STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Mr. Chairman and members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

Mr. Chairman, the DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs that many service-connected disabled veterans rely upon. At the Committee's request, the DAV is pleased to present our views on nineteen (19) bills before the Committee today.

S. 423 - Veterans Health Care Budget Reform and Transparency Act of 2009

Mr. Chairman, while great strides have been made to increase the level of VA health care funding during the past several years, there is a long history of significant delays in actually receiving those funds. Notwithstanding notable improvements over the past two years, including passage of a regular appropriation on September 30, 2008, VA has received its annual funding for veterans' health care late in 19 of the past 22 years. Unlike Medicare's mandatory trust funds, the VA must rely on Congress and the President to pass a new discretionary appropriations law each year to provide VA hospitals and clinics with the funding they need to treat sick and disabled veterans.

Due to the late and unpredictable budget process, VA is increasingly challenged to properly treat the physical and mental scars of war for all veterans needing care. Further, not knowing when or at what level VA will receive funding from year to year – or whether Congress would approve or oppose the Administration's proposals – hinders the ability of VA officials to efficiently plan and responsibly manage VA health care.

Broken financing causes unnecessary delays and backlogs in the system: hiring key staff is put off, or just not done, while injuries like PTSD or traumatic brain injury (TBI) are too often not diagnosed or treated in a timely manner. Since 2001, the number of VA patients has grown by two million – a 50 percent increase – and our newest generation of veterans has increasingly complex mental and physical health care needs that will require a lifetime of care. Moreover, a

2007 report by the VA's Office of Inspector General concluded that 27% of the injured veterans seeking treatment at VA facilities had to wait more than 30 days for their first appointments.

For the past decade, the DAV and its allies in the Partnership for Veterans Health Care Budget Reform – a coalition of nine veterans service organizations with a combined membership of eight million veterans – have sought to fundamentally change the way veterans health care is funded. While mandatory funding has been the focus over the past several years, the Partnership helped develop and fully endorsed S. 3527, the Veterans Health Care Budget Reform Act, introduced in the 110th Congress. This legislation was endorsed by The Military Coalition, comprised of 35 organizations representing more than 5.5 million members of the uniformed services – active, reserve, retired, survivors, veterans – and their families.

We believe this legislation, the successor to S. 3527, proposes a reasonable alternative to achieve the same goals as mandatory funding, by authorizing Congress to appropriate funding for veterans' health care one year in advance, and by adding more transparency to VA's health care budget formulation process. With the goal of ensuring sufficient, timely, and predictable funding through advance appropriations, Congress retains full discretion to set actual appropriated funding levels for each fiscal year. The legislation does not eliminate, reduce or diminish, but rather enhances, Congress's ability to provide strong oversight over VA programs, services and policies.

We at DAV are delighted to know this important VA health care funding reform bill is being considered by the Committee today. We thank the 32 Senators who have given this bill co-sponsorship on a bipartisan basis, including ten of the 15 Members of this Committee. Also, only in recent days have we confirmed in a meeting with President Obama and Secretary Shinseki that both the President and the VA Secretary fully endorse the Senate's decision to make provision for advance appropriations for VA health care funding for Fiscal Year 2011 in the Fiscal Year 2010 Senate budget resolution. We hope the Committee would approve, that the Senate and House would pass, and that President Obama would sign S. 423 into law.

Passage of the Veterans Health Care Budget Reform and Transparency Act in the 111th Congress would address DAV's highest priority in VA health care; thus, we urge its enactment.

S. 597 - Women Veterans Health Care Improvement Act of 2009

Title I, Section 101 would require the Secretary to submit a report to Congress on existing stigma and other barriers that impede or prevent women from accessing health care and other services from VA. The bill would require an assessment of its existing health care programs for women veterans, and an evaluation of the needs of women who are currently serving, and women veterans who have completed service, in OIF/OEF.

Section 102 would require VA to contract with a non-VA entity to study the health consequences is women veterans from environmental and occupational exposures while serving in OIF/OEF.

Section 103 would require the VA to report to Congress on whether there is at least one established full-time women veterans program manager at each VA medical center.

Title II, section 201 requires the Secretary to identify available services, personnel and other resource requirements to develop a plan and make recommendations to appropriately meet the future health care needs, including mental health care needs, of women who served in OIF/OEF.

Section 202 would make improvements in VA's ability to assess and treat veterans who have experienced military sexual trauma (MST) by requiring a new training and certification program to ensure VA health care providers develop competencies and the use of evidence-based treatment practices and methods in caring for these conditions consequent to MST. The Secretary would be required to establish staffing standards to ensure adequacy of supply of trained and certified providers to effectively meet VA's demands for care of MST. Section 202 would also require VA to ensure appropriate training of primary care providers in screening and recognizing symptoms of sexual trauma and procedures for prompt referral and would require qualified MST therapists for counseling. Under this authority the Secretary would also be required to provide Congress an annual report on the number of primary care and mental health professionals who received the required training, the number of full-time employees providing treatment for MST and PTSD in each VA facility, and the number of women veterans who had received counseling, care and services associated with MST and PTSD.

Section 203 would establish a non-medical model pilot program of counseling in retreat settings for recently discharged women veterans who could benefit from VA establishing off-site counseling to aid them in their repatriation with family and community after serving in war zones and other hazardous military duty deployments.

Section 204 would require recently separated women veterans to be appointed to certain VA advisory committees.

Section 205 would authorize a two-year pilot program in at least three VISNs of providing subsidies for child care services expenses for qualified veterans receiving mental health, intensive mental health or other intensive health care services, whose absence of child care might prevent veterans from obtaining these services. "Qualified veteran" would be defined as a veteran with the primary caretaker responsibility of a child or children. The authority would be limited to subsidizing expenses.

Section 206 would amend title 38, United States Code to authorize a period of not more than seven days of VA-provided or authorized contract care for the newborn infant child of a woman veteran.

Mr. Chairman, women veterans are a dramatically growing segment of the veteran population. The current number of women serving in active military service and its reserve and Guard components has never been larger. According to VA, the number of women veterans utilizing VA health care will likely double in the next 2 to 4 years. We expect they will undoubtedly use other VA benefits in addition to health care. Also, women are serving today in

military occupational specialties that take them into combat theaters and expose them to some of the harshest environments imaginable, including service in the military police, medic and corpsman, truck driver, fixed and rotary wing aircraft pilots and crew, and other hazardous duty assignments. VA must prepare to receive a significant new population of women veterans in future years, who will present needs that VA has likely not seen before in this population.

We recently had occasion to help organize and sponsor a Capitol screening of the independent documentary film *Lioness*, to be shown on the Public Broadcasting System on June 2, 2009. It is the story of five Army women who served in Iraq, in regular military occupational specialties, but who were pressed into service in Marine ground combat teams in Falujah and Ramadi, Iraq to assist in offensive operations providing body weapons searches of Iraqi women and children, to ensure the safety of the Marines and other Iraqi civilians. These women, who were not trained as infantry combatants, were exposed to some of the most violent counterinsurgency combat hazards in this war.

This comprehensive legislative proposal is fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, the *Independent Budget*, and DAV. DAV was proud to work with Senator Murray and the original cosponsors of the bill in crafting this proposal. A similar bill was introduced in the House (H.R. 1210) on a bipartisan basis by Representatives Herseth Sandlin and Representative Moran of Kansas. DAV strongly supports this measure and urges the Committee to approve it and move it toward enactment.

FAMILY CAREGIVER SUPPORT SERVICES

S. 543 - Veteran and Servicemember Caregiver Support Act of 2009

This legislation would establish a pilot program at six locations, with one required to be conducted at a VA facility in a rural area and another at a qualified private rehabilitation facility. The proposed pilot program would provide support services and financial assistance to family caregivers of veterans or members of the military seriously injured in the line of duty since September 11, 2001. VA would provide training and certification of family caregivers, and of an alternate caregiver to relieve a primary caregiver, if deemed necessary. Once trained and certified, family caregivers would receive payments for the care they provide.

In addition, the bill would require VA and DOD to make available to caregivers, mental health and support services, on the assumption that the need for services would be related to their role as caregivers. VA would be required to conduct a survey of family caregivers to better understand the value of the services they provide and to assess and report to Congress on the effectiveness of these pilot programs. Furthermore, if the pilot programs are successful, they could be expanded nationwide.

While we support the spirit of this bill, appreciate Senator Durbin's leadership in introducing it, and would not object to its passage, we believe a number other provisions are necessary to underwrite a more fully developed caregiver support program.

S. 801 - Family Caregiver Program Act of 2009

Section 2 of this bill would amend Section 1784, title 38, United States Code, to require VA to waive any charges for emergency medical care provided on a humanitarian basis to family caregivers while accompanying certain severely injured veterans. This provision would only apply to family caregivers of those veterans whose injury was sustained on or after September 11, 2009, and such injuries meet a prescribed level of severity.

Section 3 of this bill would create a new VA program for family caregivers or personal care attendants of severely injured veterans. The goal of this program would be to allow eligible veterans to reside in their communities and maintain their quality of life with caregiver assistance. We note that veterans, or servicemembers awaiting discharge for their injuries sustained on or after September 11, 2001, and in need of personal care services, would be the first categories to be eligible for this program. The DAV believes the program proposed in this bill would be beneficial to all disabled veterans, and we thank the Chairman for including a provision in the bill to address this matter. Specifically, for all other veterans, the Secretary would be required to make a determination two years following enactment of this bill to "include the largest number of veterans possible" in this program.

Taking on the role of a family caregiver is a personal choice made by the family member and the veteran affected. We believe this bill would respect the privacy of this decision, and recognizes the contributions caregivers make to the health and well being of severely injured veterans. Under this program, more than one caregiver could receive basic instructions. In addition, only one caregiver would be certified by VA as the primary personal care attendant of a veteran after completing basic instructions provided by VA and any additional training identified by an evaluation of the veteran's needs. To assist in completing the required training and certification, this bill would require VA to provide for necessary travel, lodging, and per diem to the caregiver, and respite care to the veteran as needed during such caregiver training and certification.

To support and sustain caregivers, the bill would provide ongoing assistance such as mental health counseling, eligibility for the Civilian Health and Medical Program of Veterans Affairs (CHAMPVA), payment of a stipend, and other critical services such as respite care. Even though most family caregivers take great pride in providing care to their loved ones so that these veterans can remain at home, the physical, emotional and financial consequences can be overwhelming for them without support, with respite services being a good example thereof. Research has shown that providing respite for caregivers can have a positive effect on the health of the caregiver as it provides the much needed temporary break from the often exhausting challenge imposed by constant attendance of a severely disabled person. Currently, VA's system for providing respite care is fragmented and inflexible, governed by local policies for Community Living Center (formerly VA Nursing Homes) and Adult Day Care programs. As part of the ongoing assistance this bill proposes, VA would be required to provide no less than 30 days annually, including 24-hour respite care. The DAV is hopeful this provision will encourage

VA to establish clearer policies expecting every Community Living Center and Adult Day Care Program to provide priority for age-appropriate respite care for severely injured veterans.

The DAV believes that family caregivers are motivated by empathy and love, but they are also often dealing with guilt, anger and frustration. The very touchstones that have defined their lives – careers, love relationships, friendships, and their personal goals and dreams – have been sacrificed, and they face a daunting lifelong duty as caregivers. Put simply, family caregivers of severely disabled veterans, who are vital for VA's patient-centric care provided in the least restrictive settings, must not remain untrained, unpaid, unappreciated, undercounted, and exhausted by their duties.

DAV Resolution No. 165 was passed by the delegates to our most recent national convention. That resolution calls for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to immediate family member caregivers of veterans severely injured, wounded or ill from military service. Accordingly, the DAV supports this measure. We thank Senator Akaka for introducing this bill and congressional staffers for working with DAV to address the unmet needs of caregivers of severely injured veterans.

This bill is an important measure and DAV urges the Committee's approval. In addition, we believe S. 543, as discussed above, contains worthwhile provisions that we hope will be considered by this Committee as it finalizes the authorization of these new benefits.

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

Section 2 of this bill would amend Section 111, title 38, United States Code, to insert a fixed rate of 41.5 cents for the purposes of VA's travel beneficiary program. Reimbursement at this rate may exceed the cost of travel by public transportation regardless of medical necessity. A report is required no later than 14 months upon enactment of the Act.

Section 3 of this bill would require VA to establish at least one and no more than five Centers of excellence for rural health research, education, and clinical activities.

Section 4 would require the Secretary to establish a transportation grant program to veterans service organizations to allow for other transportation options to assist veterans residing in highly rural areas to travel to VA facilities.

Section 5 would require the VA's Office of Rural Health to conduct demonstration projects with the goal of expanding care in rural areas.

Section 6 of the bill would require the VA to establish a contract care program through community mental health centers and other "qualified entities" for the provision of certain readjustment, mental health, peer counseling and similar services to OIF/OEF veterans and their dependents in rural and remote regions. The program would be restricted to areas determined by the Secretary to be inadequately served by direct VA services.

Section 7 of the bill would establish a Native American health care coordination function in the 10 VA medical centers that serve the greatest number of Native Americans per capita, with specification of the duties associated with the new function. Also, the bill would require the Secretary and the Secretary of the Interior to execute a memorandum of understanding that would ensure the health records of Indian veterans may be transferred electronically between the Indian Health Service and the Veterans Health Administration (VHA).

Section 8 would require an annual report to Congress as a part of the President's budget on a variety of matters concerned with rural veterans.

The conference report accompanying the Consolidated Appropriations Act of 2008, specified that $125 million of the funds provided for Veterans Medical Services should be used to increase the travel reimbursement rate. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009, provided an additional $133 million to increase the beneficiary travel reimbursement mileage rate to 41.5 cents per mile, while freezing the deductible at current levels. Subsequently, the Veterans' Mental Health and Other Care Improvements Act of 2008 revised VA's beneficiary travel program to establish a mileage reimbursement rate equal to that for Federal employees when a government vehicle is available, but the individual chooses to use their own vehicle. Further, Public Law 110-387 changed the mileage deductible to $3 for each one-way trip; $6 per round trip; with a calendar month cap of $18 as specified in title 38, United States Code, section 111 (c)(1) and (2) for travel expenses incurred on or after January 9, 2009.

The DAV appreciates Senator Tester's leadership in improving health care for veterans residing in rural areas. We support enactment of this bill as consistent with our DAV Resolutions 159 (on beneficiary travel policy) and 177 (on access to rural health care), adopted by our membership at DAV's 2008 National Convention.

S. 404 -Veterans' Emergency Care Fairness Act of 2009

This bill would amend subparagraph (b)(3)(C) of section 1725, title 38, United States Code, by striking the words "in whole or in part" where they appear in current law. The bill would also add new language to clarify Congressional intent that VA would be required to assume responsibility as payer of last resort in a case in which an otherwise eligible veteran has private insurance coverage that pays a portion or part of the cost of an episode of emergency care in a private facility. Under the bill, VA would pay the remainder of the veteran's obligation, less any required copayments under the associated private insurance coverage.

While the bill also provides the date of the enactment as the effective date, many veterans have been adversely affected by the VA's non-reimbursement for emergency treatment under the current law. This bill provides VA discretionary authority to reimburse veterans for emergency treatment provided prior to the date of enactment who have been financially harmed under the VA's current non-reimbursement policy.

DAV supports the purposes of this bill and appreciates the sensitivity of the Committee leadership in developing an effective solution to a nagging problem plaguing both service-connected and nonservice-connected veterans who rely on VA to meet their primary health care needs, but who find themselves confronted by medical emergencies.

S. 252 - Veterans Health Care Authorization Act of 2009

Sections 101, 102, and 103. These provisions would aid VA in retaining health care professionals in the VA system, and clinical executives in facilities and in VA Central Office; would limit VA's use of overtime, clarify policies on weekend duty and use of alternative work schedules for nurses; and, would improve VA's educational assistance programs. DAV provided detailed testimony during the 110th Congress on these matters in S. 2969, from which its sections 2, 3, and 4 were incorporated as sections 101, 102, and 103 in this bill.

Mr. Chairman, DAV has no resolution adopted by our membership addressing these specific matters, but we are strong supporters of VA as a preferred federal employer. We believe these provisions in general would be supportive of that goal; therefore, DAV would not object to their enactment. Nevertheless, we note that our colleagues in the VA labor community appear to be deeply concerned about ceding additional authority to the Secretary to expand the "hybrid" title 5-title 38 appointment authority without further authorization by Congress. Labor has made the point strongly that VA should first be held accountable for disclosing the manner by which the Department has carried out prior authority in dealing with hybrid appointments across more than 20 career fields. Based on VA's apparent struggle to establish qualification and classification standards for some of the occupational classes already included in the hybrid appointment authority, we believe federal unions may have a valid basis for those concerns. Therefore, we defer to their expertise in this case and ask the Committee's further consideration of those matters in sections 101, 102 and 103 in Title I of the bill in recognition of the concerns of labor.

Section 104. DAV provided testimony in the past Congress on S. 2377, Section 2 thereof which has been incorporated as Section 104 of this bill.

DAV has no adopted resolution from our membership on these specific issues. Under current policy, VA is required to investigate the background of all appointees, including verifying citizenship or immigration status, licensure status, and any significant blemishes in appointees' backgrounds, including criminality or other malfeasance. The facility in question that likely stimulated the sponsor to introduce S. 2377 was not in compliance with those existing requirements, thus raising questions about VA's ability to oversee its facilities in the area of physician employment. Corrective action was taken by the VA Central Office when some unfortunate incidents related to these lapses came to light at that particular facility, and VA has advised that it has strengthened its internal policies.

We appreciate and strongly support the intent of the bill to stimulate recruitment and to promote VA physician careers with various new incentives, and, while it seems clear that additional oversight is necessary, we trust that the new reporting, State licensure and certification

requirements in the bill would not serve as obstacles to physicians in considering VA careers in the future.

Section 201. At the Chairman's request, DAV provided testimony in the 110th Congress on Title III of S. 2984, which has in part been incorporated as Sections 201 through 206 of this bill. Although DAV has no resolutions specific to the matters entertained in S. 2984, we were generally supportive of the provisions in that bill with the exception of those matters in section 304 (now in section 201 of this bill). We believe in both instances of its knowledge of, and oversight in, VA practices with regard to compensating nursing personnel and in conducting long-term strategic planning, that these reporting requirements should be retained. We are particularly concerned at the prospect of VA's discontinuing its construction-related reporting with the Committee relying primarily on VA's annual budget proposal as a source for relevant information on construction planning. The current reporting requirement in Section 8107 of title 38, United States Code, covers extensively more than simply the requested facility construction and leasing authorizations contained in the annual budget for a given year. We believe both Congress and the community of veterans service organizations, in properly representing and protecting veterans' interests, need to continue receiving comprehensive reports on VA's strategic plans, including its major construction planning.

Sections 202-206. DAV takes no positions on these matters, but offers no objections to their enactment.

Sections 207-208. These sections would establish health care quality management officers and new functions nationally, regionally and locally in the VHA, and would require a series of reports to document progress in quality management. DAV provided testimony in the 110th Congress on S. 2377, section 3, which has been incorporated as Sections 207 and 208 of this bill. DAV has no adopted resolution from our membership on these specific issues; however, we expressed our appreciation and strong support the intent of S. 2377 and do so again with respect to these provisions. While it seems clear that additional oversight is necessary given the VA Office of Inspector General's January 2008 report documenting unacceptable practices at the VA Medical Center Marion, Illinois, that served in part as an impetus for section 207 in this bill, we trust that the new reporting, State licensure and certification requirements in the bill would not serve to dampen future physicians' interest in considering VA careers.

Sections 209 and 210. These provisions would establish training and certification pilot programs, an innovative respite program for family caregivers, and new health care trainees in caring for severely brain-injured veterans. DAV provided testimony in the past Congress in support of Sections 2 and 3 of S. 2921, which have been incorporated as Sections 209 and 210 of this bill.

Section 211. DAV provided previous testimony in the past Congress on S. 2796, which has been incorporated as Section 211 of this bill. This section would establish a five-site pilot program to facilitate veterans' use of community-based organizations to ensure they receive the care and benefits they deserve in transitioning from military to civilian life. The program would be conducted through VA grants to community-based organizations with the goal of providing

information, outreach, mental health counseling, benefits, transition assistance, and other relevant services in rural areas and in areas with a high proportion of minority veterans.

While we have no adopted resolution from our membership supporting this precise concept, DAV believes this is a well-intentioned proposal. We have some concerns about VA becoming a granting agency for such broad purposes, but we believe if it is targeted and carefully managed by VA, this function could be an important and creative new tool in rural and remote areas where establishing a direct VA service presence would be impractical. If this section is enacted, we also recommend VA carefully craft the services expected from a grantee in the area of aiding these veterans with their VA disability benefits claims. These are highly technical matters and require the assistance of expert service officers from the states, the veterans service organization (VSO) community and the Veterans Benefits Administration through its veterans benefits counselor function. Finally, for any health care involvement associated with these grants, we urge VA to coordinate this new grant program through its Office of Rural Health. With these caveats, DAVsupports the enactment of this section.

Section 212. DAV provided previous testimony last Congress on S. 2889, which has been incorporated as section 212 of this bill. Section 212 would provide VA a specific contracting authority to obtain specialized residential care and rehabilitation services for OIF/OEF veterans who are suffering from TBI and who are exhibiting such cognitive deficits that they would otherwise require admission to nursing home facilities. DAV Resolutions 161 and 164, adopted by our members at our 2008 national convention, call for strengthening and enhancing VA long-term care programs for service-disabled veterans, and for addressing comprehensively the needs of disabled veterans of all wars who suffer from TBI. Again, we ask the Committee to consider broadening the eligibility for this new contract residential rehabilitation care option in Section 212 of the bill to any veteran with a service-incurred TBI.

Section 213. This section was incorporated from Section 6 of S. 2889 from the 110th Congress. This section would authorize VA to disclose the name and address of a member of the armed services or of a veteran to a third party insurer in order to bill for collections of reasonable charges for care or services provided for an individual's nonservice-connected condition(s). DAV does not have a resolution from our membership on this matter; therefore, DAV takes no position on this provision.

Section 214. This section would require VA to contract with the Institute of Medicine for an expanded study related to veterans' health-related exposures from participating in Project Shipboard Hazard and Defense ("Project SHAD"). DAV does not have a resolution from its membership on this matter. However, the DAV believes this is a worthwhile provision in light of our policy regarding environmental exposure of sick and disabled Persian Gulf War Veterans and in recognition of DAV Resolution 022, adopted at our 2008 National Convention, that opposes any rule or provision that would authorize use of servicemembers for human experimentation without their knowledge and informed consent.

Section 215. DAV provided previous testimony during the last Congress on Section 4 of S. 1233, which has been incorporated in part in Section 215 of this bill. We note that in passing Public Law 110-181, the National Defense Authorization Act for Fiscal Year 2008, Section 1703

did not follow the language contained in Section 4 of S. 1233 of the last Congress. We believe Section 215 of this measure would clarify that veterans with traumatic brain injury have a right to access community based rehabilitation, but only when VA cannot provide the care and when the non-VA provider is accredited and adheres to appropriate VA clinical and rehabilitation standards. We support Section 215 of this measure which contains the same two key implied presumptions that we supported in Section 4 of S. 1233 in the 110th Congress: 1) that the VA must have the capacity to be the provider of choice, and 2) that proximity to care is a key component to ongoing rehabilitation and community reintegration for the traumatically brain-injured veteran.

Also, we support the implicit goal of this section to give VA an incentive to further develop its capacity to provide high quality specialized care. VA's four lead Poly-trauma Rehabilitation Centers have achieved and maintained, without qualification, accreditation from the Commission on the Accreditation of Rehabilitation Facilities for acute inpatient TBI rehabilitation programs; however, to date and to our knowledge not a single VA facility has achieved accreditation for outpatient, home-based, residential or community based TBI rehabilitation. We urged this Committee then, as we do now, to encourage VA to seek such accreditation at Level II and Level III poly-trauma sites.

Section 216. This section would make federally-recognized tribal organizations eligible to participate in VA's State extended care grant programs, including the treatment of existing beds in tribally-owned health facilities as State veterans home beds for purposes of the per diem subsistence program administered by VA.

DAV does not have a resolution from its membership on this specific matter, but as a part of the FY2010 *Independent Budget*, DAV has expressed concerns about the status of the State extended care construction grant program, and in particular, with respect to the fact that nearly $1 billion in backlogged construction, new home and renovation grants are pending in VA Central Office, affecting existing State veterans homes in nearly every State. Given this backlog and Congress's inability to appropriate sufficient funding annually to properly maintain this system, we are concerned that adding as many as 500 tribal organizations to the competition for these severely limited funds will only serve to diminish the existing State home program. Therefore, we ask that the Committee withhold approval on this section to enable our staffs to work toward an acceptable compromise to enable tribal organizations to participate more directly in this unique VA-State partnership.

Section 217. We appreciate the intent of the bill which would require VA to contract with a dental insurer to administer a new dental plan provided under a three-year pilot program. Moreover, each individual covered by the dental insurance plan would be required to pay the entire premium for coverage under the dental insurance plan, in addition to the full cost of any copayments. DAV Resolutions 167 and 172 support legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans, but without any additional costs to be borne by the veteran or their survivors and dependents.

Title III—Women Veterans Health Care. For Title III of this measure, sections 301-309, we refer this Committee to our views on S. 597, the Women veterans Health Care

Improvement Act of 2009, contained herein. We believe the small differences in the two bills can be worked out by your able staffs. We strongly support improved services for women veterans, are deeply grateful to the Chairman and Members of this Committee for their interest in women's health, and urge the Committee to report an appropriate compromise bill during this session.

Sections 401 and 402. DAV provided previous testimony during the last Congress on Sections 2 and 3 of S. 2963, which have been incorporated as Sections 401 and 402 of this bill. While DAV has no resolutions from our membership supporting the specific matters entertained by these sections, we believe each of these proposals would be helpful to survivors of military service members and veterans whose lives are lost to suicide. Therefore, DAV supports the purposes of these sections and would have no objection to their enactment.

Section 403. DAV provided testimony during the last Congress on Section 3 of S. 2899, which has been incorporated as Section 403 of this bill. DAV has no adopted resolution from our membership dealing specifically with suicides in the veteran population. However, we agree that full and accurate data on the issue of suicide is crucial to VA's ability to reduce veterans' suicides. Also, and more importantly in our view, DAV believes strongly that improving, expanding and enhancing VA's mental health programs across the board, including those dealing with depression, adjustment disorders, PTSD, mild-to-moderate traumatic brain injury, marital and family relations (including readjustment from long deployment separations), and substance-use disorders – particularly with early interventions, will not only provide more effective care but can stem suicidal ideation in untreated or poorly treated populations.

Section 404. We note that Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, includes provisions (Section 227) very similar to Section 404 of this measure, so we are concerned that this provision may be unnecessary or duplicative of current law. Nevertheless, DAV does not have a resolution from our membership on this specific matter; therefore, we take no position.

Title V—Homeless Veterans. DAV provided testimony during the last Congress on S. 2273, which has been incorporated as Title V of this bill. The *Independent Budget* for Fiscal Year 2010 included a series of recommendations that are consistent with the five sections under this Title; therefore, we support its purposes and urge its enactment.

Title VI—Nonprofit Research and Education Corporations. DAV provided previous testimony last Congress on S. 2969, which has been incorporated as Title VI of this bill. While DAV has no adopted resolution on this particular matter, DAV is a strong supporter of a robust VA biomedical research and development program. We believe enactment of this Title would be in that program's best interest, and therefore, we urge its enactment.

Sections 701 and 702. These sections are derived from Sections 401 and 402 of S. 2984 from the 110th Congress. These provisions would expand certain authorities set out in title 38, United States Code, relating to VA police officers so as to better reflect the current scope of their duties and responsibilities, and would modify the authority of VA to pay an allowance to VA

police officers for the purchase of police uniforms. DAV has no resolution from its membership on this specific matter; therefore, we have no position on this measure.

S. 821 - A bill to amend title 38, United States Code, to prohibit the Secretary of Veterans Affairs from collecting certain copayments from veterans who are catastrophically disabled, and for other purposes

Mr. Chairman, thousands of veterans survive catastrophic traumas in civilian life. Some of them have been able to surmount the tremendous challenges imposed on them by accidents or disease, and have been able to rejoin the workforce to be productive citizens. We believe they should not face the double jeopardy of catastrophic disability and an additional financial penalty of paying VA copayments in order to access VA health care and services. These veterans, many permanently wheelchair bound and spinal cord injured, already spend thousands of their own dollars annually on health-related supports and services that able-bodied veterans do not need to bear, or even think about. If a catastrophically ill or spinal-cord injured veteran succeeds in the daunting personal quest to remain in, or re-join, the labor force, we believe the government where possible ought to provide that veteran proper incentives to remain employed, in this case by forgiving VA copayments.

In conjunction with DAV's national resolution from our membership calling for legislation to repeal all copayments for military retirees and veterans' medical services and prescriptions, and as a partner organization constituting fiscal year 2010 *Independent Budget*, the DAV fully supports this provision. It matches the *Independent Budget'*s recommendation that veterans designated by VA as being catastrophically disabled for the purpose of enrollment in health care eligibility priority group four (4) should be made exempt from health care copayments and other fees. We note this legislation was passed by the House in the past Congress but was not considered by the Senate. We urge this Committee to approve and move this provision to enactment during this Congress.

S. 793 - Department of Veterans Affairs Vision Scholars Act of 2009

This measure would direct the Secretary of Veterans Affairs to establish and carry out a scholarship program of financial assistance for individuals who: (1) are accepted for, or currently enrolled in, a program of study leading to a degree or certificate in visual impairment or orientation and mobility, or both; and (2) enter into an agreement to serve, after program completion, as a full-time VA employee for three years within the first six years after program completion. It would set maximum assistance amounts of $15,000 per academic year and $45,000 in total per participant. The legislation would require pro-rata repayment for failure to satisfy education or service requirements, while allowing the Secretary to waive or suspend such repayment whenever noncompliance is due to circumstances beyond the control of the participant, or when waiver or suspension is in the best interests of the United States.

DAV has no resolution on this issue adopted by our members; however, the *Independent Budget* for FY 2010 contains a series of recommendations for VA improvements in its vision care programs. One such recommendation urges VA to require its health care networks to restore clinical staff resources in inpatient blind rehabilitation centers and increase the number of full-time Visual Impairment Services Team coordinators. This measure would improve recruitment for these positions. On that basis, DAV fully supports the intent of this bill.

S. 772 - Honor Act of 2009

A bill to enhance benefits for survivors of certain former members of the Armed Forces with a history of post-traumatic stress disorder or traumatic brain injury, to enhance availability and access to mental health counseling for members of the Armed Forces and veterans, and for other purposes

This bill would create a scholarship program within VA to produce graduate-level behavioral sciences practitioners among qualified veterans, in exchange for specified obligated federal service in either the VA or the Department of Defense health care systems. It would also create a Defense program of employment, training and deployment of combat veterans as psychiatric technicians and nurses, to serve in future combat zones as determined by the Secretary of Defense. The bill would reauthorize Vet Centers to refer former military service members with character of discharges that make them ineligible as veterans, to community resources for counseling and other mental health services, and it would specifically authorize serving members of the armed forces to be eligible for counseling and related mental health services at VA's Vet Centers. The bill would deem certain post-deployment suicides among combat veterans to have been deaths in the line of duty. Finally, this bill would require a series of reports to Congress dealing with its provisions.

DAV has no resolution adopted by our membership specific to these issues; however, we believe this to be a helpful bill, particularly with respect to the Vet Center related provisions. Therefore, we would offer no objection to its enactment.

S. 498 - A bill to amend title 38, United States Code, to authorize dental insurance for veterans and survivors and dependents of veterans, and for other purposes

This measure is similar to Section 217 of S. 252 with the exception that under this measure the provision of dental insurance by VA would not be a pilot program with respect to duration and location of availability. As discussed in our views on section 217, we appreciate the intent of this bill. However, DAV Resolutions 167 and 172 support legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans but without any additional costs to be borne by the veteran or their survivors and dependents.

S. 669 - Veterans 2nd Amendment Protection Act

Under the terms of this bill, in absence of a judicial determination of mental incompetency, VA would be prohibited from reporting an individual veteran's identity or

competency status to any authority that could restrict that veteran from his or her Second Amendment rights to bear arms.

The DAV has no resolution from its membership on this issue and, therefore, we take no position on this bill.

VHA WORK FORCE

S. 246 - A bill to amend title 38, United States Code, to improve the quality of care provided to veterans in Department of Veterans Affairs medical facilities, to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities, and for other purposes

Mr. Chairman, this bill is very similar to S. 2377, introduced in the 110th Congress. We appreciate and strongly support the intent of the bill to stimulate recruitment and to promote VA physician careers with various new incentives, and, while it seems clear that additional oversight in physician appointments is necessary, we trust that the new reporting, State licensure and certification requirements in the bill would not serve as obstacles to physicians in considering VA careers in the future.

We noted in testimony on May 21, 2008 to the Senate Committee on Veterans' Affairs on S. 2377, the predecessor version of this bill, VA raised a number of valid concerns with respect to State licensure limitations this bill would impose on VA physicians. We ask the Committee to take those concerns into account as you consider the merits of this bill.

S. 362 - A bill to amend title 38, United States Code, to improve the collective bargaining rights and procedures for review of adverse actions of certain employees of the Department of Veterans Affairs, and for other purposes

Mr. Chairman, this bill would restore bargaining rights for clinical care employees of the VHA that were eroded over the past eight years by the former Administration. A similar version of the bill was introduced in both bodies in the 110th Congress but did not advance.

DAV does not have an approved resolution from our membership on the specific VA labor-management dispute that prompted the introduction of this bill. However, we believe labor organizations that represent employees in recognized bargaining units within the VA health care and benefits systems have an innate right to information and reasonable participation that result in making VA a workplace of choice, and particularly to fully represent VA employees on issues impacting working conditions and ultimately patient care.

Congress passed section 7422, title 38, United States Code, in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management and its labor force representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, United States Code. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other federal

employees appointed under title 5, United States Code. Nevertheless, federal labor organizations have reported that VA has severely restricted the recognized federal bargaining unit representatives from participating in, or even being informed about, human resources decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for nurses, physician market pay compensation panels, etc.).

Facing VA's refusal to bargain, the only recourse available to labor organizations is to seek redress in the federal court system. However, recent case law has severely weakened the rights of title 38 appointees to obtain judicial review of arbitration decisions. Title 38 employees also have fewer due process rights than their title 5 counterparts in administrative appeals hearings.

It appears that the often hostile local environment consequent to these disagreements diminishes VA as a preferred workplace for many of its health care professionals. Likewise, veterans who depend on VA and who receive care from VA's physicians, nurses and others can be negatively affected by that environment.

We believe this bill, which would rescind VA's refusal to bargain on matters within the purview of section 7422, through striking of subsections (b), (c) and (d), and that would clarify other critical appeal and judicial rights of title 38 appointees, is an appropriate remedy, and would return VA and labor to a more balanced bargaining relationship on issues of importance to VA's professional workforce. VA clearly has indicated vigorous disagreement with the intent of the measure, but has not to date been willing to compromise its position in refusing to bargain across a wide group of issues that are dubiously defined by VA as "direct patient care." Given the stalemate, our only recourse is to endorse the intent of the bill, yet continue to hope that VA and federal labor organizations can find a basis for compromise.

S. 734 - A bill to amend title 38, United States Code, to improve the capacity of the Department of Veterans Affairs to recruit and retain physicians in Health Professional Shortage Areas and to improve the provision of health care to veterans in rural areas, and for other purposes

Section 2 of this bill would enhance VA's existing education debt reduction program by removing the current dollar limitation ($44,000 per participant) and equating it to the actual level of debt and interest payable by individual employees of the Department, with amended procedures for offers and acceptances of such debt reduction employment incentives. Section 3 of the bill would include certain VA medical facilities, located in health professional shortage areas, in the list of facilities eligible for assignment of participants in the National Health Service Corps scholarship program administered by the Department of Health and Human Services (HHS). The section would require VA to transfer to HHS $10 million to carry out the purposes

of the section. Section 4 of the bill would require VA's Office of Rural Health to develop and submit to Congress a five-year strategic plan, with specifications of the content of this report.

Section 5 of the bill would enhance VA's Vet Centers to meet needs of veterans of OIF/OEF through the establishment, training and deployment of volunteers, paraprofessionals and veteran-students to provide counseling and other mental health services to OIF/OEF veterans in established Vet Centers. Section 6 of the bill would establish a new section 1709, title 38, United States Code, to establish consultation and teleretinal imaging functions in the VHA, including the establishment of clinical and technical standards to carry out these programs; and amendments to VA's internal allocation (VERA) and workload reporting data systems to accommodate and give creditable resources to VA facilities conducting such programs.

Section 7 of the bill would improve oversight and administration of contract and fee basis care authorized by the Department. It would require VA to consolidate contracting for community-based outpatient clinics (CBOC) at the VHA Network (VISN) level to the maximum extent practicable; establish rural outreach coordinators at each CBOC with a majority of enrolled veterans who reside in "highly rural" areas; establish incentives to obtain accreditation of participating fee-basis private providers, and to encourage these providers to participate in VA's peer review system. Section 8 of the bill would amend section 111, title 38, United States Code, to provide reimbursement for airfare and other actual necessary expenses to certain enrolled veterans when air travel is the only practical way for such veterans to gain access to direct VA health care, with conforming changes to section 111.

Section 9 of the bill would establish a pilot program wherein full-time VA physicians would be authorized to assume attending responsibilities for primary care or mental health services at community hospitals located in health professional shortage areas, with financial incentives for them to assume these responsibilities, and including establishment of a series of rules to govern and control such participation.

Mr. Chairman, this bill largely conforms with recommendations of the IB for FY 2010, particularly in respect to the provisions related to rural health, continuity of care, innovations, quality of care, and improving access to direct VA health care. Also, it comports with the IB recommendations with respect to better coordinating and improving the quality of contract and fee-basis care. On this basis, DAV fully supports the intent of this bill and urges the Committee to approve it.

VHA FACILITIES

S. 226 - To designate the Department of Veterans Affairs outpatient clinic in Havre, Montana, as the Merril Lundman Department of Veterans Affairs Outpatient Clinic

This is a local matter, and DAV takes no position on this bill.

S. 239 - A bill to amend title 38, United States Code, to ensure that veterans in each of the 48 contiguous States are able to receive services in at least one full-service hospital of the

Veterans Health Administration in the State or receive comparable services provided by contract in the State

Mr. Chairman, while the bill is a general mandate that every state have a "full-service" VA medical center within its borders, the circumstances surrounding the bill make clear that its intent is to restore the VA Medical Center in Manchester, New Hampshire. As such, this is a local matter, and DAV takes no position on this bill.

S. 509 - To authorize a major medical facility project at the Department of Veterans Affairs Medical Center, Walla Walla, Washington, and for other purposes

This is a local matter, and DAV takes no position on this bill.

S. 699 - To provide for the construction of a full service hospital in Far South Texas by the Secretary of Veterans Affairs

This is a local matter, and DAV takes no position on this bill.

Mr. Chairman, this concludes DAV's testimony. We appreciate the opportunity to have provided our views on these bills. I will be pleased to respond to any questions that you or other members of the Committee may have.