STATEMENT OF

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BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good Afternoon Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on a number of bills that would affect Department of Veterans Affairs (VA) programs of benefits and services. With me today are Walter A. Hall, Assistant General Counsel and Joleen Clark, Chief Workforce Management and Consulting Officer for VHA. Unfortunately, we do not yet have views and estimates on several bills including S. 239, S. 498, S. 699, S. 772, S. 793, subsection (f) of S. 252 and S. 821. We will forward those as soon as they are available. Our support for the bill provisions discussed below is contingent upon VA's ability to fund such activities within the President's 2010 budget.

S. 226 "Renaming of the Havre, Montana Outpatient Clinic"

Mr. Chairman, the first bill on the agenda is **S. 226**, a bill to rename the Havre, Montana VA Outpatient Clinic the Merrill Lundman Department of Veterans Affairs Outpatient Clinic. VA defers to Congress concerning this matter.

S. 246 "Veterans Health Care Quality Improvement Act"

S. 246 is intended to encourage highly qualified doctors to serve in hard-to-fill positions. Section 2(a) would establish additional standards for appointment and practice as a VA physician. We note that S. 252, Section 104, has substantially similar provisions. Section 2(a) would require physicians, both before and

following appointment, to disclose lawsuits, civil actions, other claims (whether open or closed) that result in payment and settlement payments and judgments that are based on the physician's medical malpractice or negligence, each investigation or disciplinary action taken relating to the individual's performance as a physician, and written notification from a State of a potential termination of license for cause or otherwise. It also would require a physician before appointment and at the time of biennial review of performance to authorize the State licensing board in each State in which the physician holds or has held a license to disclose anything in State records concerning such matters. Other provisions of this section would mandate enrollment of any privileged physician in the National Practitioners Data Bank (NPDB) Proactive Disclosure Service and encourage the hiring of board-certified physicians. VA has no objection to these requirements. However, legislation is unnecessary. VA already requires physicians to disclose anything that would adversely affect or otherwise limit their appointment and/or clinical privileges. Following appointment and at the biennial review of performance, VA also requires physicians to authorize the relevant State licensing boards to disclose information. Failure to disclose or provide authorization may be grounds for denial of appointment or termination from employment. Mandatory enrollment of VA physicians in the NPDB Proactive Disclosure Service has been required since November 2008. VA has long recognized board certification as important evidence of professional attainment and has given it significant consideration in recruiting and hiring physicians.

VA has no objection to the majority of the provisions in Section 2 relating to standards for appointment and practice of physicians in VA medical facilities and has already implemented most in agency policy. However, VA strongly opposes the requirement in Section 2 for Network Directors to approve physician appointments. This will introduce unacceptable and unnecessary delays into the process for appointing physicians. It is unnecessary since significant safeguards have been implemented to strengthen the process of medical staff appointments. Also it is important to recognize that granting clinical privileges requires local

knowledge, including clinical performance and peer-review information, which is not readily accessed at the VISN level.

Section 3 would require the appointment of board-certified physicians as Quality Assurance Officers (QAO) at the national, VISN, and facility level. It would also mandate a comprehensive review of all quality and safety programs and policies, including a detailed review of the National Surgical Quality Improvement Program (NSQIP). A report to Congress of the results of this review would be due within 60 days of enactment. VA does not oppose Section 3, and has already taken steps to increase the involvement of qualified physicians in quality leadership throughout the healthcare system. We note that the needs of smaller facilities can often be met by a part-time QAO, who may also have other clinical or administrative duties.

Under Section 4(a), VA would provide certain incentives, including student loan repayment, to physicians for service in hard-to-fill positions. Since we do not believe another loan repayment program is necessary, VA does not support this provision. VA can currently authorize educational loan repayment incentives to physicians in hard-to-fill positions through the Education Debt Reduction Program (EDRP). The provisions of S. 246 would establish a second debt repayment program operating under separate legal authority and regulatory guidelines, increasing complexity and potential confusion. In addition, the legislation creates a loan repayment program only for physicians and excludes all other occupations, regardless of the hiring needs and priorities of the Department. Current law provides comprehensive incentives available to more than 32 health care professional occupations. We estimate that the cost of the loan repayment incentive program described in Section 4(a) would be $4.6 million in the first year, $54.9 million over five years, and approximately $186.5 million over ten years.

We are opposed to another incentive program in Section 4(a) that would require VA to institute a program of tuition reimbursement for a course of education leading to board certification for physicians who agree to serve as physicians in VA. We cannot support this provision for several reasons. The time between the granting of tuition reimbursement and when the physician would become board certified is too long. Medical school and internship together can take seven years or longer to complete, depending on the specialty. Hard-to-fill specialties would likely have longer education requirements. During that time, VA's priorities and hard-to-fill positions can change significantly. Signing a contract today for services and obligations that will not begin for several years is subject to many risk factors that cannot be foreseen. Undoubtedly the personal circumstances and career objectives of many physicians would change, administering the contracts and monitoring the program would be complex, and the opportunities and occasions for civil court actions could also require substantial resources. Further, many students may fulfill their contract obligations but for one reason or another may not be an appropriate hire for VA at the time they are eligible. For example, certification may be beyond the capabilities of the graduating students in the tuition reimbursement program. There could be many circumstances under which VA's investment would not pay off but there would be insufficient grounds for seeking repayment. Assuming a student would receive the full reimbursement each year, as well as the annual stipend, over an eight-year period taxpayers will have invested $280,000 in the student before he or she begins working for VA. If upon graduation the doctor does not or cannot fulfill his or her employment obligation to VA, such a sizable investment would be very difficult to recoup. Considering the amount of the reimbursement and stipend per student and the cost of administration, we estimate that the program cost to be $283,000 in the start-up year, $51.7 million over five years, and $174.7 million over ten years.

Section 4(b) would require VA medical facilities to seek to establish an affiliation with a medical school within reasonable proximity of such facility. Mr. Chairman,

VA strongly supports the concept of affiliations and we are actively engaged in their expansion. In 2008, more than 100,000 medical and associated health students, residents, and fellows received some or all of their clinical training in VA facilities through affiliations with more than 1,200 educational institutions, including 107 medical schools. Many of these trainees have their health profession degrees and contribute substantially to VA's ability to deliver cost-effective and high-quality patient care during their advanced VA clinical training. As the nation's health care system evolves, VA continues to be on the leading edge with innovative education and training programs. Therefore, we believe that the statutory requirement to pursue affiliations is unnecessary.

S. 252 "Veterans Health Care Authorization Act of 2009"

S. 252 contains seven separate titles addressing a wide range of issues including personnel matters, homeless veterans, nonprofit research and education corporations and many health care matters including provisions specific to mental health and women veterans health care. Title I contains several provisions intended to enhance VA's ability to recruit and retain nurses and other health-care professionals and set certain standards for appointment and practice of physicians. These provisions are virtually identical to those reported in S. 2969 from the 110th Congress. We appreciated the opportunity to work with Committee staff on the prior bill and to provide technical comments and operational observations. We note that the reported bill and now Title I of S.252 address many of our concerns and comments. However, there are several provisions we cannot support.

Section 101 contains provisions for the enhancement of authorities for retention of medical professionals.

Secretarial Authority to Extend Hybrid Status to Additional Occupations

Subsection (a) would provide the Secretary authority to extend hybrid status to additional occupations. It would add "nurse assistants" to the list of so-called

hybrid occupations for which the Secretary is authorized to appoint and to determine qualifications and rates of pay under title 38. In addition, it would authorize the Secretary to extend hybrid status to "such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department" subject to a requirement to provide 45 days' advance notice to the Veterans' Affairs Committees and OMB. Before providing such notice, VA would be required to solicit comments from unions representing employees in such occupations.

VA favors such a provision. Nursing Assistants are critical to the Veterans Health Administration's (VHA) ability to provide care for a growing population of older veterans, who are high-acuity patients and/or frail elderly requiring 24-hour nursing care. Turnover data, 11.1 percent for 2007 and 10.96 percent for 2008, illustrate the great difficulty VA experiences in retaining this occupation. It is increasingly critical for VHA to be able to quickly and easily employ these nurse extenders. The same holds true for other hard-to-recruit health care occupations. This bill would give the Secretary the ability to react quickly when it is determined that these authorities would be useful to help recruit and retain a critical occupation without seeking additional legislative authority. However, the bill language should be modified to specifically apply to occupations that clearly involve the delivery of health care. In addition, because this authority involves the conversion of title 5 occupations to title 38 hybrids, the 45-day notice requirement should be modified to add OPM. Thus, we recommend modifying subsection 2(a) of the bill to read:

> (a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.
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> (1) IN GENERAL.-Paragraph (3) of section 7401 of title 38, United States Code, is amended by striking "and blind rehabilitation outpatient specialists." and inserting in its place the following: "blind rehabilitation outpatient specialists, and such other classes of health care occupations who

(A) are employed in the Administration (other than administrative, clerical, and physical plant maintenance and protective services employees);

(B) are paid under the General Schedule pursuant to section 5332 of title 5;

(C) are determined by the Secretary to be providing either direct patient care services or services incident to direct patient-care services; and

(D) would not otherwise be available to provide medical care and treatment for veterans;

(E) as the Secretary considers necessary for the recruitment and retention needs of the Department.

(2) Notwithstanding chapter 71 of title 5, United States Code, the Secretary's authority provided in paragraph (1) is subject to the following requirements:

"(A) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, the Office of Personnel Management, and the Office of Management and Budget notice of such appointment.

"(B) Before submitting notice under subparagraph (A), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice."

Probationary Periods for Part-Time Nurses

Subsection (b) provides for probationary periods for part-time (PT) Registered Nurses (RN) and revises the probationary period for RNs, both fulltime (FT) and PT, from 2 years to a maximum of its equivalency in hours, 4180. It also provides that a PT appointee who previously served on a FT basis in a "pure" title 38 position (7401(1)), and completed a probationary period in the FT position, would not have to serve a probationary period in the PT "pure" title 38 position. VA

opposes this provision. We believe this provision is technically flawed and would not be helpful.

Part-time title 38 employees, including RNs, do not serve probationary periods. Probationary periods apply to full-time, permanent employees. We see no benefit to creating a probationary period for part-time nurses as these positions are temporary.

Prohibition on Temporary Part-Time Nurse Appointments In Excess of 4,180 Hours

Subsection (c) would add a new section 7405(g) that would provide that part-time appointments of RNs are no longer temporary after no more than 4180 hours. After completion of the 4180 hours, the RN in essence would be converted to a permanent employee under section 7403(a) who has completed the probationary period. VA opposes this provision because it would impair our ability to adapt to changing demands in patient need and resource allocations. VA currently has the authority to create temporary appointments for up to three years. If this proposal is enacted, VA would lose this valuable flexibility. VA uses this flexibility to manage positions during periods of changing patient care needs and budgets. Without this current flexibility, VA's ability to make adjustments in the size of our temporary workforce would be limited. VA and its employees would be put into an untenable dilemma of either preemptively dismissing employees just prior to the expiration of the their probationary periods when patient demand justifies their continued employment or allowing a nurse to convert and retain employment, even if patient demand no longer justifies that position. In either scenario, patient care would be placed in competition with organizational flexibility, while the current system allows VA to achieve and maintain both.

Reemployed Annuitant Offset Waiver

Subsection (d) generally provides that annuitants may be temporarily reemployed in a title 38 position without being subject to having their salary offset by the

amount of their annuity. VA opposes this provision as 5 USC 8344 and 8468 provide the agency access to retired title 38 health care providers.

Rate of Basic Pay for Section 7306 Appointees Set to Rate of Basic Pay for SES

Subsection (e) would amend section 7404(a) to add a provision setting the basic pay of non-physician/dentist section 7306 employees in accordance with the rate of basic pay for the Senior Executive Service (SES). This amendment would be effective the first pay period that is 180 days after enactment.

VA supports the principle of pay equity with SES rates for its section 7306 non-physician/dentist executives as a tool needed to meet the challenge of recruitment and retention. Equity in pay for executive level managers and consultants is essential to attracting and retaining candidates for key positions. The pay schedule for 38 USC §7306 appointees is capped at the pay rate for Level V of the Executive Schedule (currently $143,500). Locality pay is paid up to the rate for Level III (currently $162,900).

Individuals appointed under 38 USC §7306 serve in executive level positions that are equivalent in scope and responsibility to positions in the SES. By comparison, employees in the SES receive a significantly higher rate of basic pay. The maximum SES pay limitation is the rate for Level II (currently $177,200) pending OPM certification that the agency meets all regulatory criteria for certified performance appraisal systems, including that the employing agency makes meaningful distinctions based on performance. We estimate the costs of this provision to be $343,917 in FY 2010 and $3,765,786 over a 10-year period.

As noted, the SES pay system conditions pay up to EX Level II on OPM certification that an agency's SES rating system meets all regulatory criteria for certified performance appraisal systems. In this regard we note that VHA uses the same rating system for its section 7306 executives as it uses for its SES

members. OPM has certified this system in the past, and just last year recertified VA through July 2010. For consistency, we recommend that the bill be modified to require that the Secretary make the same certification for the rating system covering section 7306 employees. Thus, we suggest that section 101(e)(3) be modified to read as follows:

> (3) Positions to which an Executive order applies under paragraph (1) and are not described by paragraph (2) shall be paid basic rates of pay in accordance with section 5382 of title 5 for Senior Executive Service positions and not greater than the rate of basic pay payable for level III of the Executive Schedule; or if the Secretary certifies that the employees are covered by a performance appraisal system meeting the certification criteria established by regulation under section 5307(d), level II of the Executive Schedule.

Comparability Pay Program for Section 7306 and SES Appointees

Subsection (f) would amend section 7410 to add a new subsection to establish "comparability pay" for VHA non-physician/dentist section 7306 employees and SES employees of not more than $100,000 per employee in order to achieve annual pay levels comparable to the private sector. Similar to provisions for RN Executive Pay in section 7452(g), it would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

VA supports the concept of comparability pay for its non-physician/dentist executives. However, we recommend that the new administration be given an opportunity to review this matter. Public sector executive pay is dramatically below the private sector for comparable positions, particularly in the health care sector. This proposal would allow VA executives to receive salaries far exceeding executives in other agencies which also must compete with the private sector. It would be a potentially precedent-setting departure from the unitary approach to government-wide SES pay.

Special Incentive Pay for Department Pharmacist Executives

Subsection (g) would further amend section 7410 to authorize recruitment and retention special incentive pay for pharmacist executives of up to $40,000. VA's determination of whether to provide and the amount of such incentive pay would be based on: grade and step, scope and complexity of the position, personal qualifications, characteristics of the labor market concerned, and such other factors as the Secretary considers appropriate. As with RN Executive Pay and comparability pay proposed by subsection (f), this subsection would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

This provision will provide a retention incentive to about 40 positions: pharmacy benefit managers (PBM), consolidated mail outpatient pharmacy (CMOP) directors and VISN formulary leaders (VFL). VA supports this provision. Long-standing, severe and worsening pay compression exists within the ranks of senior pharmacy program managers in VHA. A national survey performed yearly by the American Society of Health System Pharmacists provides evidence that a similar trend exists in the private sector. Currently VHA has had extreme difficulty in recruiting pharmacists for leadership positions. Some examples include: the VA Medical Center in Bay Pines has not had a permanent Pharmacy Manager for two years; the VA Medical Center, Portland, Oregon position has been vacant for one year; the VA Medical Center, Asheville, NC has been vacant over one year; and numerous other facilities are experiencing the same recruiting difficulties. Several other facilities with extended vacancies that were recently been filled include: the VA Medical Center, Omaha, NE for two years; VA Medical Center Dayton, OH for two years; and VA Medical Center, Las Vegas, NV vacant for one year. The current pay rate that we are able to pay executives varies minimally from staff pharmacist positions and therefore is not an incentive to recruit pharmacy executive/those in leadership roles to VA. This

provision will provide a mechanism to alleviate this compression. VA is still developing costs for this proposal and will submit them for the record when they are available.

Physician/Dentist Pay

Subsection (h) concerns physician/dentist pay. VA supports this provision. Paragraph (1) would provide that the title 5 non-foreign cost of living adjustment allowance for physicians and dentists would be determined as a percentage of base pay only. This would clarify the application of the title 5 non-foreign cost of living adjustment allowance to VHA physicians and dentists. The VA physician/dentist pay statute, 38 U.S.C. § 7431, does not address how the allowance is determined for physicians and dentists. We recommend that this provision be amended to clarify that it is applicable only to these physicians and dentists employed at Department facilities in Alaska, Guam, Hawaii, and Puerto Rico. These are the only Department facilities to which the title 5 non-foreign cost of living adjustment allowance is applicable.

Paragraph (2) would amend section 7431 (c)(4)(B)(i) to exempt physicians and dentists in administrative or executive leadership provisions from the panel process in determining the amount of market pay and pay tiers for such physicians and dentists. In situations where physicians or dentists occupy these leadership positions as chief officers, network directors, and medical center directors, the consultation of a panel has some limitations. The small number of physicians and dentists who would qualify as peers for these leaders results in their serving on each other's compensation panels and, in some cases, on their supervisor's panel. Providing the Secretary with discretion to identify administrative or executive physician/dentist positions that may be excluded from the panel process would resolve these issues.

Paragraph (3) would provide an exception to the prohibition on the reduction of market pay for changes in board certification or reduction of privileges correcting

an oversight in the recent revision of the physician/dentist pay statute. This modification would allow VA to address situations where there is a loss of board certification or an adverse reduction in clinical privileges. No costs are associated with this provision.

RN and CRNA Pay

Subsections (i) and (j) relate to RN and Certified Registered Nurse Anesthetist (CRNA) Pay. Subsection (i) would amend the current cap for registered nurse from EL V to EL IV. VA supports this provision. This would increase the cap from level V to level IV for both RNs and CRNAs, consistent with the pay cap that applies to the GS locality pay system. We note that subsection (i) would obviate the need for subsection (j) as the two pay scales affected are already tied to each other. We estimate the cost of this provision to be $6.16 million for FY 2010 and $72.31 million over a 10-year period.

Subsection (k) would make amendments to the RN locality pay system (LPS). These provisions are not helpful and are unnecessary. No costs are associated with this provision.

Paragraph (1) would require the Under Secretary for Health to provide education, training, and support to VAMC directors in the "conduct and use" of LPS surveys, including third party surveys. Paragraph (2) would require the annual report VAMCs must provide to VA Central Office to include the methodology for every schedule adjustment. These reports form the basis for the annual VA report to Congress. We are concerned that this provision, especially in conjunction with proposed paragraph 3, could result in the inappropriate disclosure of confidential salary survey data, contrary to current section 7451 (d)(5). It also would impose an onerous burden inasmuch as VHA has nearly 800 nurse locality pay schedules. We do note that VA policy does provide for how these surveys are to be obtained or conducted. Paragraph (3) would require the most recent VAMC

report on nurse staffing to be provided to any covered employee or employee's union representative upon request. This provision should be modified to specify at what point the report must be provided. It would not be appropriate to provide an individual a copy of the VAMC report before Congress receives the VA report.

Subsection (l) would increase the maximum payable for nurse executive special pay to $100,000. This provision would make the amount of nurse executive pay consistent with the Executive Comparability Pay proposed in section 2(f) of this bill. However, special pay of this amount would allow VA nurse executives to receive salaries far exceeding executives in other agencies that also must compete with the private section and there is no evidence that such levels of pay are necessary. Thus, VA opposes this provision.

The caption for subsection (m) suggests it provides for eligibility of part-time nurses for certain nurse premium pay. However, many of the substantive amendments are not limited to part-time nurses, or to all registered nurses. VA opposes subsection (m) as it has serious technical flaws, is unnecessary, and is costly.

Subparagraph (1)(A) would amend section 7453 (a) to make part-time nurses eligible for premium pay under that section. However, part-time nurses already are eligible for section 7453 premium pay where they meet the criteria for such pay.

Subparagraphs (1)(B) and (1)(C) would require evening tour differential to be paid to all nurses performing any service between 6 pm and 6 am, and any service on a weekend, instead of just those performing service on a tour of duty established for those times to meet on-going patient care needs. Under current law, these differentials are limited to the RN's normal tour of duty and any additional time worked on an established tour.

The "tour of duty" requirement in the current law is intended to ensure adequate professional care and treatment to patients during off and undesirable tours. The limitation of tour differential and weekend pay only for service on a "tour of duty" rewards those employees who are subject to regular and recurring night and weekend work requirements. If that is changed to "period of service", any employees performing night or weekend work on an occasional or ad-hoc basis would also be entitled to this premium pay in addition to overtime pay, providing an inappropriate windfall for performing occasional work.

Subparagraph (2) would authorize title 5 VHA employees to receive 25 percent premium pay for performing weekend work on Saturday and Sunday. We understand the purpose of this provision is to limit the expansion of weekend premium pay to non-tour hours to registered nurses. However, it does not fully achieve that purpose. Pursuant to section 7454(a) and (b)(2), physician assistants, expanded-function dental auxiliaries, and hybrids are also entitled to weekend pay under section 7453. The expansion of weekend pay proposed in this subparagraph would apply to them as well. In addition, because physician assistants and expanded-function dental auxiliaries are entitled to all forms of registered nurse premium pay under section 7453, the expansion of the night differential premium pay also would apply to them. Furthermore, where VA has authorized section 7453 night differential for hybrids, the expansion of the night differential premium pay would apply to them as well.

Subsection (n) would add additional occupations to the exemption to the 28th step cap on title 38 special salary rates: LPNs, LVNs, and unspecified "other nursing positions otherwise covered by title 5". Notwithstanding the exemption, under current statute, title 38 special salary rates cannot exceed the rate for EL V. It is not clear what positions "nursing positions otherwise covered by title 5" would include. RNs are appointed under title 38, LPNs/LVNs are hybrids, and section 101(a)(2) of the bill would convert nursing assistants to hybrid. Moreover, it is not apparent why only these positions and not all positions

authorized title 38 special rates would be exempted. Using the same formula for the cap on title 5 special rates would afford VA the most flexibility in establishing maximum rates for title 38 special rates. We also note that adopting the title 5 fixed-percentage formula would render unnecessary the section 7455(c)(2) report for exceeding 94 percent of the grade maximum and, so, propose deleting it.

Thus we recommend amending section 7455 to read as follows:

> (a)(1) Subject to subsections (b), (c), and (d), when the Secretary determines it to be necessary in order to obtain or retain the services of persons described in paragraph (2), the Secretary may increase the minimum rates of basic pay authorized under applicable statutes and regulations, and may make corresponding increases in all rates of the pay range for each grade. Any increase in such rates of basic pay-
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> (c) The amount of any increase under subsection (a) in the minimum rate for any grade may not exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent, and no rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.

VA's concerns that pay setting authorized by this provision may be subject to collective bargaining are discussed in conjunction with S. 362.

Section 102(a)(1) would add new section 7459, imposing restrictions on nurse overtime. Section 7459 generally would prohibit mandatory overtime for nurses (RNs, LPNs, LVNs, nursing assistants, and any other nurse position designated by the Secretary). It would permit mandatory overtime by nurses under certain conditions: an emergency that could not have been reasonably anticipated; the emergency is non-recurring and not due to inattention or lack of reasonable contingency planning; VA exhausted all good faith, reasonable attempts to obtain voluntary workers; the affected nurses have critical skills and expertise; and the

patient work requires continuity of care through completion of a case, treatment, or procedure. VA could not penalize nurses for refusing to work prohibited mandatory overtime. Section 7459 provides that nurses may work overtime hours on a voluntary basis.

VA favors this mandatory overtime restriction with the caveat that first and foremost, VA needs to be able to mandate overtime where issues of patient safety are identified by facility leadership. We note VAMCs currently have policies preventing RNs from working more than 12 consecutive hours and 60 hours in a 7 day period pursuant to section 4(b) of PL 108-445.

Section 102(b) would amend 38 U.S.C. 7456 (the "Baylor Plan"), which authorizes VA to allow nurses who perform two 12-hour regularly scheduled tours of duty on a weekend to be paid for 40 hours. This work-scheduling practice typically would be used when facilities encounter significant staffing difficulties caused by similar work scheduling practices in the local community. It would delete current section 7456(c), the current Baylor Plan requirement, which provides for a 5-hour leave charge for each 3 hours of absence that reflects the relative value of the truncated Baylor tour, in effect increasing the value of leave for affected employees. Currently, VA has only one employee working on the Baylor Plan. VA opposes this provision as providing an unwarranted windfall.

Section 102(c) would amend section 7456A to change the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that under the schedule six 12-hour "periods of service" anytime in a pay period would substitute for three "12-hour tours of duty" in each week of the pay period. Similar changes would be made to section 7456A's overtime, premium pay and leave provisions.

VA is experiencing planning problems with the use of the current 36/40 schedule. The problem stems from the 36/40 language requiring three 12-hour tours in a work week and because VA defines "work week" as Sunday to Saturday. The

problem occurs because the work week requirement prevents scheduling one of the 12-hour tours over two different weeks, e.g., 6PM Saturday to 6AM Sunday. Changing "work week" to "pay period" only makes the problem occur every 2 weeks instead of every week, so we do not view that as helpful. We do support changing the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that the six 12-hour tours can occur anytime in a pay period, providing more work scheduling/planning flexibility. We would be glad to provide appropriate bill language.

Section 103 would make amendments to VA's Education Assistance Programs. VA supports these proposals. Section 103(a) would amend section 7618 to reinstate the Health Professionals Educational Assistance Scholarship Program through the end of 2014. The program expired in 1998. The Health Professional Scholarship Program would help reduce the nursing shortage in VA by obligating scholarship recipients to work for 2 years at a VA healthcare facility after graduation and licensure. This proposal would also expand eligibility for the scholarship program to all hybrid occupations. This would be helpful in recruiting and retaining employees in the several hard-to-fill hybrid occupations. We are still determining costs for this provision and will forward them to the Committee as soon as they are available.

Section 103(b) would make certain amendments to the Education Debt Reduction Program. It would amend section 7681(a)(2) to add retention as a purpose of the program and amend section 7682(a)(1) to make it available to "an" employee, in lieu of "recently appointed." It would also increase the authorized statutory amounts in section 7683 to $60,000 and $12,000, respectively.

The "recently appointed" requirement limits eligibility to employees who have been appointed within six months. VA's experience has been that this is not a sufficient period. In several instances, employees applying just missed the six

month deadline. In many cases it takes more than six months for employees to become aware of this very helpful recruitment and retention program. This proposal offers greater flexibility to VA in applying the program. VA also supports the increased amounts in light of increased education costs since the program was enacted. We note this program can be implemented in a cost-neutral fashion.

Section 103(c) would authorize VA researchers from "disadvantaged backgrounds" to participate in a loan repayment program that the VA may establish using the Public Health Service Act authorities for the NIH Loan Repayment Program. We agree that loan repayment incentives would be helpful to clinicians with medical specialization and research interests who might consider career clinical care or clinical research opportunities relating to the work of VHA.

Section 104 is nearly identical to S. 246, Section 2(a), which I have previously discussed.

Section 201 would eliminate two reporting requirements: the Nurse Pay Report and the Long-Term Planning Report. VA supports this provision. There would be no discernible cost savings associated with this provision. Similarly, VA supports Section 202 to amend the Persian Gulf War Veterans' Health Status Act to change the due date of the annual report to Congress from March 1 to July 1. This change would have no impact on cost.

VA also supports Section 203. Section 203 will provide clarification of the legal authority beyond the existing regulations that will prevent providers from collecting from the beneficiary any amounts in excess of the CHAMPVA determined allowable amount. VA favors this provision. There would be no significant cost to VA.

Section 204, relating to payer provisions for care furnished to certain children of

Vietnam Veterans, has been made moot by the passage of P. L. 110-387, Section 408, “Spina Bifida Comprehensive Health Care.”

VA strongly supports Section 205 of S. 252, which would permit VA health care practitioners to disclose the relevant portions of VA records of the treatment of drug abuse, alcoholism and alcohol abuse, infection with the human immunodeficiency virus, and sickle cell anemia to surrogate decision makers who are authorized to make decisions on behalf of patients who lack decision-making capacity, but to whom the patient had not specifically authorized release of that legally protected information prior to losing decision-making capacity. This provision would only permit such a disclosure when the practitioner deems the content necessary for the representative to make an informed decision regarding the patient’s treatment. This provision is critical to ensure that a patient’s surrogate has all the clinically relevant information needed to provide full and informed consent with respect to the treatment decisions that the surrogate is being asked to make.

Section 206 would authorize VA to require that applicants for, and recipients of, VA medical care and services provide their health-plan contract information and social security numbers to the Secretary upon request. It would also authorize VA to require applicants for, or recipients of, VA medical care or services to provide their social security numbers and those of dependents or VA beneficiaries upon whom the applicant or recipient’s eligibility is based. Recognizing that some individuals do not have social security numbers, the provision would not require an applicant or recipient to furnish the social security number of an individual for whom a social security number has not been issued. Under this provision, VA would deny the application for medical care or services, or terminate the provision of, medical care or services, to individuals who fail to provide the information requested under this section. However, the legislation authorizes the Secretary to reconsider the application for, or reinstate the provision of, care or services once the information requested under this section

has been provided. Of note, this provision makes clear that its terms may not be construed to deny medical care and treatment to an individual in a medical emergency.

Given the significant privacy concerns related to this provision, we defer views until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 207 addresses quality management in VA facilities and establishes quality management officer positions at the national, VISN and facility level. Section 207 is similar to S.246, Section 3, although the position established is termed “Quality Management Officer” (QMO), and there is no stipulation that the position be filled by a board-certified physician. Section 207 would require the QMO to be responsible for and undertake specific actions to carry out VHA’s quality management program. Section 207 additionally would require the National QMO to assess quality of care by developing an aggregate quality metric from existing data sources, monitoring and analyzing existing measures of quality, and encouraging research and development in the area of quality metrics. Section 207 would authorize appropriations necessary to carry out the quality management program, including $25,000,000 for the quality metric provisions during the 2 fiscal year period following enactment. Mr. Chairman, we support the intent of these provisions, that is enhancing VA’s quality management programs, and have already undertaken actions to achieve many of the same goals. We would welcome the opportunity to meet with the Committee to discuss recent actions we have undertaken to improve the quality of care across the system, including program oversight related measures.

Section 208 requires submission of an annual report to Congress describing progress toward implementing provisions of Sections 104 and 207. VA has no objection to this requirement and, in fact, supports the concept of transparency in

health care. We note that a comprehensive Hospital Quality Report was prepared by the Department in 2008 and is updated annually.

We estimate that the requirement that the VISN Director review all information needed for physician appointment would require an additional FTEE (GS 14) at the VISN level. We also estimate that the appointment of a board-certified physician to serve as QAO at the facility and network levels would require 162 physicians for 141 medical staffs and 21 networks. We estimate salary and benefits costs for each QAO to be approximately $200,000 (actual will vary according to specialty, time commitment, and local market factors). We estimate total costs for a FTE MD QAO and FTE VISN coordinator to be $35.10 million in the first year, $188.05 million over five years, and approximately $413.22 million over 10 years. We estimate that salaries plus benefits for the new positions will include a 4% increase in costs for each subsequent year.

Section 209 would require the Secretary to conduct a pilot program, in collaboration with the Secretary of Defense, to assess the feasibility of training and certifying family caregivers to be personal care attendants for veterans and members of the of the Armed Forces suffering from TBI. The pilot program would be conducted at three VA medical centers and, if determined appropriate, at one DoD medical center. VA would be required to determine the eligibility of a family member to participate in the pilot programs, and such a determination would have to be based on the needs of the veteran or service member as determined by the patient's physician. The training curricula would be developed by VA and include applicable standards and protocols used by certification programs of national brain injury care specialist organizations and best practices recognized by caregiver organizations. Training costs would be borne by VA, with DoD required to reimburse VA for the costs of training family members of service members. Family caregivers certified under this program would be eligible for VA compensation and may receive assessments of their needs in the role of caregiver and referrals to community resources to obtain needed services.

VA does not support section 209. Currently, we are able to contract for caregiver services with home health and similar public and private agencies. The contractor trains and pays them, affords them liability protection, and oversees the quality of their care. This remains the preferable arrangement as it does not divert VA from its primary mission of treating veterans and training clinicians. Moreover, it does not put VA in the position of having to tell family members how, at the risk of losing their caregiver compensation, they have to care for their loved ones. If enacted, we estimate the cost of the three-year pilot to be $178.4 million.

Section 210 would require VA, in collaboration with DoD, to carry out a pilot program to assess the feasibility of providing respite care to family caregivers of service members and veterans diagnosed with TBI, through the use of students enrolled in graduate education programs in the fields of mental health or rehabilitation. Students participating in the program would provide respite relief to the service member's or veteran's family caregiver, while also providing socialization and cognitive skill development to the service member or veteran. VA would be required to recruit these students, train them in the provision of respite care, and work with the heads of their graduate programs to determine the amount of training and experience needed to participate in the pilot program.

VA does not support section 210. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care does not require specialized skills, and its functions are not applicable to curricula objectives in the graduate degree programs related to mental health or rehabilitation that we are aware of. Further, section 210 would require VA to use graduate students in roles that are not permissible under academic affiliation agreements, and we have serious doubts this proposal would be acceptable to graduate schools.

Moreover, VA has a comprehensive respite care program. We also have specialized initiatives underway for TBI patients to reduce the strain on their caregivers, which overlap with this bill. We also provide respite care by placing the veteran in a local VA facility for the duration of the respite period. Veterans may receive up to 30 days of respite care per year. We estimate the costs of conducting the pilot program to be $3.5 million in the first year and approximately $11.4 million over five years.

Section 211 would require the Secretary to carry out a two-year pilot grant program (at five locations selected by the Secretary) to assess the feasibility of using community-based organizations and local and State government entities to increase the coordination of VA benefits and services to veterans transitioning from military service to civilian life, to increase the availability of medical services available to these veterans, and to provide their families with their own readjustment services. Grantees could use grant funds for purposes prescribed by the Secretary.

VA opposes section 211 because it is duplicative of the Department's on-going efforts. Vet Centers are already providing many of the services contemplated by this provision. Additionally, VA case managers and federal recovery coordinators already coordinate the delivery of health care and other VA services available to veterans transitioning from military service to civilian life, including supportive services for their families. VA is committing ever increasing resources to these ends. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary.

To the extent the Secretary determines external resources are necessary to provide the services described in the bill, VA already has the necessary authority to contract for them. We favor using contracts instead of grants, as the former allow VA to respond to changing local needs and assure the quality of services provided. That approach also gives us an accurate way to project the cost of the

services. This provision, on the other hand, would not. It would also not be cost-effective as it is likely that a grant awarded under the program would be for an amount significantly less than the cost VA incurs in administering the grant. We also note the bill would not include authority for VA to recapture unused grant funds in the event a grantee fails to provide the services described in the grant.

Although the proposed pilot project is limited to five locations, the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost of this provision due to the lack of specificity.

Section 212 would authorize VA to contract for specialized residential care and rehabilitation services for veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) who: (1) suffer from traumatic brain injury, (2) have an accumulation of deficits in activities of daily living and instrumental activities of daily living that affects their ability to care for themselves, and (3) would otherwise receive their care and rehabilitation in a nursing home. These veterans do not require nursing home care, but they generally lack the resources to remain at home and live independently; this represents an extremely small subset of the OEF/OIF population. In fact, for FY 2010, VA estimates only 10 veterans would qualify and participate in this program. Age appropriate day health and other community programs, VA's home based primary care, and medical foster homes will be expanded to provide these Veterans with long-term specialized rehabilitation services. VA supports this legislation as it would enable us to provide these veterans with long-term rehabilitation services in a far more appropriate treatment setting than we are currently authorized to provide. VA estimates the discretionary cost of section 212 to be $923,000 for the first year, $12.2 million over five years, and $76.8 over ten years.

Section 213 would amend sections 5701 and 7332 of title 38, United States Code. The amendments would authorize VA to disclose individually-identifiable patient medical information without the prior written consent of a patient to a

third-party health plan to collect reasonable charges under VA collections authority for care or services provided for a non-service-connected disability. The section 5701 amendment would specifically authorize disclosure of a patient's name and address information for this purpose. The section 7332 amendment would authorize disclosure of both individual identifier information and medical information for purposes of carrying out the Department's collection responsibilities.

Given the significant privacy concerns related to this provision, we defer views on this section until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 214 would require VA to enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD). VA opposes this proposal. The 2007 four-year, $3.8 million, VA-sponsored study by the National Academies of Sciences (NAS) "Long-Term Health Effects of Participation in Project SHAD" represented an exhaustive effort to locate and evaluate the health of every living or deceased SHAD veteran. That study found little or no long-term health effects linked to SHAD participation, and spending additional resources with the hope that possibly tracking down a small number of additional SHAD veterans might significantly change those results is unrealistic. We have been assured by the NAS group who conducted the original study that they have spared no effort in tracking down every SHAD participant as part of their study. We estimate that such a study would cost $2.5 million.

When VA is providing inpatient or outpatient care for a patient with traumatic brain injury, VA is required to develop an individual plan for the veteran or service member. In implementing such plans, 38 U.S.C. § 1710E authorizes the Secretary to provide hospital care and medical services through cooperative agreements with appropriate public or private entities that have established long-

term neurobehavioral rehabilitation and recovery programs. Section 215 would amend this authority by defining covered individuals as service members or veterans receiving inpatient or outpatient rehabilitative hospital care or medical services for traumatic brain injury to whom the Secretary is unable to provide treatment or services at the frequency or for the duration described in the plan, or for whom the Secretary determines such care is optimal. This provision would also require that facilities participating in such cooperative agreements maintain standards for the provision of treatment or services that have been established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.

VA supports this provision but recommends that the plan referenced in this provision be described as the VA Individualized Rehabilitation and Reintegration Plan developed in accordance with section 1710C. Further, the bill as currently drafted states that the Secretary may not provide treatment or services at the non-VA facility unless the facility "maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury."

Section 216 would include federally recognized tribal organizations in certain State home programs. Specifically, section 216(a) would authorize VA to treat a health facility or certain beds in a health facility of a tribal organization as a State nursing home for veterans. This would allow VA to pay per diem to the organization for the nursing home care of veterans in the home. The home would be required to meet the existing standards for State homes and such other standards as VA requires. In addition, the organization would have to demonstrate that, but for treatment in the home, a substantial number of veterans residing in the area would not have access to nursing home care, and the Secretary would have to determine that treatment of the facility or beds as a State home would best meet the needs of veterans for nursing home care in the

area. Finally, tribal organizations would be subject to limitations on the number of beds that could receive per diem under this provision.

VA opposes Section 216(a). It would be very difficult to maintain a critical mass of staff with expertise in the care of frail, elderly patients in such a setting. Moreover, this would duplicate the function of the existing Community Nursing Home Program under which VA can pay for the care of Veterans placed in nursing homes in the private sector. VA contracts with more than 4,500 community nursing homes nationally and can add more as needed to assure Veterans' access to care.

Section 216(b) would authorize VA to award grants to tribal organizations for the construction or acquisition of state homes in the same manner and under the same conditions as grants awarded to States subject to exceptions prescribed by VA to take into account the unique circumstances of tribal organizations. This provision would require VA to give priority to grant applications from tribal organizations that had not previously applied for a grant even if the State in which the tribal organization was located had previously applied for (or received) a grant.

VA also opposes Section 216(b). The proposal would disenfranchise the states for which the construction grant program was expressly established since priority for awarding of grants is prescribed in statute and regulation. The first priority is for renovations necessary to protect the lives and safety of Veterans residing in the home. The second priority is for grants to states, or under this provision, tribal entities, that have *never previously* received a grant from this program. Since every state has received a grant and no tribal entity ever has, all construction and renovation applications from tribes would take precedence over all applications from states, except for life safety grants, until all tribal entities that wished to submit applications had done so. Since there are more 500 recognized tribal entities, it could be years before states are again able to receive

grants other than life safety grants, and even then they would have to compete with more than 500 eligible applicants instead of the 50 states and a few territories now eligible for the grants. The radical change being proposed would be detrimental to the states for which this program was specifically established.

VA estimates the cost of Section 216 to be $2.6 million for the first year, $14.2 million over five years, and $31.5 million over ten years.

Section 217 would require the Secretary to carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans enrolled for VA health care pursuant to section 1705 of title 38 and survivors or dependants enrolled for care under section 1781 of title 38 (CHAMPVA). Under this plan, VA would manage and administer a group dental plan. VA opposes section 217 as this provision would establish an entirely new and dramatically different role for VA.

Section 301 of this bill corresponds to section 101 of S. 597, another bill on today's agenda. This section would require VA to contract with a qualified independent entity or organization to carry out a comprehensive assessment of the barriers encountered by women veterans seeking comprehensive health care from VA, building on the VA's own "National Survey of Women Veterans in Fiscal Year 2007-2008" (National Survey). Many requirements related to sample size and the scope of the survey would apply to the conduct of the assessment. Section 301 would also require the contractor-entity to conduct research on the effects of the following concerns on the study participants:

- The perceived stigma associated with seeking mental health care services.
- The effect of driving distance or availability of other forms of transportation to the nearest appropriate VA facility on access to care.
- The availability of child care.

● The acceptability of integrated primary care, or with women's health clinics, or both.

● The comprehension of eligibility requirements for, and the scope of services available under, such health care.

● The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.

● The gender sensitivity of health care providers and staff to issues that particularly affect women.

● The effectiveness of outreach for health care services available to women veterans.

• The location and operating hours of health care facilities that provide services to women veterans.

● Such other significant barriers identified by the Secretary.

Additionally, section 301 would require the Secretary to ensure that the heads of the Center for Women Veterans and the Advisory Committee on Women Veterans review the results of the comprehensive assessment and submit their own findings with respect to it to the Under Secretary for Health and other VA offices that administer health care benefits to women veterans.

The results of our National Survey will not be available until later in the fiscal year. Consequently, we do not think it feasible to enter into a contract for the mandated assessment and research until we have first had a chance to complete and fully analyze the results of the National Survey. Only in this way can the assessment and research adequately build on the National Survey and reliably augment, rather than duplicate, VA's efforts in this area. We estimate the cost of section 101 to be $3.5 million.

The next section, section 302, corresponds to section 201 of S. 597 and requires VA to develop a plan to improve the provision of health care services to women veterans. VA fully supports the evaluation and enhancement of care to women

veterans and initiated a planning and implementation program in September 2008. Consequently, this provision is unnecessary as the initiative is already underway.

Section 303 of S. 252 corresponds to section 102 of S. 597. This section would require VA to enter into a contract with an entity or organization to conduct a very detailed and comprehensive assessment of all VA health care services and programs provided to women veterans at each VA facility. The assessment would have to include VA's specialized programs for women with PTSD, homeless women, women requiring care for substance abuse or mental illnesses, and those requiring obstetric and gynecologic care. It would also need to address whether effective health care programs (including health promotion and disease prevention programs) are readily available to, and easily accessed by, women veterans based on a number of specified factors.

After the assessment is performed, the bill would require VA to develop an extremely detailed plan to improve the provision of health care services to women veterans, taking into account, among other things, projected health care needs of women veterans in the future and the types of services available for women veterans at each VA medical center. VA would then be required to report to Congress on the assessment and plan, including any administrative or legislative recommendations VA deems appropriate. What is unclear in the bill is whether the contractor-entity conducting the assessment would also be required to develop the follow-up "plan," as the terms of section 303 refer to the contractor's conduct of "studies and research" required by that section. VA supports section 303 only if the development of the mandated plan would be conducted by a contractor-entity. We estimate the total costs of this section to be $4,354,000 during the period of Fiscal Year 2010 through Fiscal Year 2012.

Section 304 corresponds to section 202 of S. 597. This provision would require the Secretary to establish a program for education, training, certification and

continuing medical education for VA mental health professionals furnishing care and counseling services for military sexual trauma (MST). VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based treatment. The provision would establish extremely detailed reporting requirements. VA would also have to establish education, training, certification, and staffing standards for VA health care facilities for full-time equivalent employees who are trained to provide MST services.

We do not support the training-related requirements of section 304 because they are duplicative of existing programs. In FY 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual four-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. VA has recently unveiled the MST Resource Homepage, a webpage that serves as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to section 304's requirement for staffing standards. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population, workload, staffing, and other capacity issues. Retaining this flexibility is essential to permit VA and individual facilities

to respond to changing needs and available resources. Imposition of national staffing standards would be an inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 305 would require VA, not later than six months after the date of enactment, to conduct a pilot program to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting to women veterans recently separated from service after a prolonged deployment. Participation in the pilot would be at the election of the veteran. Services provided under the pilot would include, for instance, traditional VA readjustment counseling services, financial counseling, information on stress reduction, and information and counseling on conflict resolution.

We are unclear as to the purpose of and need for this provision. The term "group retreat setting" is not defined, but we assume it could not include VA medical facilities or Vet Centers, as we could not limit Vet Center access to any one group of veterans. Moreover, it is important to note that many Vet Centers are already well designed to meet the individual and group needs of women veterans. We estimate that the cost of the pilot would be around $300, 000.

Section 306 mandates a report to Congress to ensure that health care needs of women are met and to assess whether there is at least one full-time Women Veterans Program Manager employed at each VAMC. This section is substantially similar to section 103 of S. 597. The report shall include an assessment of whether there is at least one full-time employee at each VA medical center who is a full-time women veterans program manager. VA does not oppose this provision but we believe it is unnecessary. VA is already reporting regularly on the employment of Women Veteran Program Managers. To date, 137 of the 144 positions have been filled as full-time employees. No additional funds would be required to submit this report.

Next, section 307 (and the corresponding provision in S. 597, section 204) would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. These requirements would apply to committee appointments made on or after the bill's enactment. We fully support section 307. These amendments would help both Committees to better identify and address the needs of their respective veteran-populations.

Section 308 would require the Secretary, commencing not later than six months after the date of enactment, to carry out a two-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of childcare they incur to travel to and from VA facilities for regular mental health services, intensive mental health services, or other intensive health care services specified by the Secretary. The provision is gender-neutral. Any veteran who is a child's primary caretaker and who is receiving covered health care services would be eligible to participate in the pilot program. The corresponding provision is in section 205 of S. 597.

VA is very cognizant of the veterans' needs for convenient access to health care; however, we oppose section 308 as this expansion would divert resources from direct medical care.

We support section 309, which would authorize VA to furnish health care services up to seven days after birth to a newborn child of a female veteran who is receiving maternity care furnished by VA if the veteran delivered the child in a VA facility or in another facility pursuant to contract for service related to such delivery. This provision corresponds to section 206 of S. 597. We estimate that

the cost would be $55.3 million the first year, $293.6 million over five years, and approximately $589.4 over ten years.

VA supports Section 401, which would make members of the armed forces who serve in Operation Enduring Freedom or Operation Iraqi Freedom eligible for counseling and services through Readjustment Counseling Service, but we are concerned with the precedent that would be established by providing disparate eligibility to veterans of different conflicts. Under this provision active duty combat veterans of OEF/OIF would have access to Vet Centers for counseling and related mental health services and behavioral health services, including substance abuse assessment, counseling, and referral. Active duty veterans of the Persian Gulf War or other prior or subsequent combat would not have access to those services. Providing these services to active duty OEF/OIF personnel would cost approximately $3.7 million in the first year, $19.8 over five years, and $44.1 million over ten years. DoD has reimbursed VA for services provided to active duty members; however, we have not yet discussed the funding of this provision or possible reimbursement rates with DoD for readjustment counseling services.

Until 1996, VA had specific statutory authority to refer ineligible veterans to non-VA resources and to advise such individuals of the right to apply for review of the individual's discharge or release. VA supports Section 402, which would reinstate these provisions. Reinstatement of these provisions would give the Vet Centers the latitude to help Veterans with problematic discharges with problems deemed by Vet Center staff to be related to war trauma, through referral to services outside the VA and/or referral for assistance with discharge upgrades when appropriate. The total number of Veterans this provision would affect is assumed to be small so the costs of this provision would be negligible.

VA opposes Section 403, requiring VA to conduct a study to determine the number of Veterans who have committed suicide between January 1, 1997, and

the date of the bill's enactment. VA opposes conducting the study because other information, more valuable in guiding VA's strategy for suicide prevention, is already available and is continually being refined through other research and data collection efforts. Moreover, we do not believe that the new requirement would yield any additional information of significant value.

Rates and counts of deaths from suicide are available from 2000 onward for Veterans who utilized the VHA Health Care System. In addition, they are available on specific cohorts of Veterans including those who served in OEF/OIF and in the first Persian Gulf War, whether or not they utilize VHA health care services. Finally, they are available on all individuals identified at the times of their deaths as Veterans by their families in the sixteen states that participate in the Centers for Disease Control and Prevention's National Violent Death Reporting System. VA estimates that the overall cost for conducting such a study would be $2,356,000 in FY 2010 and $7,224,000 over five years.

VA is opposed to Section 404, which would transfer $5 million from VA to the Department of Health and Human Services (HHS) by the end of FY 2010 for a graduate psychology education (GPE) program. This transfer of funds to the GPE Program would reduce funding available for VA programs or services without any clear benefit to VA in exchange for those services. VA much prefers to target these funds to increasing internship and post-doctoral training positions within VA facilities. VA already supports 435 Psychology internship positions in 90 different programs and 200 postdoctoral fellowship programs in 54 programs. Thus we already provide the "training of psychologists in the treatment of Veterans with post traumatic stress disorder, traumatic brain injury, and other combat-related disorders" that this legislation aims to achieve. Assuming that this $5 million would become a recurring transfer of funds, the estimate over ten years is $50 million.

Sections 501 and 502 of S. 252 would authorize VA to conduct two five-year pilot grant programs under which public and non-profit organizations (including faith-based and community organizations) would receive funds for coordinating the provision of local supportive services for very low income, formerly homeless veterans who reside in permanent housing. Under one of the pilot programs, VA would provide grants to organizations assisting veterans residing in permanent housing located on military property that the Secretary of Defense closed or slated for closure as part of the 2005 Base Realignment and Closure program and ultimately designated for use in assisting the homeless. The other pilot program would provide grants to organizations assisting veterans residing in permanent housing on any property across the country. Both pilot programs would require the Secretary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

The 2005 Base Realignment and Closure process has been completed and local plans have already been developed. Therefore the new authority as proposed in section 501 would be ineffective. Further, the Veterans Mental Health and Other Care Improvement Act of 2008, Public Law 110-387, Title VI, Section 604 provided authorization for VA to facilitate the provision of supportive services for very low income veterans for veteran families in permanent housing. VA is in the process of writing regulations and hopes to offer funding later this year. Section 604 allows VA to effectively aid veterans better than either of the two pilots. We respectfully suggest that the two pilots are no longer needed and believe that the supportive services grants under PL 110-387 which this Committee approved last year to be a more effective way to assist veterans.

Section 503 of S. 252 would require that VA establish a pilot program for financial support of entities that provide outreach to inform certain veterans about pension benefits. To this end, the bill would provide VA with additional authority to make grants to public and non-profit organizations (including faith-based and

community organizations) for purposes of providing outreach to inform low-income and elderly veterans and their spouses residing in rural areas about potential eligibility for VA pension. The bill authorized the expenditure of $1,275,000 from General Operating Expenses (GOE) in each of fiscal years 2010 through 2014. Although VA supports the intent of Section 503 of S. 252, we oppose the bill because it duplicates ongoing outreach efforts by VBA to conduct outreach to low income and elderly veterans and their spouses and dependents. If this legislation is enacted, VA would need additional GOE to administer the pilot program and to train the public and non-profit organizations to accurately discuss VA benefit programs.

VA's outreach efforts to elderly veterans and their survivors include several approaches. We have provided the Social Security Administration with our pamphlet *Federal Benefits for Veterans and Dependents.* Additionally, we have participated and will continue to participate in the annual conference of the American Association of Retired Persons (AARP). This year VA will participate in the National Convention of the Association of Directors of Assisted Living Facilities. From January 2008 to January 2009 the number of veterans receiving disability pension declined about two percent or less than 7,000 veterans. That decline can be almost entirely accounted for by the decline in the number of World War II veterans receiving pension. The decline in this population accounted for 85 percent of the decline. The Vietnam Era veteran population is only now reaching age 65 where entitlement exists based on age. We expect their participation in the pension program to rise. With respect to survivor pension, the number of widow(ers) on the rules has increased 5,924 or 7.2 percent over the same January to January period. In light of the significantly lower allowable income limits for survivors, this rise is primarily attributable to entitlement being established as a result of high medical expenses. The rise is reflective of our work with social security and AARP and soon with the assisted living organizations.

Section 504 of the bill would authorize a 3-year pilot program to assess the feasibility of providing grants to public or nonprofit organizations as a means of providing expanded services to veterans participating in vocational rehabilitation programs under chapter 31 of title 38, United States Code. Under this program, VA would provide financial assistance through grants to public or nonprofit organizations that would then establish new programs or activities, or expand or modify existing programs or activities, to provide assistance to veterans participating in vocational rehabilitation programs under chapter 31. The type of assistance to be provided includes transportation, childcare, and clothing to facilitate participation in a vocational rehabilitation program or related activity. The pilot program would be used to assess the feasibility of providing such expanded services to veterans through these types of grants.

VA supports efforts to facilitate successful completion of vocational rehabilitation programs under chapter 31. However, VA does not support the use of grant programs to achieve this objective. The administrative burden associated with creating and administering such a grant program would be prohibitive, particularly since VA must continue to monitor grantee's activities to ensure alignment with VA program objectives and each program participant's individual rehabilitation plan. VA personnel already use existing systems to process direct reimbursements to veterans for authorized, necessary costs associated with participation in their specific vocational rehabilitation programs. VA believes that, subject to the availability of funding for the purpose, any incentive programs to facilitate completion of vocational rehabilitation programs should be built onto existing VA reimbursement authorities.

The Department would be authorized $5 million from the amounts available in VA's GOE account in each of fiscal years 2010 through 2012 to carry out section 504 of this bill.

Section 505 would require that not less than one year before the expiration of the authority to carry out the pilot programs established under section 501 through 504, VA would submit a report to Congress including the following: lessons learned, recommendations on whether to continue such pilot program, the number of veterans and dependents served by such pilot program, an assessment of the quality of service provided to veterans and dependents, the amount of funds provided to grant recipients, and the names of organizations that have received grants.

VA supports sections 601 to section 606 of Title VI, which would update and clarify provisions of P.L. 100-322 authorizing VA-affiliated Nonprofit Research Corporations (NPCs). Title VI promulgates revisions that will allow the NPCs to better serve VA research and education programs while maintaining the high degree of oversight applied to these nonprofits. There are no added costs associated with Title VI. VA supports Title VI.

Subsection (a)(1) of section 701 of the bill would amend section 902(a) of title 38, U.S.C., so as to permit VA police officers to: (1) carry VA-issued weapons, including firearms, while off VA property in an official capacity or while in official travel status; (2) conduct investigations, on and off VA property, of offenses that may have been committed on VA property, consistent with agreements with affected local, state, or Federal law enforcement agencies; (3) carry out, as needed and appropriate, any of the duties described in section 902(a)(1), as revised, when engaged in such duties pursuant to other Federal statutes; and (4) execute any arrest warrant issued by a competent judicial authority. Subsection (a)(2) of section 701 would further amend section 902 of title 38 to specify that the powers granted to VA police officers be exercised in accordance with guidelines approved by the Secretary and the Attorney General of the United States. VA will work with the Department Justice to formulate our views on this proposed legislation. We will submit our views at a later date.

Section 702 of the Committee bill would amend section 903(b) of title 38, U.S.C., which governs the uniform allowance for VA police officers, to limit the allowable amount to the lesser of: (1) the amount prescribed by the OPM; or (2) the estimated or actual costs as determined by periodic surveys conducted by VA. The provision would also amend section 903(c) of title 38 to provide that the allowance established under subsection (b) of section 902 of title 38, as modified by the Committee bill, shall be paid at the beginning of an officer's appointment for those appointed on or after October 1, 2008, and for other officers at the request of the officer, subject to the fiscal year limitations established in subsection (b), as modified by the Committee bill.

VA supports these provisions. Under current section 903, uniformed Department of Veteran Affairs Police are paid $400 for an initial uniform allowance, and then $200 annually throughout their careers. This is a marginal amount and does not cover the actual costs of uniforms and equipment required by the Department for our officers. VA Police officer uniforms are required by the Department and purchased by the officers using the statutorily authorized allowance. These amounts were last updated in 1991. Our Police Officers generally have to reach into their own pockets to supplement both the initial purchases and annual upkeep.

The Office of Personnel Management (OPM) published new regulations in the Federal Register that increase the authorized uniform allowance amount up to $800 initially and $800 annually. Section 702 would allow the Department to occasionally review and increase initial allowances up to the OPM-authorized maximum, if that is necessary.

The Department requires that all VA police officers present an image of professionalism and authority. Authorizing an updated uniform allowance will help to achieve that. We also note that uniform allowances are a recruiting tool.

We estimate costs at $1.58 million for one year, $6.5 million for five years, and $16.82 million for ten years.

S. 362 "Repeal of Exceptions to Rights of Certain Department of Veterans Affairs Employees to Engage in Collective Bargaining"

S. 362 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. More specifically, it would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines concern the professional conduct or competence, peer review, or compensation of Title 38 employees. Lastly, the bill imposes an unrealistic and unworkable time limit on certain grievance appeals. VA strongly opposes this provision.

Our concern with this bill is its potential to adversely impact VA's ability to deliver quality patient care. While we appreciate the many positive contributions collective bargaining and labor-management partnership make to VA's mission, VA strongly opposes S. 362, which, if enacted, would imperil VA's ability to furnish timely and quality care for veterans. S. 362 would transfer VA's Title 38 specific authorities, namely the right to make direct patient care and clinical competency decisions, assess Title 38 professionals' clinical skills, and determine discretionary compensation for Title 38 professionals, to independent third-party arbitrators and other non-VA, non-clinical labor third parties who lack the clinical training and health care management expertise to make such determinations. While S. 362 would result in a host of untenable situations, we limit our comments here to the most significant problems raised by the legislation.

First, the rules for collective bargaining often lead to protracted negotiations and third-party proceedings. On average, it takes 60 days to negotiate national MOUs with AFGE, which does not include local-level bargaining which can take

as long as 30 to 60 days. While this is acceptable for most workplace matters, it is not when it comes to providing quality patient care. If this bill were enacted, critical changes in patient care (e.g. new, mandated training on care of traumatic brain injury or extended hours for mental health facilities) could not be implemented until after national and local bargaining had been completed. This would very likely result in veterans' experiencing delays or gaps in their receipt of needed clinical care or services. Indeed, we foresee the situation where a VA facility is not able to change the standards requiring 24-hour assessments of patients without first engaging in collective bargaining, even though immediate patient care concerns are the cause for the change. Such delays and the very practice of negotiating clinical matters would be an anathema to patient-centered medicine.

Second, S. 362 would allow Title 38 professionals to grieve matters or file Unfair Labor Practice grievances on clinical matters currently exempted from collective bargaining. If a grievance were not resolved at the informal stage, it would go to a third party arbitrator for decision. Labor grievance arbitrators and the Federal Service Impasses Panel would have considerable discretion to impose a clinical or patient care resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of the clinical or patient care issue. VA would be bound by that third-party's decision. As a provider, this is wholly unacceptable. VA clinicians need to make the clinical decisions involving their patients to ensure care is furnished in compliance with VA and prevailing medical practice standards.

Moreover, these decisions should not be made by a non-clinical third party who is not accountable for ensuring the health and safety of the veterans receiving their care through the Department. If the Secretary and the Under Secretary for Health are going to be held responsible and accountable for the quality of care provided to veterans, it is they who must be able to determine which matters affect that care. They must be able to establish standards of professional

conduct for, and competency of, our clinical providers based on what is best for Veterans from a medical perspective rather than what is the best that can be negotiated through collective bargaining or based on what a non-clinical arbitrator or FLRA judge decides is appropriate. At the least, because the third-party's final decision on a clinical matter would be imposed on VA, the relevant union should be held accountable and liable, along with the Department, for any adverse patient outcomes resulting from the decision.

Additionally, S. 362 would adversely affect patient care and safety by permitting Title 38 providers to file grievances based on changes made in their shifts (e.g., whether or not to utilize compressed work schedules) that are needed to maximize providers' skills and best meet patient care needs. VA needs the ability to quickly change shift assignments to meet patient needs that cannot be anticipated. Shift changes may also be necessitated by a medical emergency. However, S.362 would permit the union to submit a proposal to define what constitutes emergency situations, limiting situations when VHA could schedule staff, such as RNs, to work longer than 12-hour shifts. In such a case, the impact on patient care would be four-fold:

- By imposing a collectively bargained-for definition of "emergency," the proposal would open to grievance and arbitration any management determination that a nurse should work beyond 12 hours to meet emergent patient care needs;
- It would effectively prohibit management from determining that an emergency exists when the specific limitations of the bargained-for definition are not met;
- It could delay adequate nurse staffing for the affected unit, leave the unit under-staffed for the entire tour, or force VA into procuring expensive contract care that may not equal that of VA employees; and,
- It would place limitations on management's ability to mandate a particular nurse, with personal professional qualifications that

render him/her the preferable or necessary patient care provider under the circumstances, to work in an emergency, directly impacting patient care.

It is even foreseeable that the union could submit a proposal empowering RNs to be able to refuse mandatory overtime in excess of 12 hours, even if based on critical patient needs. This would effectively prohibit VA from taking any disciplinary action against an RN who refused to work more than 12 consecutive hours. If no RN agreed to work longer than 12 hours on a particular unit, then the unit would be left short-staffed, or VA would need to procure expensive contract care that may not equal that of VA employees, either of which would adversely impact patient care. This is not to say, however, that any changes in shift assignments at the facility level are invariably clinical care matters excepted from collective bargaining. We are committed to ensuring that changes in staffing are not the result of any facility's failure to make adequate staffing plans to meet their foreseeable, projected, and routine patient workloads.

We cannot underscore enough that veterans would find little solace in learning that their care was delayed or denied because of our statutory obligation to first participate in collective bargaining with the unions on a clinical matter related to their care (including staffing), particularly if their medical situation leads to grave consequences. Nor could our veteran-patients be expected to understand why their VA providers—a coterie of highly qualified, trained, and trusted professionals-- have no option but to follow the decisions of third-parties with whom they disagree. This would be particularly hard for them to accept when the final arbiter is a stranger to patient and provider alike and otherwise completely uninvolved in the patient's care.

S. 362 would also thwart VA's ability to immediately re-assign staff from direct patient care duties to administrative duties based on an allegation that the staff committed patient abuse or posed some other danger to patient safety. Until

such serious allegations can be properly investigated, the only reasonable action VA can take to protect patients is to immediately remove that staff member from direct patient care duties. Under the bill, however, such staff reassignments would be subject to negotiations, as staff would be able to grieve them. Such decisions should not be left to arbitrators, who lack any clinical training and who have no responsibility for providing healthcare.

Another example of the problems raised by this legislation concerns VA's Peer Review process, which VA uses to assess the clinical skills of our Title 38 professionals and also to assess whether our patients received the high-standard of care they deserve. The Peer Review program is now expressly exempted from collective bargaining under section 7422. S. 362 would change that, permitting non-VA, non-clinical third-parties to assess the clinical skills of our Title 38 professionals and determine whether they are clinically competent in their area of practice. This would be an absurdity were it not such a serious threat to our patients' welfare.

In addition to clinical-care issues, S. 362 would also result in unprecedented changes in how the Federal Government operates. It would permit unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the determination of the amount of an employee's compensation. Permitting Title 38 staff to negotiate the discretionary aspects of their compensation would simply be at odds with how other Federal employees are treated. Such inequitable treatment among Federal employees cannot be justified.

By significantly changing VA's collective bargaining obligations, S. 362 would also adversely impact VA's budget and management rights. It would also skew towards a slippery slope the current balance maintained between providing beneficial working conditions for Title 38 professionals and providing quality

patient care services that are timely and that meet, if not exceed, the diverse, and often complex, medical needs of our veterans.

Congress purposefully left it to the Secretary's discretion to decide which matters would be excluded from collective bargaining. In so doing, Congress implicitly acknowledged that our large, dynamic health care system should not permit real-time clinical decisions and clinical management decisions to be decided through the collective bargaining process. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. Since 1992, there have been no more than 17 decisions issued by the Under Secretary in a one-year period. This means that very few section 7422 grievances have been filed and pursued by employees up to the Under Secretary level. This is particularly striking given the number of VA healthcare facilities and bargaining unit employees at those facilities.

In fact, our data reflect that, on the whole, our efforts to recruit and retain health care professionals (particularly nurses) have been widely successful notwithstanding the exceptions from collective bargaining now provided for by section 7422. We are glad to share our data with the Committee and brief the members on our continuing efforts in this area.

In view of the foregoing, we strongly oppose this legislation. Although we appreciate the valuable role the unions can play on behalf of their members, this bill would give them bargaining rights on clinical care matters that would clearly and foreseeably endanger the well-being of our veteran-patients.

In addition, section 2 of the bill, a proposed new section 7463(f)(1), would impose a requirement for VA to decide grievance appeals no later than sixty days after the grievance is filed. In many cases however, the grievance examiner's review could take most or all of those sixty days, leaving no time for a review of, and decision on, the examiner's findings and recommendations called for in section

7463(d)(3). If the Committee does not forebear in its consideration of S. 362, we suggest that provision of the bill be modified to (1) amend section 7463(d)(2) to impose a 120-day time limit for the examiner's review and recommendations, and (2) to amend 7463(d)(3) to impose a 60-day time limit for that section's review and decision on the examiner's findings and recommendations.

Finally, section 3 of the bill would amend the Disciplinary Appeals Board statute to require the provision of a transcript to the employee three weeks before the submission of post-hearing briefs. We think this unnecessarily constrains the time for DABs to consider their decisions, which must be rendered within 45 days of the DAB hearing and no later than 120 days after commencement of the appeal. In fact, there may be instances where it will be impossible to provide the three weeks and meet the 120-day time limit.

In sum, VA's ability to manage its healthcare facilities and to monitor the professional conduct and competence of its employees are management actions that must be reserved for the VA professionals responsible for delivering quality patient care.

S. 404 "Veterans' Emergency Health Care Fairness Act of 2009"

VA supports S. 404, the "Veterans' Emergency Care Fairness Act." This bill would expand Veteran eligibility for reimbursement by VA for emergency treatment furnished in a non-VA facility. Under current law, VA is a payer of last resort. Consequently, a Veteran who would otherwise be eligible for reimbursement or payment of private emergency medical expenses is ineligible for the benefit because a third party makes partial payment toward the Veteran's emergency treatment expenses pursuant to other contractual or legal recourse available to the Veteran. In these cases, Veterans are often left with sizeable medical debts for which they are personally liable. VA payment as secondary payer would fully extinguish the Veteran's liability to the private provider who furnished the emergency treatment.

It is difficult to cost this proposal without extensive data on Veterans' personal liability for non-VA emergency care expenses. We have estimated the cost based on the average payment made by VA for unauthorized non-VA emergency treatment of Veterans' non-service connected disabilities. We estimate the cost of implementing this draft bill to be $500,000 for FY 2010, $3 million over a 5-year period, and $7.8 million over a 10-year period.

S. 423 "Veterans Health Care Budget Reform Act"

S. 423 would authorize advance appropriations for certain medical accounts of the Department by providing two-fiscal year budget authority. Mr. Chairman, we know that Congress and the Administration share the same objective – to ensure VA delivers timely, accessible, and high-quality care that Veterans expect and deserve. On April 9, 2009, the President emphasized that care for Veterans should never be hindered by budget delays and expressed support for advanced funding for Veterans' medical care. We believe that advanced funding will ensure that sufficient resources are available from the first day of the fiscal year so that the health care needs of Veterans can be provided on a timely basis. We look forward to working with Congress to make advanced funding for VA health care a reality.

S. 509 "Authorize a major medical facility project at the Department of Veterans Affairs Medical Center, Walla Walla, Washington."

S. 509 would authorize a major medical facility project at the VA Medical Center in Walla Walla, Washington, in an amount not to exceed $71,400,000. The project includes construction of a new multi-specialty outpatient clinic, campus renovations and upgrades, as well as additional parking. Mr. Chairman, funds for this project were appropriated last year in PL 110-329. We support this bill.

S. 543 "Veteran and Service-Member Caregiver Support Act of 2009"

Mr. Chairman, S. 543 describes a pilot program to train, certify and pay family caregivers for care provided to an eligible veteran or service member. There are similarities between this provision and the previously described section 209 of S. 252, which would also establish a pilot program for family caregivers, but there are also some significant differences. While S. 252 pertains specifically to veterans or service members with traumatic brain injury, the eligibility criteria set forth in S. 543 would authorize a much larger and less well-defined population. In addition, S. 543 differs in the duration and location of the pilot programs and also authorizes the inclusion of private facilities in the pilot. S. 543 provides more specificity concerning eligibility of family members, veterans and service members, and is more proscriptive in describing the development of the curriculum. It also sets forth a detailed mechanism for determining amounts paid to family caregivers. Another provision in the bill directs the Secretary to review VA respite care programs, identify options for enhancing respite care and enhance the availability of such care. The bill also directs the Secretary to collaborate with the Secretary of Defense to develop a pilot program to make certain counseling and social services available to each eligible family caregiver participating in the pilot program.

The concerns we identified with section 209 of S. 252 also apply to this pilot program. VA currently contracts for caregiver services with home health and similar public and private agencies. The contractor trains and pays the family member, affords them liability protection, and oversees the quality of their care. As previously noted, this arrangement is preferable because it does not divert VA from its primary mission of treating veterans and training clinicians.

VA does not oppose the intent of the subsection of this bill addressing respite care but believes that it is unnecessary. VA already has a comprehensive respite care program that provides Veterans with short-term services to give the caregiver a period of relief from the demands of daily care for the chronically ill or

disabled Veteran or active duty service member. Respite care services are planned in advance for the benefit of the caregiver in conjunction with the necessary medical care of the patient. As noted earlier with regard to section 210 of S. 252, Veterans are entitled to 30 days of respite care a year in inpatient, community, or other settings.

VA has two pilot programs underway to expand respite services. VA Voluntary Services (VAVS) is establishing and operating a community-based volunteer home respite program to benefit Veterans and their primary caregivers. Respite services provided through VAVS are in addition to the 30 days of respite care per year. This program is underway at ten VA medical centers. A caregiver assistance pilot program is also underway to provide 24-hour in-home respite care at two VA medical centers. Additionally, every Veteran and caregiver has access to a VA social worker who provides an assessment of individualized needs of the family caregiver with respect to the family member's role as a caregiver, assistance with the development of a plan for long-term care of the Veteran, and implementation of a treatment plan.

S. 597 "Women Veterans Health Care Improvement Act"

S. 597, is nearly identical to sections 301 through 309 of S. 252. The views expressed regarding those sections are also applicable to the provisions in S. 597.

S. 658 "Rural Veterans Health Care Improvement Act of 2009"

S. 658 contains several sections. I will address each section separately.

Section 2 would establish the beneficiary travel allowance for mileage at a rate of 41.5 cents per mile. It would also require the Secretary amend the VHA Handbook to clarify that the allowance for mileage may exceed the cost of public transportation. VA does not oppose this provision but believes that it is unnecessary. VA currently reimburses beneficiary travel mileage at 41.5 cents

per mile. Public Law 110-387 gave the VA Secretary authority, based on availability of funds, to prescribe a rate higher than the federal employee rate and, using this authority, the Secretary raised the mileage reimbursement rate to 41.5 cents per mile effective November 17, 2008. S. 658 would also remove the Secretary's authority to adjust the mileage reimbursement rate when it is determined that such change is appropriate.

Section 3 directs VA to establish at least one and no more than five, geographically dispersed centers of excellence for rural health research, education, and clinical activities. VA opposes this legislation because proposed centers of excellence are duplicative of the Veterans Rural Health Resource Centers (VRHRCs) that were established to improve care and services for veterans residing in geographically isolated areas. Provisions within this section are also duplicative of efforts of VA's Veterans Rural Health Advisory Committee which was established to examine ways to enhance VA health care services for Veterans in rural areas by evaluating current programs and identifying barriers to health care. We estimate the cost of Section 3 to be $2 million in the first year, $10.8 over five years, and $23.8 million over ten years.

Section 4 would require the Secretary to establish a grant program for State veterans' service agencies and Veterans Service Organizations to provide innovative transportation options to veterans in rural areas. VA supports this provision. Section 4 authorizes appropriations of $3,000,000 annually for fiscal years 2009-2013.

Section 5 would require the Secretary to create demonstration projects through partnerships with the Department of Health and Human Services and the Indian Health Service to examine the feasibility and advisability of alternatives for expanding care for Veterans in rural areas. VA does not support this provision as it is duplicative of pilot programs that are required under Section 107 and Section 403 of Public Law 110-387. Section 107 of that law requires VA to

establish pilot programs in rural areas to use contracted community health centers, the Indian Health Service, or other appropriate entities to provide peer outreach, peer-to-peer counseling, readjustment counseling, and other mental health services to Operation Enduring Freedom and Operation Iraqi Freedom Veterans. The enactment of section 403 requires VA to establish a pilot program under which VA provides health services to highly rural Veterans through qualifying non-VA health care providers. Overall, we estimate that the demonstration projects outlined in Section 5 would cost **$**4.4 billion over three years.

Section 6 directs the Secretary to establish a program to provide peer outreach services, peer support services, readjustment counseling services, and mental health services to Veterans of Operation Enduring Freedom and Operation Iraqi Freedom, particularly those who served while in the National Guard and Reserves. This section would also provide the Secretary the authority to contract with community mental health centers and other entities to provide services in areas not adequately served by Department facilities. VA opposes this section as it would blur the fundamental distinction between the readjustment counseling services and mental health services currently provided by the Department. These services are authorized by separate authorities and employ different eligibility criteria. Moreover, they should not be combined as they are conceptually and operationally very distinct areas of treatment.

Readjustment counseling is a special community-based counseling service that goes beyond medical care to provide combat veterans services needed to facilitate a successful readjustment to civilian life. VA's authority to furnish readjustment counseling services already includes the authority to furnish limited mental health services necessary for effective treatment of the veteran's readjustment issues. Vet Centers, for example, provide professional treatment for combat-related PTSD, depression, and substance abuse and, if necessary, refer the veteran to VA facilities for treatment of additional or more complex

mental health needs. In contrast, comprehensive mental health services are furnished as medically needed to all enrolled Veterans, regardless of combat status, as part of VA's standard medical benefits package.

VA currently contracts for readjustment counseling and related readjustment services with private sector community mental health agencies and other professional entities. Most of these contract providers are located in rural areas. Similarly, VA has authority to contract for mental health services for enrolled Veterans if VA cannot provide needed services in a timely manner. In this regard, section 6 is duplicative of existing contract authorities and ongoing activities.

Vet Centers also provide veteran-peer outreach and counseling. In 2004, VA began an aggressive outreach effort, which included hiring theater of combat OEF/OIF Veterans to provide outreach services and peer counseling to their fellow veterans. To date, the Vet Center program has hired 100 OEF/OIF outreach workers. In addition, the program has seen a significant expansion of its resources. Starting from a total of 206 Vet Centers in fiscal year (FY) 2006, there are now 232 Vet Centers, and another 39 planned to be operational by the end of FY 2009. Funding to support all of the Vet Center program initiatives is included in the program's annual operating budget.

Section 7 would establish an "Indian Veterans Health Care Coordinator" at the 10 medical centers which serve the greatest number of Indian veterans to improve outreach to tribal communities, coordinate medical needs with the Indian Health Service, expand access and participation in the Veterans Affairs Tribal Veterans Representative program, and advocate on behalf of Indian veterans. This section would also require the integration of electronic health records between VA and the Indian Health Service and would permit the Secretary to transfer medical and IT equipment to the Indian Health Service.

VA does not support Section 7 because the agency is already providing support to American Indian Veterans, primarily through our rural health initiatives. VA encourages cooperation and resource sharing between the Indian Health Service and VHA to deliver quality health care services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans. VA also maintains the VISN Tribal Veterans Representative (TVR) Program, which provides outreach and open communication to veterans in extremely rural and underserved areas, especially the AI/AN and Hawaiian Native (HN) populations. The VISN TVR program trains individuals on outreach techniques to assist, facilitate and encourage veterans to access their full range of earned VA benefits. Multiple agencies use VA's VISN TVR outreach services including the Indian Health Service, Tribal Health Services, Community Health Centers and veterans' service organizations. VA estimates the cost of the provisions in Section 7 at $985,000 in the first year, $5.3 million over five years, and $11.6 million over ten years.

Section 8 would require the Secretary to provide an annual report to Congress on matters related to care for Veterans who live in rural areas. VA is not opposed to this reporting but we believe it is unnecessary. VA already provides a number of periodic reports to Congress on the status of rural and highly rural Veterans. For example, Public Law 110-329 requires that the Secretary of the Department of Veterans Affairs report quarterly to the Congress on new rural health initiatives implemented through appropriations funding. The Office of Rural Health also provides regularly recurring reports to the SVAC and HVAC.

S. 669 "Veterans 2nd Amendment Protection Act"

S. 669 would clarify the conditions under which certain persons may be treated as adjudicated mentally incompetent for certain purposes. Pursuant to section 103(e)(1) of the Brady Handgun Violence Prevention Act (P. L. 103-159), VA is required to provide the Department of Justice (DOJ) with information concerning individuals who, due to a determination by VA, are prohibited from purchasing or possessing firearms under the standards imposed by 18 U.S.C. § 922(d)(4) and

(g)(4), which prohibits the purchase or possession of firearms by any person "adjudicated as a mental defective." Under existing DOJ regulations, the phrase "adjudicated as a mental defective" includes persons found to be a danger to themselves or others and persons found to lack the mental capacity to manage their own affairs. Pursuant to those requirements, VA's Veterans Benefits Administration (VBA) currently provides DOJ with information on persons adjudicated by VA under 38 C.F.R. § 3.353, as lacking the mental capacity to contract or manage their own affairs. This information is then included in databases managed by DOJ's Federal Bureau of Investigation and Bureau of Alcohol Tobacco and Firearms, and serves to prevent, through the National Instant Criminal Background Check System, prohibited individuals from purchasing firearms.

S. 669 would provide that a person VA finds to be mentally incapacitated, mentally incompetent, or experiencing an extended loss of consciousness "shall not be considered adjudicated as a mental defective" for purposes of 18 U.S.C. § 922(d)(4) and (g)(4), unless a "judge, magistrate, or other judicial authority of competent jurisdiction" concludes that the individual is a danger to himself or herself or to others." This amendment would revise the reporting requirements contained in title 18 of the United States Code, by adding additional prerequisites to the reporting by VA to DOJ, of information pertaining to persons VA adjudicates as incompetent. VA takes no position on this bill at this point as the Administration is still working with the Department of Justice to formulate views.

S. 734 "Rural Veterans' Health Care Access and Quality Act of 2009"

I will address individually the several sections of S. 734.

VA opposes Section 2, which would remove the current cap for the Education Debt Reduction Program (EDRP) and would cover the full cost of the principal and interest owed by participants. This section could result in significantly higher

awards, but would mean significantly fewer people could participate. Moreover, EDRP is a reimbursement program, meaning that VA provides awards to employees at the end of the year covering their out-of-pocket payments on their loans. In many situations, employees would be unable to bear the cost of higher per year awards. For example, an individual with a $150,000 loan would have to pay $30,000 on their own before VA could reimburse them at the end of the year. We also note by removing the cap on loan repayment awards, VA's programs would be inconsistent with other student loan repayment or reimbursement programs in the federal government. Moreover, this bill does not eliminate the 6-month eligibility requirement and thus does not improve the retention value of EDRP. VA estimates section 2 would cost $9.7 million in FY 2010, with a five-year total of $145.9 million and a ten-year total of $389.2 million.

Section 3 proposes to transfer $20 million to the Department of Health and Human Services to include VA among the list of facilities eligible for assignment of participants in the National Health Service Corps Scholarship Program. VA believes that participation in this program would help attract high caliber research-focused candidates to VA; however, we believe that VA funding would be better spent supporting our current recruitment and retention initiatives, such as the Employee Debt Reduction Program, the Employee Incentive Scholarship Program, or the Health Professionals Educational Assistance Scholarship Program, which would be resumed under section 103 of S. 252.

Section 4 of S. 734 would require the Director of the Office of Rural Health (ORH) to develop a five-year strategic plan. VA does not oppose this provision but believes it is unnecessary. The ORH is already developing a national strategic plan and has informed Congress of it's planning process. The plan under development will exceed the requirements of the bill by enabling ORH to focus on six key areas: access, technology, quality, education and training, collaborations, and workforce recruitment and retention. Additionally, the national ORH strategic plan will meet ORH's mission requirements, which are to

promulgate policies, best practices and innovations to improve health care services to Veterans who reside in rural and highly rural areas, while undertaking ongoing initiatives to find better health care solutions and improving overall access. This national strategic plan will include specific goals for timely and quality access and incremental milestones for measuring the achievement of these objectives. Telehealth and telemedicine are important elements of these objectives and ORH will work in close collaboration with VHA's Office of Care Coordination Services to appropriately include this method of health care delivery. VA estimates there would be no significant costs associated with section 4.

Section 5 of S. 734 would permit VA to use paraprofessional volunteers and eligible volunteer counselors to support the mission of Vet Centers and outreach efforts. VA does not oppose section but believes it is unnecessary as VA already has the authority under 38 USC 513, 38 USC 7405, and VHA Directive 1620 (September 28, 2005) to use volunteers for these services to supplement, rather than replace, VA compensated staff. Additionally, these authorities permit volunteer assistance by physicians, dentists, nurses and other professionally licensed persons to assume full responsibility for professional services in their respective fields with the approval of the facility Chief of Staff, provided the volunteer is properly privileged and credentialed to perform such service and that any activities in which they engage are under the supervision of VA-compensated clinical staff. VA estimates there would be no significant costs associated with Section 5.

Because they are either unnecessary or redundant of current activities, VA does not support a number of the provisions in Section 6. This section would require VA to: (1) carry out a program of tele-consultation for the provision of remote mental health and traumatic brain injury (TBI) assessments; (2) carry out a program of tele-retinal imaging in each VISN, expanding the number of patients enrolled in such a program by five percent annually through FY 2015; (3) develop

in cooperation with affiliated universities an elective rotation in telemedicine for medical residents; and (4) modify the Veterans Equitable Resource Allocation (VERA) system to provide incentives for utilizing telehealth and to incorporate such consultations in facility workload data.

Regarding the first provision, VA has already implemented a national program to provide tele-consultation for remote mental health assessments. VA is currently undertaking a pilot of the remote assessment of TBI via tele-consultation in Denver. There are also clinical, technological, and business processes that need to be formalized before national implementation. We are working within VA and with external partners to establish technical and clinical care standards. The costs that would result from this proposal are insignificant.

VA similarly does not support the second provision concerning tele-retinal imaging. VA has already instituted tele-retinal imaging programs in each of the 21 VISNs. While VA's tele-retinal imaging program is currently growing by more than five percent each year, we do not want this requirement enacted into law because it is overly prescriptive. Advances in technology or clinical care within the next five years could produce a more effective approach to treatment, so a requirement to expand enrollment in one program that has been superseded by another would run contrary to the best interests of our Veterans. VA estimates this proposal would cost $455,000 in FY 2010 and would have a five-year cost of $2.5 million.

While VA supports the concept of expanding opportunities for medical residents to participate in telemedicine programs and to gain experience in these technologies, we oppose the provision in this bill that would require each facility involved in resident training to develop an elective rotation in telemedicine as it cannot be implemented. The curriculum in medical residency training programs is tightly regulated by the Accreditation Council for Graduate Medical Education, which does not approach specific delivery methods as separate from the

scientific curriculum. However, VA does provide opportunities for many residents to participate in telemedicine health care delivery and will continue to do so. There are no significant costs associated with this provision.

VA supports subsection 6(c) concerning enhancements of VERA. In the absence of appropriate VERA incentives to encourage VISNs and facilities to adopt telehealth, the expansion of telehealth can be delayed and in some cases faces disincentives when compared with other means of care delivery. This proposal would expand access to care in areas where telehealth can address unmet patient needs while reducing costs through home telehealth and tele-mental health. VA estimates no costs associated with this provision.

Section 7 addresses oversight of contracts and fee basis care. From a legal perspective, the provision 7(a) raises issues with regard to prohibited 'bundling' of contracts. 'Bundling' is combining two or more requirements previously performed under separate contracts and thus making it unlikely to be suitable for award to small businesses. Many VA Community-Based Outpatient Clinic acquisitions are set aside for small business. Our interpretation of "consolidate such contracts" would be to make a single contract whenever multiple contracts awarded to the same provider. Upon re-competition, VA would then necessarily advertise that combined requirement and that may make the requirement too large for a small business set-aside. Federal Acquisition Regulation 7.107 includes specific determinations that have to be made, including anticipated cost savings, for bundling that must be made and approved prior to 'bundling' contracts. While this section includes a qualifier, that each VISN "to the maximum extent practicable" shall consolidate such CBOC contracts, if enacted, this section would create a conflict with the bundling rules. Further, we do not believe this provision would result in any significant administration or oversight savings or relief.

Subsections (c), (d), and (e) appear to treat peer review and accreditation as worthy of additional compensation. VA does not support these provisions as we believe our obligation is to ensure Veterans receive the highest possible standard of care, regardless of where that care is provided. Accreditation and participation in peer-review programs are "floor requirements" that every provider should already meet. Moreover, we interpret these provisions as providing the same level of compensation for participation in a peer review program as for obtaining accreditation. This would create a greater incentive to participate in peer review as there are additional costs for the medical practice associated with accreditation that are not present for peer review. VA estimates this section would cost $385,000 in FY 2010, with five-year costs of $2 million, and ten-year costs of $4.6 million.

Section 8 would authorize the use of air transportation when travel by air is the only practical way to reach a Department facility. We believe this criterion is vague and subject to broad interpretation. Even with carefully crafted regulatory implementing language, this criterion could result in substantial confusion for Veterans and VA staff and wide variations in actual benefit implementation and administration. Moreover, the benefit outlined in section 8 would not be limited to veterans living in rural areas. The cost of implementing Section 8 is also very difficult to calculate since VA does not know how many Veterans, either currently eligible or eligible under the new legislation, might be considered to require air transport. We cannot precisely predict the distances that will be traveled, how often air travel will be required, and any special requirements such as oxygen, gurney, or other special needs that may be necessary during flights. Based on available data and assumptions of usage, we estimate the cost of this provision to be $400 million for the first year, approximately $2.3 billion over five years and approximately $5.4 billion over ten years.

Finally, VA opposes Section 9, which would create a three-year pilot program offering incentives for physicians who assume inpatient responsibilities at

community hospitals in health professional shortage areas. VA has no statutory authority to bill third-party payers for services provided to non-Veterans in non-VA facilities. A more practical approach would be to develop agreements with the community hospital to reimburse VA for the care provided by VA physicians to non-Veterans. This would remove the logistical challenges of billing for care not provided in a VA facility, not documented in VA records, and for which no authority or rate exists. However, VA must strongly emphasize that assigning VA doctors to non-VA facilities to provide care to non-Veterans is outside of the scope of our mission to care for Veterans and other eligible beneficiaries. VA is unable to estimate the cost of this section because VA does not currently have authority to treat, bill or collect for care provided to non-Veterans.

S. 801 "Family Caregiver Program Act of 2009"

S. 801 is divided into four separate sections. I will address each section separately; however, VA has not yet evaluated the costs of implementing the provisions of S. 801. We will provide an estimate to the Committee as soon as it is completed.

Section 2 would authorize VA to waive charges for humanitarian care provided to caregivers accompanying certain severely injured veterans as they receive medical care. VA does not object to the concept of providing humanitarian medical benefits to caregivers but we must oppose this section. As currently written, Section 2 identifies an extensive list of family members as potential caregivers and provides no criteria regarding the extent or duration of their service to the Veteran. Family caregivers could change frequently and we are concerned that the provision of humanitarian care could become a primary factor in designating a caregiver rather than that person's ability to assist the veteran. Further, language that has historically appeared in VA appropriation statutes (requiring reimbursement for hospital care and medical services provided to individuals who are not otherwise eligible for these benefits) may restrict VA's ability to waive charges as outlined in this provision of the bill. We are also

considering the impact of Section 2 on the implementation of the family medical care provisions of the National Defense Authorization Act of 2008 (§ 1672(b) of Public Law 110-181).

Section 3 of S. 801 addresses family caregiver assistance. I have previously discussed the family caregiver provisions of S. 252 and S. 543, which would require the Secretary to conduct pilot programs to assess the feasibility of training family caregivers as personal care attendants. While the eligibility criteria for this section are very similar to those in S. 543, S. 801 differs dramatically from S. 252 and S. 543 because it would establish a program of instruction, preparation, training, certification and ongoing support for designated family caregivers across VA. The mechanics of the program under S. 801 are also different as eligible veterans and their family member (or other designated individual) would make a joint application to VA which would then evaluate the veteran to identify the personal care services needed by that individual and determine if they could be provided by a family member. The applicant family member is also evaluated to determine the training they would need to provide those services. Unlike S. 252 and S. 253, S. 801 does not address the development of the training curriculum. However, it does distinguish between a family member who provides personal care services and a family member who is designated as the veteran's primary personal care attendant. The agency would be required to provide training, certification, technical support, and counseling to both; however, a primary personal care attendant would also be furnished mental health services, medical care under 38 USC 1781, respite care and a stipend.

VA strongly opposes Section 3. The same concerns identified in conjunction with caregiver provisions of S. 252 and S. 543 apply here as well. VA currently contracts for caregiver services with various providers and this arrangement is preferable because it does not divert VA from its primary mission of treating veterans and training clinicians. We also would like to reiterate that S. 801 would establish the caregiver program across the agency and we caution against

implementing a program of this magnitude without first exploring its feasibility and effectiveness. Should the Committee decide to proceed with a caregiver assistance proposal, we urge you to opt for the program defined in section 209 of S. 252 which would allow VA to conduct a three-year pilot providing assistance to caregivers of TBI patients. Moreover, the concerns that I addressed in discussing Section 2 relative to the large cadre of eligible caregivers would make this proposal challenging to administer and monitor for quality and effectiveness. The administrative burden on VA to re-identify and track caregivers could be considerable.

Finally, S. 801 in general, and Section 3 in particular, would create preferential benefits for one generation of Veterans that are not available to others. VA believes that caregiver assistance would benefit veterans of all ages and periods of service and any initiative to support caregivers should not be limited to post-September 11 veterans.

Section 4 would amend VA's beneficiary travel statute (38 USC 111) to include lodging and subsistence as travel expenses for attendants of certain veterans receiving VA health care. This provision would also define the travel period to include travel to and from the facility and the duration of the treatment episode. We believe that the proposed amendments would apply to all attendants eligible for beneficiary travel under 38 USC 111, not just those attendants defined by S. 801. VA opposes section 4 as this benefit expansion would divert resources from medical care. In addition, 38 USC 111 already provides travel benefits attendants for severely injured veterans.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Committee may have.