate that the VA be able to fill the gap left by DoD.

Furthermore, it will allow the VA to identify veterans who have experienced a TBI but whose symptoms have been masked by other conditions. We have heard anecdotally that this is a particular problem for veterans who have incurred a spinal cord injury in the upper cervical spine. Veterans who have incurred this level of injury as a result of a blast incident often have experienced a traumatic brain injury as well. However, their symptoms may be diagnosed as the result of their significant impairment at the cervical spinal level.

PVA certainly supports the need for a comprehensive long-term care program for veterans who have experienced TBI. The VA is the only real healthcare system in America capable of providing complex sustaining care over the life of the seriously disabled veteran. Private treatment options often give no consideration whatsoever to the long-term care needs of the veteran. Meanwhile, the VA has developed its long-term care program across the broad spectrum of services for many years.

However, we have some concern about the provision of this legislation that defines an eligible veteran as one who has served on active duty in a combat theater of operations. Recognizing that the vast majority of newly injured TBI veterans have experienced their injury as a result of combat service, this should not preclude the VA from providing long-term care services to any TBI veteran whose condition is service-connected.

PVA also is concerned about the provision within the section establishing TBI transition offices that further encourages cooperation with public and private entities. We understand that outside facilities and programs can bring some level of expertise to this population of veterans. However, we would hope that the VA would see fit to invest the majority of its resources in improving its own TBI programs, even as it taps into outside expertise. We urge the Congress, and VA, to proceed with caution as it looks to services provided outside of the VA healthcare system.

THE "VETERANS RURAL HEALTHCARE ACT"

PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through the Community-Based Outpatient Clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

PVA has no objection to the proposal to create two mobile vet centers. However, the one caution we would offer is that services provided in this manner tend to be more expensive and less cost-effective. I would suggest that mobile services tend to be much more cost-effective in areas where a large segment of the target population can be served because it drives down the overall cost-per-patient. This implies that mobile centers would be best served in urban areas. However, we are willing to allow this pilot program to test the waters. We would suggest that the length of the program be shortened to 3 years or less so as to allow a sooner cost-benefit analysis of that program.

We fully support the creation of an Advisory Committee on Rural Veterans. We are particularly pleased that the legislation includes a provision for Veterans Service Organization representation; however, we believe that more than one voice should be included. While the proposal includes the Secretary of Health and Human Services and the Director of the Indian Health Service as ex officio Members of the Committee, we believe that the Department of Defense Under Secretary for Personnel and Readiness or the Assistant Secretary of Defense for Health Affairs should also be included. This committee could provide well-researched and reasonably considered alternatives for rural healthcare.

We also support the creation of rural health research, education, and clinical care centers. These centers would essentially serve as centers-of-excellence for rural healthcare. This could allow the VA to address the needs of rural veterans through broad application of the "hub-and-spoke" principle. This is the same structure utilized in the spinal cord injury service. A veteran can get his or her basic care at a Community-Based Outpatient Clinic (spoke). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to the larger rural research, education, and clinical care center (hub). This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system. It will also allow the VA to develop

excellence within the actual VA healthcare system, instead of farming out these services to the private sector.

Mr. Chairman and Members of the Subcommittee, we recognize that the challenges the VA faces in the healthcare arena are difficult. However, we must reiterate that the VA will struggle to meet the ever-growing demand of veterans, particularly rural veterans, as long as it does not receive adequate resources in a timely manner. It is unreasonable, and frankly unacceptable, to place expectations on VA to meet certain types of demand, if it is not given the resources and tools necessary. Furthermore, allowing the VA to send veterans out into the private sector for care will absolutely not be the most cost-effective approach, nor will it allow veterans to get the best quality of care.

We look forward to working with the Subcommittee to develop workable solutions that will allow veterans to get the best quality care available. I would like to thank you again for allowing us to testify on these important measures. I would be happy to answer any questions that you might have.

Prepared Statement of Dennis M. Cullinan
Director, National Legislative Service
Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.4 million members of the Veterans of Foreign Wars of the U.S. (VFW) and our auxiliaries, I would like to thank you for your invitation to testify at today's important hearing on healthcare legislation.

The bills under consideration today mostly revolve around what has been the most critical issue confronting the Department of Veterans Affairs (VA) healthcare system: access. We have long argued that the primary reason for most of the access problems veterans have is because of the lack of adequate and timely funding given to VA. We appreciate the increases of the last few years, and this year's historic budget resolution, but we need to ensure that VA receives the money on time, and that subsequent increases in future years keep pace with the needs of the veterans' population.

H.R. 92, the *Veterans Timely Access to Healthcare Act*

This legislation would establish access standards within VA for veterans seeking care. For primary healthcare appointments, it would require veterans to be seen within 30 days. In certain circumstances, it would require VA to contract for care when VA is unable to live up to that access standard.

The VFW strongly supports the intent of this legislation, but we do have some concerns about the contracting aspect. There is no doubt that veterans should not have to wait to access healthcare, especially for primary appointments. A few years ago, there were over 300,000 veterans throughout the country who were waiting 6 months or more for primary healthcare appointments, but VA has made great strides to reduce this and most initial appointments are being made within that 30-day standard. We do understand that there are certain geographical areas where this is not the case, however.

We are concerned about the cost of contract care, especially when VA is acknowledged to provide healthcare at a lower cost than other providers. While it would greatly benefit veterans in areas with long waiting times, we must be mindful of it not eating into the healthcare budget for other locations. If other areas have fewer funds to work with they, too, will ration healthcare, increasing waiting times systemwide. We must be mindful of these unintended effects, and ensure that the entire healthcare system has the funding and resources it needs to adequately care for all veterans.

H.R. 315, the *HEALTHY Vets Act*

This legislation aims to improve healthcare access for rural veterans by increasing contracting opportunities for veterans in geographically remote areas. This issue is of particular concern to our members, as a great number of them live far from VA medical centers, and often have difficulty accessing their earned healthcare.

We strongly support the intent of this legislation, which creates a sliding scale for contracting eligibility depending on distance and county density to determine whether a veteran lives in a rural area.

We do have concerns, however, with the potential for overuse of contracting care, as we did with H.R. 92, but there are certainly areas where its use is proper. We must be mindful of a demonstration project VA is currently undergoing, Project HERO. We have been supportive of Project HERO's aims, and think it might be

wise to see how effective the demonstration project is, and what lessons can be learned from it before making a sweeping legislative change.

Despite this, there are areas, particularly with respect to the challenges faced by today's returning servicemembers suffering from traumatic brain injuries and other blast injuries that could be supplemented with fee-basis care, but this is an area that is going to require strong Congressional oversight to ensure that these wounded warriors are receiving optimal care.

H.R. 33

The VFW supports the intent of this legislation, which is similar to H.R. 92, in that it establishes standards of care for veterans waiting to receive care from VA. In the case of H.R. 339, it establishes a 6-month access standard for any care a veteran is to receive, and if that standard is not met, VA must provide fee-basis care.

In the wide majority of cases, this standard would not come into play for primary care, but there are a great many places, especially in more rural areas, where specialty care presents unique access problems. In these areas, VA might not have the full number of specialists it needs, or they have overwhelming patient loads. Regardless, a 6-month wait is inexcusably long, and we cannot expect our sick and disabled veterans to wait that long, especially when none of us in the room today would wait that long for our care.

H.R. 463

The VFW strongly supports the goal of this legislation, which would end the 4-year freeze on the enrollment of new Category 8 veterans. Category 8 veterans are those mostly nonservice-connected veterans making above a geographically adjusted amount, and it includes veterans making as little as $26,902. These veterans, since January 2003, are no longer allowed to enroll in the healthcare system, and are turned away from their earned healthcare. VA estimates that 1.5 million veterans will have been denied enrollment by the end of fiscal year 2008.

If this legislation is enacted, Congress must also ensure a corresponding funding increase to pay for the care of these veterans. It is not enough to have VA make do; that will just result in the return of healthcare rationing and growing lines for care. Further, this cannot be a 1-year fix. Congress must continuously and fully fund VA healthcare in a timely manner in future years.

The VFW believes that all veterans have earned access to high-quality healthcare in a timely manner through their service to this Nation. When the freeze was put into place, it was a time of severe budget shortages and extreme waiting times. We believe that the policy was a short-term fix to allow VA to manage the crisis and feel that it is time to end this unfair policy.

H.R. 542

The VFW supports this bill, which would make mental health services available for veterans with limited English proficiency.

An increasing number of service men and women are coming from foreign countries. There are approximately 30,000 non-citizens serving in the military today, coming from around the globe. The vast majority of these heroes plan to use their military service as a springboard for citizenship, and their dedication to this country's ideals and their patriotic spirit, as manifested through their willingness to serve, cannot be questioned. These men and women put their lives on the line the same way any American-born servicemember does as they fight side-by-side. And they often suffer the same disabilities and illnesses.

Although we understand the difficulty some would have with providing options for treatment in other than English, we must be mindful that this legislation only covers mental health services, where clear and direct communication is integral to treatment and recovery. It is often difficult enough for English-speaking natives to communicate the emotions and problems they are facing; we cannot throw another barrier up for the treatment of those who have given much for this country. Their service is just as valuable as that of an English speaker, and the care and treatment—to make them whole—is just as essential.

H.R. 1426

The VFW strongly opposes this legislation, which would allow any veteran to elect to receive contracted care whenever they choose. As we have acknowledged in our comments to previous legislation, there are certainly cases where contract care is appropriate. A blanket and widespread use of it to anyone and everyone, however, is shortsighted and misguided.

First, we reiterate our concerns with the costs of such care. Fee-basis care is more expensive than that of VA, and we believe that it would do great harm to those vet-

erans who elect to stay in the high-quality VA healthcare system by taking away funding for the system as a whole.

Second, we have strong concerns about the viability of the healthcare system should this bill be enacted. VA has four essential missions, all of which depend on one another, and which greatly improve the quality of care for all Americans, not just our veterans. (1) It serves as the healthcare system for this Nation's sick and disabled veterans; (2) It acts as the primary education and training grounds for America's healthcare professionals (48,000 medical residents and students receive training at VA each year); (3) It provides world-class research opportunities and the development of new medical technologies; and (4) It is the backup to the Department of Defense healthcare system in national emergencies.

We cannot lessen one of these missions without sacrificing the others. Reducing the number of veterans seeking care from VA would do irreparable damage to the others, affecting all Americans.

Further, contract care would present problems, especially with the continuum of care and VA's ability to monitor and track the healthcare needs of veterans over their entire lives. It would also potentially erode the quality of care VA provides, especially with respect to the illnesses and disabilities veterans suffer from, such as gunshot wounds or prosthetics, and for which VA is uniquely qualified to treat.

Although this legislation aims to expand the coverage available to veterans, it would only dilute the quality and quantity of the services provided to new and existing veterans today and into the future. That is unacceptable.

H.R. 1470, the *Chiropractic Care Available to All Veterans Act*

The VFW supports this legislation which would require VA medical centers to begin hiring chiropractors at each facility. Currently, VA averages around one chiropractor per VISN.

A great number of veterans suffer from musculoskeletal injuries, and although chiropractors are not for every veteran, they should be available as an option. As part of a team that includes pain management and orthopedic specialists as well as physical therapists, a great number of injuries can be managed and symptoms improved.

H.R. 1471

The VFW opposes this legislation, which would allow veterans to receive direct access to chiropractic services. Although we support these services, we believe that they should be part of the specialty care process, requiring a referral from a primary care physician. This is important for case management and to ensure that a veteran's primary physician is fully aware of the treatments a veteran is undergoing, especially if that chiropractor service is a part of the team-based approach we discussed in our comments on H.R. 1470.

Further, it is important to remember that no other VA healthcare specialty allows for direct access by patients.

H.R. 1527

We also support the intent of this legislation that would, like H.R. 315 discussed above, allow for the contracting of care for certain veterans in rural areas.

Despite our support, our concerns about this legislation are similar to those of that bill as well.

Namely, we are concerned with the continuity of care, as records would need to be transferred back and forth, which could create difficulties with VA's state-of-the-art electronic medical records system. We are also concerned with the costs that such a program could incur as fee-basis care is more expensive than that provided by VA.

We would urge the Committee to consider the results of Project HERO before passage of this bill, though. The lessons we can learn from this—which would answer some of these questions we have laid out—would be beneficial to the entire system, and determine whether a large-scale proposal such as this is truly feasible.

H.R. 1944

The VFW offers our strong support for this legislation which would require VA to implement a screening program for traumatic brain injuries (TBI).

TBI is the signature wound of this war, as thousands of our men and women in uniform are being exposed to blasts and other traumas which are doing great damage to their brains. This is an area where this Nation clearly must do more to care for our sick and disabled, the wounded warriors of this war.

TBI manifests itself in a number of ways. While some are able to live with its effects, it makes life extremely difficult for others. We know much about its causes and immediate symptoms, but we must know more about it. We have repeatedly

called for more studies to fully understand the injuries, their causes, their effects, and especially their long-term impacts.

This legislation considers the long-term impact, and for those who need it, it would establish programs to provide long-term care and rehabilitation. This is sorely needed.

Further, it fosters the development of partnerships with other healthcare institutions through the creation of a TBI transition office, which is charged with coordinating services that are not readily available through VA. Given the difficulties we have sadly seen with some of these wounded warriors receiving the care they need, especially for those who live far from the polytrauma centers, this is an excellent step. Many of these clinics and specialty care facilities have great experience with brain injuries and can provide these patients the care they desperately need, and VA with the expertise and training it needs to fulfill its most sacred of missions.

Draft Bill, the *Rural Veterans Healthcare Act*

The VFW supports this bill which would make changes and improvements to the availability of healthcare for rural veterans.

This legislation includes important provisions that would expand vet centers, and create an Advisory Committee on rural veterans. In concert with last year's passage of a law that creates an Office of Rural Health within VA, there is much potential to reach those veterans who have difficulty accessing their earned VA healthcare.

It also would create four VA healthcare centers on rural health research, education and clinical care. These centers would allow for research into the delivery of healthcare to rural veterans, education and training for healthcare professionals, and for the innovation of clinical activities to benefit rural veterans.

With over 44% of returning servicemembers living in rural areas, the access problems they and all veterans face is of increasing importance. This legislation acknowledges that, and we are happy to support it.

Mr. Chairman, I thank you for the opportunity to present the VFW's views on these important bills today, and I look forward to any questions that you or the Members of this Subcommittee may have.

Prepared Statement of Richard F. Weidman
Executive Director for Policy and Government Affairs
Vietnam Veterans of America

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee on Health, Vietnam Veterans of America (VVA) thanks you for the opportunity to testify here today. And on behalf of our officers, our Board of Directors, our members and their families, we thank you, too, for the important work you are doing, and the initiatives you are taking, on behalf of our Nation's veterans.

We would like to focus our comments this morning on three of the bills up for your consideration. They are H.R. 463, H.R. 1944, and the discussion draft of the "Rural Veterans Healthcare Act of 2007."

***Priority 8 Veterans*/H.R. 463, the "Honor Our Commitment to Veterans Act,"** would re-open the VA healthcare system to Priority 8 veterans. These are veterans with an income of less than $28,000 a year who are not afflicted with a service-connected disability and who agree to make a co-payment for their healthcare and prescription drugs.

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

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

On January 17, 2003, the Secretary made the decision to "temporarily" suspend Priority 8 veterans from enrolling. While this decision may be reconsidered on an annual basis, every budget proposal from the Administration since has omitted funding for unenrolled Priority 8 veterans and attempts to discourage use and enrollment of those "higher income" veterans.

Priority 8 veterans are, for the most part, working- and middle-class Americans without compensable disabilities incurred during their military service. In its budget proposal for fiscal year 2007, the VA estimated that some 1.1 million of these "higher income" veterans would be discouraged from using *their* healthcare system because of a $250 enrollment fee and increased co-pays for prescription drugs. Thankfully, you in Congress have not let this scheme get much beyond the proposal phase.

H.R. 463 would amend Section 1705 of Title 38, United States Code, by adding this new subsection: *The Secretary shall administer the healthcare enrollment system under this section so as to enroll any veteran who is eligible under this section for such enrollment and who applies for such enrollment.*

Enacting this bill into the law of the land would keep the promise, keep the covenant with those veterans who, for whatever reasons, would choose to use the VA for their healthcare needs. We believe that their addition to the rolls would ease some of the fiscal pressures experienced by the VA insofar as it is Priority 7 and 8 veterans whose private health insurance accounts for some 40 percent of the VA's third-party collections.

Of course, the bottom line is funding—the funding Congress provides—to enable the VA to accommodate those Priority 8 veterans who want to avail themselves of the VA's medical services. VVA will be releasing shortly a White Paper on veterans' healthcare funding, which will place this issue in context.

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

We understand that the Administration is going to order the military to screen all returning troops for mild to moderate cases of TBI; those whose brain injuries are more serious are quite obvious to clinicians. **H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act of 2007,"** would go a long way toward assuring troops afflicted with this debilitating condition that help will be there for them. Focusing TBI care at four VA polytrauma centers, establishing and maintaining a registry of veterans diagnosed with TBI, and developing and inaugurating a comprehensive program for long-term TBI rehabilitation will go a long way toward healing the wounded from these latest military ventures.

Rural Veterans Access to Care*/*How to provide more convenient access to quality healthcare for veterans residing in rural areas has been the subject of more than a few hearings over the past two sessions of Congress. The language in this proposed bill is as sensible as it is needed. It would establish pilot projects to see what is most effective in providing care. One of these pilots would expand access to vet centers via mobile centers in rural areas. Another would establish a health information technology program.

Perhaps more importantly, this legislation would direct the Secretary of Veterans Affairs to establish an Advisory Committee on Rural Veterans, which would identify specific problems and areas of concern and suggest cost-effective solutions. It would require the Under Secretary for Health to designate a minimum of four VA healthcare facilities as the locations for centers of rural health research, education, and clinical activities. And it would establish programs to enhance the education, training, recruitment, and retention of nurses and other health professionals in rural areas.

In seeking ways to better serve our rural veterans, this bill would not impose bureaucratic "solutions" that could and, we believe, would only serve to undermine the VA healthcare system. **H.R. 92, the "Veterans Timely Access to Healthcare Act,"** would give the VA a scant 30 days to set up an appointment with a primary-care provider; if a VA medical center is unable to meet this standard for access to care, the option would be to send a veteran to a non-VA facility. **H.R. 1426, the "Richard Helm Veterans' Access to Local Healthcare Options and Resources Act,"** would offer an eligible veteran the option of obtaining healthcare from a non-VA facility or provider. **H.R. 1527, the "Rural Veterans Access to Care Act,"** would expand the use of fee-basis care through which private hospitals, healthcare facilities, and other third-party healthcare providers are reimbursed. It would impose a series of conditions, or distances, to help define "rural." Like **H.R. 1527**, **H.R. 315**, the inelegantly named **"Help Establish Access to Local Timely Healthcare for Your Vets (HEALTHY Vets) Act of 2007"** would add bureaucratic clutter to those whose responsibility it is to provide healthcare for veterans in "geographically inaccessible" areas.

Rather than improve healthcare for veterans, this quartet of bills, along with **H.R. 339, the "Veterans Outpatient Care Access Act of 2007,"** would, if enacted,

usurp the VA healthcare system. Today, one out of every ten VA healthcare dollars goes to clinicians and facilities outside the VA system. Through a scheme called Project HERO—the acronym for Healthcare Effectiveness through Resource Optimization—the VA is attempting to get a better handle on the dollars spent by VA medical centers on care provided outside of the system. We believe that HERO—and this quartet of bills—would only serve to hurt what has developed into one of the best-managed care systems in the Nation. HERO is a pilot in four VISNs, one that we believe will eventuate in half care for twice the cost.

One bill we do applaud is **H.R. 538, the "South Texas Veterans Access to Care Act of 2007."** "They've been looking at this for a long time," one VVA leader in Texas told us. "We did get an outpatient clinic in Conroe, in east Texas, but there are a lot of veterans in south Texas who are poorly served." If one in five of the 114,000 veterans there uses the VA as their healthcare provider, that's 11,400 who have to trek up to San Antonio for any real care.

H.R. 538 basically says, let's find out the facts, whether the needs of veterans in far south Texas for acute inpatient care would best be met through a project for a public-private venture to provide inpatient services and long-term care in an existing facility, through construction of a new full-service, 50-bed hospital with a 125-bed nursing home, or through a sharing agreement with a military treatment facility.

This is a very worthy bill, one that deserves serious consideration by this Subcommittee and by the HVAC at large.

VVA also endorses **H.R. 542**, which would require the VA to provide mental health services in languages other than English, as needed, for veterans with limited English proficiency. While it can be argued that, to make it in today's military a troop needs proficiency in English, it is quite possible that (s)he is more conversant, and more comfortable, speaking in his/her native language. And many families of our diverse population of servicemembers are hardly fluent in English. When troops return from places like Iraq, which have seared their soul and messed up their mind, and need counseling, it is highly beneficial to have a trained and competent counselor or therapist who can "relate" better because (s)he speaks Spanish, or French, or Vietnamese.

Finally, two bills that would effectively expand chiropractic care in VA medical centers, **H.R. 1470 and H.R. 1471**, are also worthy of passage—if proper standards of care are spelled out and enforced. We also would encourage, as part of these bills, a mandate for the VA to examine other "alternative" forms of medicine, so long as they conform to VA's evidence-based medical study. To this end, VVA suggests that part of this legislation should direct the Secretary of Veterans Affairs to appoint a committee to look at the efficacy of these alternative medical techniques with an eye toward integrating the most worthy of them into the VA healthcare system.

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

Prepared Statement of Gerald M. Cross, M.D., FAAFP
Acting Principal Deputy Under Secretary for Health
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veteran healthcare benefits and services. With me today is Walter Hall, Assistant General Counsel. We are able to present views for most of the bills on the Subcommittee's agenda. However, because of the limited time we have had to evaluate these bills, we stand ready to work with you to provide further information, including costs, at a later time for those pieces of legislation we are not able to fully address today.

H.R. 92—Standards of Access to Care

Mr. Chairman, I will begin by addressing H.R. 92. This bill would establish 30 days as the standard within which VA must provide a veteran with primary care (measured from the day the veteran contacts VA seeking primary care to the day on which the primary-care visit is completed). The bill would also require VA to establish a standard for how promptly patients must be seen in relation to their scheduled appointments in VA facilities (measured from the time of day of the veteran's scheduled appointment to the time of day the veteran actually sees the pro-

vider). There would be consequences for those facilities that do not meet these standards 90 percent of the time. In such facilities, if VA is unable to meet either of these standards with respect to a veteran, VA would be required to contract for that veteran's care in non-VA facilities if the veteran is enrolled in Priority Groups 1–7. VA would be authorized (but not required) to contract for such care if the veteran is enrolled in Priority Group 8.

The bill provides that payments under these contracts could not exceed the reimbursement rate under Medicare, and the non-VA facility or provider would be prohibited from billing the veteran for the difference between the billed amount and the amount of VA's payment.

We have no significant objection to H.R. 92 with respect to the 30-day standard for the scheduling of patients but ask the Committee to change the bill language to clarify that it would in fact apply only to new patients. It is these patients who need to be tracked to understand if there are difficulties accessing the VA system of care. In most areas, VA already complies with and exceeds these standards. Almost all VA facilities currently comply with the 30-day standard 90 percent or more of the time. We note, however, that in those situations where this bill would require VA to contract for care, restricting VA to paying the Medicare rate could make it difficult for VA to obtain the care in the private sector. There is no requirement in the bill that contractors, even if they are Medicare providers, agree to accept the Medicare rate from VA. This would limit the services that the VA could provide to veterans if the services cannot be purchased in the community at that rate.

VA already has in place a standard requiring that a patient see his or her provider within 20 minutes of the scheduled appointment. We monitor facilities' compliance with this standard periodically through the use of quarterly patient satisfaction surveys. These surveys are based on a sampling of patients who report retrospectively on their perception of their last outpatient VA experience. I'll emphasize here that these "waiting room times" are important to VA as a matter of customer service. Results from the Fiscal Year 06 Customer Satisfaction Survey indicate that 77.8% of our patients waiting for primary care services are seen within 20 minutes of their appointment, and 70.5% of veterans obtaining specialty care services are seen within 20 minutes of their appointments. We are unaware of any other metric that could be used to implement the bill's requirements.

We also believe the bill's approach is overly prescriptive and, as a result, would not provide latitude that is in the patient's best interest. Quality of care would be interrupted and fragmented with an increased requirement to send veterans outside the system. Moreover, the requirement that VA contract for care for patients waiting more than 20 minutes would not remedy the wait-experience of the patient for that visit. The bill is also flawed in that it assumes that all private care in the community meets the proposed standards. There are no measures available to support this assumption.

Please be assured that VA, from top to bottom, considers within-room-time an important aspect of customer service.

We are still in the process of developing costs for H.R. 92 and will provide them for the record.

H.R. 463—Termination of the Administrative Freeze on Enrollment of Veterans in Category 8

Mr. Chairman, as you and the Subcommittee are well aware, VA suspended the enrollment of new veterans in the lowest statutory enrollment category (Priority Category 8—veterans with higher incomes and no compensable service-connected disabilities) in January of 2003. This action was taken to protect the quality and improve the timeliness of care provided to veterans in higher enrollment-priority categories. H.R. 463 would require VA to enroll all eligible veterans. VA strongly opposes enactment of H.R. 463.

In 1996, Congress passed an Eligibility Reform law that allowed VA to treat veterans in the most appropriate treatment setting. Additionally, in order to protect the traditional mission of VA (to cover the healthcare needs of service-disabled and lower-income veterans), that law originally defined seven priority levels (PL) of veterans—PL 7 veterans (higher-income and not service-disabled) were the lowest priority. The law mandated that beginning in FY 1999, VA use its enrollment decision to ensure that care to higher-priority veterans was not jeopardized by the infusion of lower-priority veterans into the system for the first time. In FYs 1999 through 2002, the VA Secretary determined in each year that all veterans were able to enroll. Prior to 1999, PL 7 veterans' care was not funded in budgets, but they could use the system on a space available basis. Consequently, they were only about 2% of the annual users. In FY 2001, 25% of enrollees and 21% of users were PL 7 veterans (using 9% of the resources). In 2001 PL 7 veterans were split into two parts—

those making *above* the geographic-specific HUD threshold for means tested benefits were moved to a new PL 8 category. More than half of the 830,000 new enrollees in FY 2002 were in Priority Group 8 and VA was not able to provide service-connected and lower-income enrolled veterans with timely access to healthcare services because of the unprecedented growth in the numbers of the newly eligible category of users. When the appropriation was finally enacted for FY 2003, VA's Secretary made the decision that the Department would not enroll any new PL 8 veterans—but those currently in the system would retain their right to care. Every appropriation since 2003 has supported this enrollment decision.

H.R. 463 would essentially render meaningless the prioritized enrollment system, leaving VA unable to manage enrollment in a manner that ensures quality and access to veterans in higher priorities. VA would have to add capacity and funding to absorb the additional workload that this bill would entail, and so the quality and timeliness of VA healthcare to all veterans, including service-disabled and lower-income veterans, would unavoidably suffer until this capacity is added.

We note VA has authority to enroll combat-theater veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom in VA's healthcare system and so they are eligible to receive any needed medical care or services.

H.R. 1426—Option for Enrolled Veterans to Receive Covered Health Services through Non-VA Facilities

Mr. Chairman, H.R. 1426 would permit enrolled veterans to elect to receive any and all hospital and outpatient care in non-VA facilities. Veterans would make their election by simply submitting an application to VA. VA would be required to authorize payment for such care pursuant to a contract entered into with the facility. In addition, the bill would require VA to fill veterans' prescriptions written by non-VA physicians.

VA strongly opposes enactment of H.R. 1426. We fully concur in the views of several of the major Veterans Service Organizations, who recently wrote to the Chairman of the Senate Committee on Veterans' Affairs in opposition to a more modest proposal, S. 815, which would permit veterans with service-connected disabilities to obtain their healthcare at any private medical facility. (We will provide this letter to the Committee for the record.) Legislation to similarly cover all enrolled veterans, as proposed by H.R. 1426, would be all the more problematic. At bottom, H.R. 1426 could lead to the undoing of the VA healthcare system—a world-class healthcare system—as we know it today. For this fundamental reason, we must oppose H.R. 1426.

We also have other concerns. The proposal would fragment the care of our veterans. VA would no longer have a complete record of all the care a veteran has received. This could lead to VA duplicating care already provided in the private sector or providing care that conflicts with what the veteran is receiving in the private sector. As you are aware, some in the private sector rely on paper records while the VA uses a comprehensive electronic health record. Electronic records promote patient safety. We are concerned that the bill, if enacted, could jeopardize continuity of care for our patients.

These patient safety concerns also extend to the requirement that VA fill veterans' prescriptions written by non-VA physicians. We are a provider of care, including pharmacological services. VA should not serve as a mere pharmacy; rather VA facilities should continue to be a point of care where a veteran can receive all needed care in a safe, coordinated, and fully integrated fashion. We provide comprehensive care and continuity of care.

We also point out that VA has neither the capacity to meet this demand nor the resources to carry out H.R. 1426. In fact, VA's mail order pharmacy service is already at full capacity. Increasing this workload would require adding additional capacity, in addition to the cost of the additional drugs.

Although we have not completed our cost projections for this bill, we underscore that the bill could have significant cost implications. As soon as the cost estimates become available, we will supply them for the record.

Mr. Chairman, I now turn to the two bills currently under consideration by the Subcommittee that would address access to healthcare for rural veterans.

H.R. 315—Fee Basis Authority for Veterans for Whom VA Facilities are Geographically Inaccessible

H.R. 1527—Rural Veterans Access to Care Act

H.R. 315 would require the Secretary to contract with non-VA facilities to furnish primary care services, acute or chronic symptom management, non-therapeutic medical services, and other medical services as deemed appropriate to veterans for whom VA facilities are geographically inaccessible. Veterans covered by this bill

would include those who live in a county with a population density of less than 7 people per square mile and who live more than 75 miles away from the nearest VA healthcare facility; those who live in a county with a population density of more than 7 and less than 8 people per square mile and who live more than 100 miles from the nearest VA healthcare facility; and those who live in a county with a population density of more than 8 and less than 9 people per square mile and who live more than 125 miles from the nearest VA medical facility. This bill would take effect at the end of a 120-day period beginning on date of the enactment.

H.R.1527 also relates to healthcare for enrolled veterans who reside in highly rural areas.

Section 2 of H.R. 1527 would permit an enrolled eligible veteran to elect to receive healthcare through a non-VA healthcare provider. Veterans covered by this bill would include: veterans seeking primary care services who reside more than 60 miles driving distance from the nearest VA facility that provides primary care services; veterans seeking acute hospital care who reside more than 120 miles driving distance from the nearest VA hospital providing acute care; and, veterans seeking tertiary care who reside more than 240 miles driving distance from the nearest VA facility providing tertiary care.

Also covered by section 2 of H.R. 1527 would be veterans whose distance from the nearest appropriate VA healthcare facility does not exceed the above-stated parameters but who experience hardship or other difficulties in traveling to a VA facility such that the Secretary deems travel to a VA facility not to be in the veteran's best interest, as determined under VA regulations.

In carrying out section 2, the Secretary would be required to consult with the Secretary of Health and Human Services to establish a partnership to coordinate care for rural veterans at critical access hospitals, community health centers, and rural health clinics.

Section 3 of H.R. 1527 would require the Secretary to furnish covered veterans with prescription drugs that are ordered by licensed, non-VA physicians. Under this section, VA would be required to furnish these medications in the same manner, and subject to the same conditions, as apply to medications that are prescribed by VA physicians.

Both bills would give rise to obstacles to successful implementation and further expansion of our strategic plans, which focus on delivering healthcare services through sources that are nearest to a rural veteran's home. Both bills would create administrative issues, and implementation may simply be unworkable. We are also concerned that the requirements of section 3 of H.R. 1527 would result in fragmentation of a veteran's medical care and the undermining of the VA formulary process, both of which put the patient at increased risk.

Mr. Chairman, while we share the Subcommittee's concern for ensuring that rural veterans have adequate access to needed healthcare and services, we ask that the Subcommittee forbear in its consideration of either H.R. 315 or H.R. 1527. In accordance with Congress' mandate in the "Veterans Benefits, Healthcare, and Information Technology Act of 2006," VA just recently established the Office of Rural Health (ORH) within the Veterans Health Administration. Part of that office's charge is to see how we can continue to expand access to care for rural veterans. We therefore recommend that no legislative action be taken in this area until VA has had sufficient time to complete and review the internal assessments currently underway by ORH and other Department components. We will of course share those findings with the Subcommittee along with our recommendations.

VA has already done much to remove barriers to access to care for enrolled veterans residing in rural areas. Currently, over 92 percent of enrolled veterans reside within 1 hour of a VA facility, and 98.5 percent of all enrollees are within 90 minutes. Still, we continue our efforts to try to ensure that all enrolled veterans living in rural areas have adequate and timely access to VA care. We expect the data for this year to be even better.

Community-Based Outpatient Clinics (CBOCs) have been the anchor for VA's efforts to expand access to veterans in rural areas. CBOCs are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area. In addition, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans, and several additional outpatient clinics are positioned to provide care for veterans in surrounding rural communities. VA's authority to contract for care under 38 U.S.C. 1703 provides a local VA medical center director with another avenue through which to meet the needs of many rural veterans.

These efforts have borne fruit. Rural veterans tell us that they are satisfied with the services and high-quality care we are providing to them. This is substantiated

by their reporting higher satisfaction with VA services in comparison to their urban counterparts. Moreover, performance measure data indicate that as a result of our intensive efforts to expand services for rural veterans, veterans have access to services much nearer to home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away. Quality of care in the rural environment matches that of urban care on 40 standard measures.

Finally, we note that among the services that VA would be required to provide under H.R. 315 are "non-therapeutic medical services." The meaning of this term is unclear. If the Subcommittee is to act on H.R. 315, we ask it specify what services this provision is intended to cover.

We are still in the process of developing cost estimates for both H.R. 315 and H.R. 1527. We will supply them for the record as soon as they become available.

H.R. 1470—Enhancement of Chiropractic Care Program

Mr. Chairman, H.R. 1470 is one of two bills relating to the provision of chiropractic care. It would require VA to increase to not fewer than 75 the number of VA facilities directly providing chiropractic care through VA medical centers and clinics. H.R. 1470 would require this to be implemented by not later than December 31, 2009. In addition, H.R. 1470 would require that chiropractic care be provided at all VA medical centers by no later than December 31, 2011.

VA does not support H.R. 1470. VA does not oppose eventually increasing the number of VA sites providing chiropractic care. Currently, there is a facility with an in-house chiropractic care program in each of our geographic service areas. However, we do not believe, based on current usage rates, that sufficient demand for chiropractic care will exist to justify the mandate to provide chiropractic care at all VA medical centers by the end of 2011. Currently, 98% of VA patients are able to get chiropractic care within 30 days of their desired date.

Mr. Chairman, costs for H.R. 1470 are not yet available. We will supply them for the record.

H.R. 1471—Chiropractic Care Practice Expansion

The second bill on chiropractic care is H.R. 1471. This bill would appear to permit eligible veterans to elect to receive needed medical services, rehabilitative services, and preventive health services from a licensed chiropractor on a direct access basis, as long as the chiropractor acts within the scope of practice authorized under his or her State license.

VA uses chiropractic care to address certain muscular-skeletal conditions. However, we strongly object to extending, through legislation, the field of chiropractic care to the treatment of other medical conditions. In our view, because VA's healthcare system is national in scope, it should limit the scope of practice of the chiropractors to those procedures that are generally recognized to be within the scope of their practice, notwithstanding that some States may authorize them to provide other procedures.

We have built our success on the primary care model using physicians who are trained and educated in primary care medicine. Primary care providers not only coordinate the delivery of healthcare services but also make referrals for specialty care, as needed and appropriate. We believe it is in our patients' best interest to continue having their individual primary care providers remain in charge of managing their care.

H.R. 1471 could also place our patients at serious risk. Our aging patient population is characterized by a high degree of co-morbidities and complex medical conditions that require intensive and highly integrated clinical management skills. Their care should remain under the care of individual primary care providers and/or teams.

Finally, this bill would prohibit the Secretary from discriminating among licensed healthcare providers in the determination of needed services. However, the meaning and intent of this provision is not clear to us.

H.R. 339—Provision of Care from Non-VA Sources When There is an Extended Waiting Period for VA Care

Mr. Chairman, H.R. 339 would require VA to furnish needed medical services from sources outside the Department to veterans who seek medical services at a VA outpatient clinic but are informed by the clinic that the waiting period for treatment of patients is 6 months or longer. This bill would also require such services to be provided under the same terms and conditions with respect to eligibility and copayments as would apply if such services were provided directly by the VA clinic. H.R. 339 would require the Secretary to issue regulations to implement this provision, which would take effect 90 days after enactment of the Act.

Mr. Chairman, we have not had sufficient time to evaluate H.R. 339 and its costs. We will provide written comments on this bill for the record.

H.R. 538—Access to Care for Veterans Residing in Far South Texas

H.R. 538 sets out a series of findings regarding the healthcare needs of veterans residing in far south Texas, a geographical area defined in the bill. Within 180 days following enactment, the Secretary would be required to determine whether the needs of veterans in far south Texas would best be met—(1) through a public-private venture to provide inpatient services and long-term care to veterans in an existing facility in far south Texas; (2) through a project for construction of a new full-service, 50-bed hospital with a 125-bed nursing home in far south Texas; or (3) through a sharing agreement with a military treatment facility in far south Texas. H.R. 538 would require the Secretary to notify Congress as to the Secretary's findings and to submit a report to Congress identifying which of these options has been selected, along with a prospectus that includes projected timelines and additional specified data.

We do not support H.R. 538. At the request of Senator Kay Bailey-Hutchison, VA has contracted with Booz Allen Hamilton to evaluate and report on current needs in this region of the country. This report is due to be delivered to VA in July 2007. VA recommends that Congress await the results of this ongoing evaluation before it considers whether to mandate a particular means for addressing the healthcare needs of these veterans.

H.R. 542—Provision of VA Services in Languages Other Than English for Veterans With Limited English Proficiency

Mr. Chairman, section 1 of H.R. 542 would require the Secretary to ensure that counseling and other authorized mental health services are available in both English and a language other than English, if requested by a veteran who has limited proficiency in the English language. H.R. 542 would further mandate that the Secretary develop procedures to identify veterans with limited English proficiency and inform them of this provision.

Section 2 of H.R. 542 would require the Secretary to implement a system by which persons with limited English proficiency can meaningfully access VA services consistent with, and without unduly burdening, the fundamental mission of the Department. This section would require the Secretary to work to ensure that recipients of financial assistance under VA programs, in turn, provide meaningful access to applicants and beneficiaries with limited English proficiency.

Under section 2, the Secretary would also be required to implement a plan to improve access to VA programs and activities by eligible persons with limited English proficiency, and to ensure that the plan is consistent with a guidance document issued by the Attorney General in conjunction with Executive Order 13166. The plan would have to include specific steps that the Secretary would take to ensure that these persons can meaningfully access VA programs and activities.

Section 3 of H.R. 542 would require the Secretary to carry out a number of specified tasks, in developing and implementing the plan required by section 2. These tasks would include: (1) conducting a thorough assessment of the language needs of the population served by VA and identifying the non-English languages that are likely to be encountered; (2) developing a comprehensive language assistance program to include hiring bilingual staff and interpreters for patient and client contact positions; (3) translating written materials into languages other than English; (4) training staff on this VA access policy and its implementation; (5) establishing vigilant monitoring and oversight to ensure that persons with limited English proficiency have meaningful access to healthcare and services; (6) establishing a task force to evaluate the implementation and prioritize needed actions to implement the access plan; (7) developing a specific plan to ensure seamless transition of veterans and their families from Department of Defense services and benefits to VA services and benefits, including bilingual readjustment and bereavement counseling; (8) establishing a process to translate vital documents and other materials, including materials available on the World Wide Web, outreach brochures provided to servicemembers transitioning into civilian life, and the post-deployment health reassessment program; and (9) conducting outreach to veterans and their families in communities which may have higher proportions of populations with limited English proficiency.

Finally, section 4 of H.R. 542 would require the Secretary to report to Congress on VA's implementation of VHA Directive 2002–006 (prohibiting discrimination on the basis of national origin for persons with limited English proficiency in federally-conducted programs and activities and in Federal financial assisted programs). This

report would also have to include an analysis of VA's capacity to provide services to members of the Armed Forces with limited English proficiency.

Because we received a copy of H.R. 542 only very recently, we are still in the process of developing views and cost estimates for this bill. Once completed, we will provide them for the record. But we would like the Subcommittee to know that VA has taken significant steps to ensure that Executive Order 13166 is fully implemented throughout the Department. On February 12, 2007, VHA issued Directive 2007–009, *Limited English Proficiency (LEP) Title VI Prohibition Against National Origin Discrimination in Federally-Conducted and Federally-Assisted Programs and Activities*. This new policy updates the guidance previously set forth in VHA Directive 2002–006 and sets forth VHA's guidance on services to individuals with LEP. Similar guidance documents have also been issued by the National Cemetery System and the Veterans Benefits Administration. These LEP actions plans ensure that VA facilities and programs fully implement all LEP requirements.

Mr. Chairman, in anticipation of this hearing, we also received a draft bill entitled the "Rural Veterans Healthcare Act of 2007" and a copy of H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act of 2007." Because we received these two bills only very recently, we do not have cleared positions or costs to provide on the measures. We will provide written comments on the draft bill and H.R. 1944 for the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Subcommittee may have.

Statement of the American Academy of Neurology

The American Academy of Neurology (AAN), representing over 20,000 neurologists and neuroscience professionals, believes that our veterans deserve the best possible care and treatment for neurological injuries sustained in their service to our country. The conflicts in Iraq and Afghanistan have created an emerging epidemic of traumatic brain injury (TBI) among combat veterans. TBI is associated with cognitive dysfunction, post-traumatic epilepsy, headaches and other motor and sensory neurological complications.

It is essential that the Federal Government allocate the resources to ensure all veterans have access to the necessary neurological interventions and long-term treatments that their injuries require. The AAN believes that Congress should fund and the Department of Defense (DoD) should fully implement pre- and post-deployment cognitive and memory screening of all active duty and reserve personnel. Recognizing that this is not yet a reality, the AAN supports the goal of H.R. 1944 to establish a program within the Department of Veterans Affairs (VA) to screen veterans who are eligible for hospital care, medical services, and nursing home care.

The AAN also supports the effort to create a comprehensive program for long-term traumatic brain injury rehabilitation, but would recommend the inclusion of a specific program to address the impacts of TBI including seizure disorder. TBI is a major cause of epilepsy. We estimate that up to 40 percent of returning service personnel who experience TBI will develop epilepsy making this a significant service-connected disorder for many veterans.

Given the likely high rate of service-connected post-traumatic epilepsy that veterans with TBI will experience, Congress should authorize and the VA should fully implement a national epilepsy program. This program should include a statutory mandate and the necessary appropriations for Epilepsy Centers of Excellence (CoEs), available to all veterans with epilepsy and related seizure disorders. Congress should authorize no less than six Epilepsy CoEs to ensure adequate geographic distribution and access by veterans to these centers. The VA should also implement epilepsy referral clinics in all Veterans Integrated Service Networks (VISNs).

Congress should also appropriate adequate funds to improve the integration and coordination of neurology, mental health and rehabilitative services in the VA's polytrauma program. Every TBI veteran should have a neurologist as part of the rehabilitation team. The Neurology and Mental Health Services should become equal partners with the Rehabilitation Services with respect to TBI in the polytrauma centers and subsequent initiatives involving TBI.

We support the Committee's efforts to improve VA's delivery of care to rural veterans. We recommend that the draft Rural Veterans Healthcare Act of 2007 include a provision to improve care to those in rural areas with an expansion in telehealth and telemental health services offered by the VA to improve the surveillance and treatment of veterans with TBI and related seizure disorders. Specifically, VA needs

to develop its telemedicine capacity to transmit and review Electroencephalograms (EEGs), a diagnostic test which measures and records brain electrical activity, to VA specialists in epilepsy for interpretation as needed. The recommended Epilepsy Centers of Excellence would play a vital role in expanding VA's capacity to provide rural veterans with state-of-the-art diagnosis and clinical care through improvements in telemedicine.

The American Academy of Neurology appreciates the opportunity to comment on H.R. 1944 and the draft Rural Veterans Healthcare Act of 2007. We stand ready to assist the Health Subcommittee and the full Committee in any efforts to help veterans who experience TBI.

Statement of Hon. Corrine Brown, a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

I appreciate your calling this hearing today to listen to the many important bills introduced this Congress relating to veterans.

As I have known since I was first sworn into Congress in 1993, when I first began my service on this Committee, veterans are very important to the security and defense of this country.

Under the leadership of you, Chairman Michaud, and Chairman Filner, we are taking back the leadership of veterans issues to this Committee. It is important for the Veterans Committee to be the conduit for the veterans of this country to the Department of Veterans Affairs.

Thank you again for holding this hearing and I look forward to hearing the testimony of the witnesses.

Statement of Hon. Rubén Hinojosa, a Representative in Congress from the State of Texas

I want to thank Chairman Michaud and Ranking Member Miller for holding this important hearing today on legislation that will help improve the quality of healthcare for our veterans. I am here to express my strong support for H.R. 538, offered by my colleague from south Texas, Congressman Solomon Ortiz, of which I am a cosponsor.

South Texas has a proud history of patriotism and thousands of south Texans have fought in all of this country's major wars. They have returned to south Texas with a variety of injuries and illnesses as a result of their military service. Unfortunately, the closest veterans' hospital is more than 300 miles away in San Antonio. Many south Texas veterans do not have the financial means to travel to San Antonio and stay overnight in hotels waiting for appointments and procedures. The VA provides some transportation in cramped vans, but the journey is long and many veterans are unable to make the trip.

In addition to the veterans who make their permanent residence in south Texas, my region also sees hundreds of so-called "Winter Texans" who travel to south Texas to avoid the cold winters. These veterans use the limited clinic services currently available and in the past the local Veterans Service Region has not even been reimbursed for their care. Although the VA has worked to resolve this problem, it still has not resolved the problem of how to provide adequate health services to this additional population.

Since coming to Congress, I have been working to get a full-service veterans hospital in south Texas. I have brought several Secretaries of Veterans' Affairs to the region and they all agree that the service is inadequate. Still, nothing has been done.

The veterans in my community are tired of waiting and have taken action. Last year, they organized a march to San Antonio to show their commitment to getting their own hospital. Hundreds of veterans made the 300 mile trek to San Antonio in the heat to show the Veterans Administration that they were serious.

I hope the Committee will approve a new veterans' hospital in south Texas so that these veterans will finally receive the healthcare they deserve.

Attached to my testimony is a petition signed by over 10,000 veterans in south Texas in support of a veterans hospital. I ask that it be made a part of the hearing record.

Thank you for your consideration and for holding this important hearing.

[THE PETITION IS BEING RETAINED IN THE PERMANENT COMMITTEE HEARING FILES AND IS NOT BEING PRINTED.]