STATEMENT OF
JOY J. ILEM
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 25, 2010

Mr. Chairman, Ranking Member Brown, and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this legislative hearing of the Subcommittee on Health. We appreciate the Subcommittee's leadership in enhancing the Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely, and we also appreciate the opportunity to offer our views on the eight bills and three draft measures under consideration by the Subcommittee today.

H.R. 84—Veterans Timely Access to Health Care Act

The stated goal of this bill is to provide timely access to VA health care. To accomplish this objective, a 30-day standard would be established as the maximum time that a veteran would be required to wait to receive a VA primary care appointment. The bill would also direct VA to establish a standard for the maximum length of time that a veteran would be required to wait to actually see a provider on the day of a scheduled appointment. Under the bill, if the Secretary found that any particular VA geographic service area failed to substantially comply with the timeliness standards, facilities in that area would be required to contract for the care of a veteran in each instance it was unable to meet those standards. The contracting requirement would be mandatory for veterans who are classified within enrollment Priority Groups 1 through 7 and discretionary for those within Priority Group 8.

The bill would require the Secretary to carry out a one-time examination of waiting time data for the entire VA health care system, stratified by geographic service area. The Secretary would be required to issue a determination regarding compliance with the standard in each geographic service area. If the compliance rate for any area were below 90 percent, facilities located in that area would be subjected to the requirement to contract for care whenever they were unable to meet those standards. Facilities with a compliance rate of 90 percent or more would be prohibited from contracting out such services.

Under the bill, VA would be required to submit two reports to the Committees on Veterans' Affairs. The first would be an annual report providing an assessment of its performance in meeting the timeliness standards. The second report would be made quarterly, and would include detailed waiting-time data for each geographic service area. The bill would require quarterly reports to include the number of veterans in each geographic service area waiting for care, distinguished by primary care and specialty care, and segregated periodically by those waiting from under 30 days to those waiting over a year, plus those who cannot be scheduled at all. The quarterly reporting requirement would continue through December 2010.

The bill provides that payments under these contracts could not exceed the reimbursement rates under Medicare, and the non-VA facilities or providers would be prohibited from billing veterans affected by this process for the difference between the billed amounts and the amounts of VA payments.

Mr. Chairman, we note similar bills, H.R. 3094 from the 108th Congress and H.R 92 from the 110th Congress, were considered by this Subcommittee in prior legislative hearings. The historical context during which the first bill was introduced is best described by then-VA Secretary Anthony J. Principi's reference to a "perfect storm" related to significantly increased demand for care and insufficient resources to meet timely access for that demand, resulting in a backlog or waiting list for access to VA medical services. Between October 1, 2001 and September 2002, VA enrolled an additional 830,237 veterans. With years of insufficient funding and an overwhelming demand for VA medical care, a July 2002 survey conducted by the Veterans Health Administration (VHA) revealed over 310,000 veterans waiting for medical appointments, half of whom were reported to be waiting

six months or more for care and the other half having no scheduled appointments at all. In January 2003, over 200,000 were waiting six months or longer. At that time, exercising its annual enrollment decision authority as required by Public Law 104–262, VA suspended the enrollment of new Priority Group 8 veterans.

While DAV and many others opposed this decision on the record, we understood the reasons for it—clearly, VA was struggling from severe underfunding across its health care programs. The run-up to that decision also fueled our determination at DAV to seek a legislative remedy for VA's flawed health care budget formulation and discretionary appropriations processes.

On September 30, 2003, your Subcommittee held a legislative hearing on H.R. 3094 (a similar version of the current bill), at a time when about 130,000 veterans were still waiting six months or longer for access to VA care. DAV testified at that hearing that veterans must have access to *timely* health care and that VA must be held accountable for meeting its own access standards. However, we were deeply concerned that this bill to contract care in order to meet its proffered access standards would ultimately shift medical services and veteran patients from VA to private providers. The effect of contracting out care to non-Department facilities and providers would encourage VA to refer patients, and the dollars that would underwrite their care outside a unique governmental system of care specifically created for veterans to meet their specialized health needs. We testified at that time that if given sufficient, timely and predictable funding, VA should be held accountable for meeting all its demands, and that only as a last resort would we support the broad contracting out of their medical care.

On April 26, 2007, DAV's testimony on H.R. 92 (another similar bill to this one) recounted our position on H.R. 3094 from the 108th Congress and included the need for consideration in the bill to reinforce that VA must have a comprehensive, systemic process for contracting care to ensure:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Therefore, we recommend the Subcommittee consider amending H.R. 84 to first implement the data requirements and reports required in the current measure prior to further considering approving provisions in the bill to automatically contract for care if the stated access standards would not be met. Over the past several years we believe VA has made tremendous effort to significantly reduce waiting times,[1] and thanks to the work of the Members of this Subcommittee VA now has the opportunity to receive timely, sufficient, and predictable funding for VA medical care through advance appropriations (Public Law 111-81).

In addition, DAV remains concerned about two weaknesses affecting the impact of H.R. 84, if enacted. Despite our recommendations in the *Independent Budget* (IB) over several years, VA has yet to establish a comprehensive, systemic program of contract care coordination to ensure that the services veterans receive in the private sector, paid for by VA, do not represent a diminished quality of care that they would have received otherwise from the VA.[2] Our second concern questions the validity of the reportable data for waiting times. DAV has raised this unresolved issue in concurrence with a report by the VA Office of Inspector General.[3] Finally, we note the bill does not seek to identify the underlying cause(s) for delays in access to care, an issue that is critical to VA's developing an effective solution.

---

[1] *Fiscal Year 2009 Performance and Accountability Report*, Department of Veterans Affairs, Office of Management. Washington, D.C. www.va.gov/budget/report

[2] *The Independent Budget, Fiscal Year 2011;* Contract Care Coordination, Non-VA Purchased Care; & Timely Access to VA Health Care. www.independentbudget.org/

[3] Department of Veterans Affairs, Office of Inspector General; *Semiannual Report to Congress, October 1, 2008 – March 31, 2009*; pg. 10. http://www4.va.gov/oig/pubs/VAOIG-SAR-2009-1.pdf

H.R. 949—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.

This bill would repeal specified exceptions to rights of certain VA health professional employees to engage in collective bargaining over conditions of employment. It would also require reviews of adverse personnel actions of VA employees be completed within 60 days after such actions have been appealed, and would permit judicial review of these final decisions by the appropriate U.S. District Court or, if a decision were made by a labor arbitrator, review would occur within the jurisdiction of the U.S. Court of Appeals for the Federal Circuit in a manner similar to processes of the Merit Systems Protection Board in reviewing decisions related to federal employees under title 5, United States Code.

Mr. Chairman, this bill would restore bargaining rights for clinical care employees of the VHA that have been eroded over the past several years. A similar version of this bill was introduced in both Chambers in the 110th Congress but did not advance.

DAV did not receive an adopted resolution from our membership on the specific VA labor-management dispute that prompted Chairman Filner's introduction of this bill. However, as a partner organization of the IB, DAV endorses its recommendations dealing with the need for VA to improve its human resources management systems and programs to make VA a better workplace for the care of sick and disabled veterans. Also, we believe VA-recognized labor organizations that represent employees in 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 (a stated longstanding VA strategic goal), and particularly to fully represent VA employees on issues impacting their working conditions, ultimately protecting the quality of care for veterans.

Congress passed section 7422, title 38, United States Code (USC), 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, USC. 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, USC. Nevertheless, federal labor organizations continue to report that VA has severely restricted the recognized federal bargaining unit representatives from participating in, or even being informed about, human resources management 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 – subsections that this bill would repeal – 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 or to discuss the fairness of these policies, 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 to DAV that the often contentious local environment consequent to these disagreements could diminish the VA as a preferred workplace for many of its health care professionals. As a result, veterans who depend on VA and who receive care from VA's physicians, nurses and others in the professional ranks can be negatively affected by that environment.

We believe this bill, that if enacted would rescind VA's claimed authority to refuse to bargain on matters within the purview of section 7422, through striking of subsections (b), (c) and (d), would clarify other critical appeal and judicial rights of title 38 appointees, and would return VA and labor to a more balanced bargaining relationship on issues of importance to VA's professional workforce. In past hearings before this Committee, VA clearly has indicated vigorous disagreement with the intent of the bill, but to date has not offered to compromise its position in refusing to bargain across a wide group of issues that are defined by VA as "direct patient care." Given the continuing stalemate, our only recourse is to support the intent of the bill in the spirit of the recommendations we

have made in the IB, yet continue to urge both VA and Federal labor organizations to seek and find a basis for compromise on these matters.

H.R. 1075—RECOVER Act (Restoring Essential Care for Our Veterans for Effective Recovery)

In the event of a declared major disaster, on or after August 29, 2005, where a VA medical facility is unable to provide covered health care services for at least 180 days due to the disaster, this measure would direct VA to contract with one or more non-VA facilities in that area to provide such services to veterans who reside within 150 miles of the affected VA facility(s). The requirement would not be applicable to VA facilities that were closed, or were intended to be closed as part of the Capital Asset Realignment for Enhanced Services (CARES) process.

Nearly four years after Hurricane Katrina, the House Veterans' Affairs Committee conducted a field hearing on July 9, 2009, in New Orleans, Louisiana, to explore the challenges faced by the VA and other local health care facilities to provide high quality safe health care to area veterans and citizens. Believing geographic and timely access to care is particularly important to disabled veterans in need of medical attention, DAV testified that our nation owes it to our veterans to properly care for them now—and not keep them waiting.

Prior to and during the disaster, VA did an admirable job of ensuring veteran patients were expeditiously evacuated, relocated and kept safe, and that local veterans' medical records were available to other VA medical facilities to meet immediate needs for medications and specialized care. However, over the last four-plus years, VA has struggled to re-establish *comprehensive* care services in the area following the devastating effects of Hurricane Katrina, and ensuring the immediate health care needs of our veterans are met without undue hardship. The network of community-based outpatient clinics and deployment of mobile clinics have created capacity to meet veterans' basic outpatient primary care needs; however, reports from many affected veterans indicated that if hospitalization or inpatient treatment in a tertiary care facility were necessary, they must still travel great distances to the nearest VA health care facilities that can provide their needed care. For some elderly, ill, brittle and disabled veterans this creates a travel hardship. In addition, family members are often unable to accompany veterans due to travel restrictions, given the cost of travel without financial assistance for subsistence or lodging. Of note, research has proven that family support during hospitalizations and recovery, or during difficult or stressful medical procedures can assist with accelerating recovery time and lowering length of stay, both resulting in cost savings for the VA.

This Subcommittee is aware of DAV's position regarding contracting care, specifically that it be utilized judiciously by VA. Current law places limits on VA's ability to contract for private health care services in instances where VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has the authority to contract to obtain the services of scarce medical specialists in VA facilities.

Hurricane Katrina impacted all of the major medical facilities in the immediate city area affected and we understand most are still not operational. However, in retrospect, it seems possible that VA could have established more contracts with other medical facilities just outside the affected city area. DAV is concerned that VA sparingly used existing authority in the instance of this major disaster, to contract with local non-VA facilities in the region to provide inpatient care but rather required veterans who were sick and in need of inpatient care to make long trips to the nearest VA facility in many cases.[4] We do not believe such actions are in the best interest of sick and disabled veterans who rely on VA, nor are they an acceptable standard in this instance, given the length of time it has taken to reestablish and rebuild new VA facilities in that location. We hope, in considering this bill, the Subcommittee will note that within mere weeks of the disaster, Congress provided billions of dollars to restore the Gulf Coast region. Those funds and mandates failed to include mandates for replacement of the destroyed VA medical centers in New Orleans and Gulfport. While Congress eventually acted to authorize the funds and projects to replace these facilities destroyed by the storm, nearly five years after Katrina, sick and disabled veterans still await the opening of the replacement facilities.

[4] Travel times and distances from the New Orleans VAMC to: Biloxi VAMC – 1.5 hours/85 miles; Sonny Montgomery (Jackson) VAMC – 3 hours/189 miles; Alexandria VAMC – 3.5 hours/199 miles; the Michael E. DeBakey (Houston) VAMC – 6 hours/352 miles; Overton Brooks (Shreveport) VAMC – 5.5 hours/319 miles.

The delegates to our most recent National Convention passed DAV Resolution No. 037, calling on VA to ensure timely access to quality health care and medical services. We therefore support the purposes of this bill as a contingency, but point out concerns that we recommend be addressed before final passage. The operational loss of a VA medical facility due to a major disaster and subsequent contracting with non-VA facilities as proposed by this measure should not become a foundation for delay of replacement facilities, or repair of the affected VA facility. Also, the bill should reflect Congressional intent that upon the completion of replacement or repair of an affected VA facility, veterans who have received care under a contract arrangement with a non-VA facility will return to the repaired or replaced VA facilities for their continuing health care needs. Accordingly, we recommend improvements outlined in DAV Resolution No. 232 (on the need for better coordination of VA contract care programs), to include ensuring that service-connected disabled veterans would not be financially encumbered in receiving non-VA care at VA's expense; and that VA would establish a systemic, comprehensive contract care coordination program for these patients.

H.R. 2698—Veterans and Survivors Behavioral Health Awareness Act

The intent of this measure would improve and enhance the mental health care benefits available to veterans as well as to enhance counseling and other benefits to survivors of veterans.

Section 2 of this bill would direct the VA Secretary to provide scholarships to individuals pursuing education or training leading to licensure or other certified proficiency in behavioral health care specialties that are critical to the operations of Vet Centers for readjustment counseling and related mental health services for veterans. These scholarships would assist in recruitment and in retaining individuals within such specialties. In order to accept scholarships, the recipients would agree to continue to serve in such a capacity for defined periods the Secretary specified in agreements—including repayment of the scholarships if encumbered individuals subject to these scholarships failed to fulfill the service requirements of the aforementioned agreements. The VA Secretary would determine the amount of the scholarships and amounts under the program would be derived amounts available to the Secretary for readjustment benefits—but would not exceed $2 million in any fiscal year (FY).

Section 3 of this bill would stipulate that upon receipt of a request for counseling from an individual discharged or released from active service, but who would not be otherwise eligible for such counseling, the Secretary would be required to 1) provide referrals to assist the individuals in obtaining mental health care and services outside the VA to extent practicable; and 2) if pertinent, would advise such individuals of their rights to apply for review of their military discharge documentation.

Section 4 would direct the Secretary to award grants to nonprofit organizations that provide emotional support services for survivors of deceased members of the Armed Forces (including National Guard and Reserves) and deceased veterans through peers of such survivors. The Secretary would establish the criteria for nonprofit organizations' eligibility through an application process to be specified by the Secretary as well as the amounts for such awards.

While the DAV has no specific resolution pertaining to section 2 of the measure, related to scholarships, we have two national resolutions that apply to the main intent of this section of the bill. The first is DAV's resolution number 101, which calls for adequately funding and sustaining the successful readjustment counseling services of the VA and its highly effective Vet Center programs. The second DAV resolution is number 243, which strongly supports program improvement and enhanced resources for VA mental health programs to achieve readjustment of new war disabled veterans and continued effective mental health care for all enrolled veterans needing such services.

In addition, the FY 2011 IB contains a section on human resources challenges facing VA. We remain concerned about the current status of human resources challenges faced in the VA and the need to consider creative and alternative programs to ensure veterans have access to the best medical and mental health services for rehabilitation of their service-related injuries. We have recommended that Congress and VA continue to work to strengthen and energize VA's human resources management programs to recruit, train, and retain qualified VA employees and to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for veterans.

Therefore, since the intent of the section is to recruit and retain mental health care providers at VA's Vet Centers, we support enactment of this section of the bill.

DAV has no objection to the provisions in Section 3 of H.R. 2698 related to referrals to assist individuals, who are not otherwise eligible for Vet Center counseling services, in obtaining mental health care and services outside the VA or to advise such individuals of their rights to apply for review of their military discharge determinations.

The DAV does not have a specific resolution related to Section 4 of the bill that pertains to federal funding through a grant program for nonprofits to provide emotional support through peer groups to survivors of deceased service members and veterans. We do support the peer-to-peer initiatives that have been employed in the VA's Vet Center program. However, DAV would not be able to participate in the program that would be authorized in this section of the bill because, as a matter of principle, DAV does not accept federally appropriated grants to provide services to disabled veterans.

H.R. 2699—Armed Forces Behavioral Health Awareness Act

The purpose of this measure would be to improve the mental health care benefits available to members of the armed forces, including Reserve components, and to enhance counseling available to service members' family members.

Section 2 of this measure would make any service member of the armed forces who deploys in support of Operations Enduring Freedom or Iraqi Freedom (OEF/OIF) eligible for readjustment counseling and related mental health services through VA Vet Centers, regardless of the member's duty status.

Section 3 would require that the Secretary of Defense award grants to nonprofit organizations that provide emotional support services for family members of members of the Armed Forces, including members of the Reserve components. The amount of each grant and duration of the program would be determined by the Secretary based on the scope of the proposed program. Such funding would be derived from the amounts authorized to be appropriated to the Department of Defense (DoD) for military personnel.

Section 4 would require the Secretary of the Army to carry out a three year pilot program to enhance awareness and understanding of post traumatic stress disorder (PTSD) among members of the Army at three military base locations: Fort Huachuca, Arizona, Fort Carson, Colorado, and Fort Leonard Wood, Missouri, and for the family members of service members covered under the bill in order to assist the families in recognizing and addressing PTSD. No later than two years after the date of enactment, the DoD Secretary would be required to submit a report to Congress assessing the effectiveness of the pilot program.

DAV takes no position on provisions in H.R. 2699 related to enhancement of post-deployment mental health services for active duty service members, Reserve components or their family members. These matters are under the jurisdiction of the Committees on Armed Services. We do provide the following comments on Section 2 of the bill related to expansion of eligibility of readjustment counseling services at Vet Centers under section 1712 A of title 38, United States Code.

DAV's resolution number 243 strongly supports program improvement and enhanced resources for VA mental health programs to achieve readjustment of new war disabled veterans and continued effective mental health care for all enrolled veterans needing services. Although we do not have a resolution specific to expanding eligibility for Vet Center services to active duty status service members, we have supported seamless transition for service members and veterans and improved collaboration between the two Departments to achieve this goal. Therefore, we have no objection to such expansion, since it would likely be most beneficial for certain service members to obtain early interventions of any deployment-related mental health concerns to avoid more complicated health challenges and costly treatment interventions at a later date. We note similar provisions are included in Title IV of the proposed negotiated agreement on an omnibus VA health care bill, the vehicle for which will be S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2010.

Should the Subcommittee plan to report this measure to the full Committee, we ask you to consider amending Section 2 of the bill to include provisions to authorize either a cost sharing agreement with DoD, as envisioned in Public Law 97-174, to cover the VA's costs of service members' care based on data verifying the number of service members who access such counseling, or to authorize additional VA resources in the bill specifically for this care of the active force, as well as the cost of the additional staff needed to provide such services. Additionally, consideration should be given to include provisions to provide proper outreach to active service members about this exceptional service and assured confidentiality when accessing such care at a VA Vet Center, to ensure the intended purpose of the program is achieved.

H.R. 2879—Rural Veterans Health Care Improvement Act of 2009

Section 2 of this bill would amend Section 111, title 38, USC, to insert a fixed rate of 41.5 cents per mile in reimbursement 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 after 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 OEF/OIF 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 (IHS) and the 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 DAV appreciates the intent of this measure to improve health care for veterans residing in rural and remote areas. With some concern outlined below, we support enactment of this bill as consistent with DAV resolution numbers 240 (related to VA's beneficiary travel reimbursement policy) and 247 (related to improved health care services and access for veterans living in rural areas), adopted by our membership at DAV's 2009 National Convention.

As this Subcommittee is aware, the conference report accompanying the Consolidated Appropriations Act of 2008 (Public Law 110-161), 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 (Public Law 110-329), 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 reduced 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, Subsection 111 (c)(1) and (2) for travel expenses incurred on or after January 9, 2009.

DAV supported the increase in mileage reimbursement afforded under Public Law 110-329. However, by prescribing in law the current travel reimbursement rate of 41.5 cents per mile without any mechanism for annual adjustment may lead to the situation that occurred prior to enactment of Public Law 110-161 to break the long period where the beneficiary travel mileage reimbursement rate had not been changed in over 30 years.

Additionally, in eliminating title 38, USC, Subsection 111 (g), we are concerned this bill does not replace the required report from VA containing full justification (including the ramifications of diverting funds not provided for in appropriations, such as those in Public Laws 110-161 and 110-329, from direct medical care for the purpose of increasing mileage) when exercising its authority to increase or decrease the rates of allowances or reimbursements. We refer the Subcommittee to Section 305 of the recently reached proposed negotiated agreement on an omnibus VA health care bill, the vehicle for which will be S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2010. In amending title 38, USC, Subsection 111 (g), S. 1963 provides certain flexibility to the Secretary as it relates to investigating and determining the actual cost of travel for establishing VA mileage reimbursement rates.

Finally, should Congress decide to strike Subsection (g) of title 38, USC, Subsection 111, as is proposed by this measure, we recommend a technical correction be made to Subsection 111 (b)(1) because it references Subsection (g)(2)(A).

H.R. 3926—Armed Forces Breast Cancer Research Act

This Act would direct the Secretaries of DoD and VA to jointly conduct a study on the incidence of breast cancer among members of the Armed Forces, including National Guard and Reserve components, and veterans and report those study results to Congress.

H.R. 3926 would also require demographic information on study participants including information on possible exposure to hazardous elements or chemical or biological agents (including vaccines), locations in which the service members or veterans were deployed, and analysis of breast cancer treatments received by Armed Forces members and veterans.

DAV Resolution No. 252 urges greater collaboration between DoD and VA to share necessary deployment, health and exposure data from military operations and deployments, in order to timely and adequately address the subsequent health concerns of disabled veterans, whatever the causes of those disabilities. Additionally, this resolution urges Congress to provide adequate funding for research to identify all disabling conditions and effective treatment for such disabilities that may have been caused by exposure to environmental hazards and man-made toxins while serving in the Armed Forces of the United States.

DAV is committed to ensuring veterans disabled by exposure to environmental hazards and toxins receive effective high quality health care and that the biomedical research and development programs of the Department are fully addressing their needs. For these reasons we are pleased to support H.R. 3926, the Armed Forces Breast Cancer Research Act, and urge its passage.

H.R. 4006—Rural, American Indian Veterans Health Care Improvement Act of 2009

The Rural, American Indian Veterans Health Care Improvement Act of 2009 directs the Secretary of VA to assign an Indian Veterans Health Care Coordinator for each of the ten VA facilities that serve communities with the greatest per capita number of Indian veterans. The Indian Veterans Health Care Coordinator would be tasked with: (1) improving outreach to tribal communities; (2) coordinating the medical needs of Indian veterans on Indian reservations with the VHA and the IHS; and (3) acting as an ombudsman for Indian veterans enrolled in the VHA health care system.

The bill would require the VA and the Department of the Interior to enter into a memorandum of understanding to ensure the electronic transfer of health records of Indian veterans between IHS and VA facilities. Moreover, VA would be authorized to transfer to IHS any surplus medical and information technology equipment.

This measure would also require VA and the Department of Health and Human Services (HHS) to report jointly to Congress on the advisability of the joint VHA-IHS establishment and operation of health clinics to serve populations of Indian reservations, including Indian veterans**.**

Since 2003, the IHS and the VHA have collaborated using a memorandum of understanding (MOU) to promote greater cooperation and resource sharing to improve the health of American Indian/Alaska Native (AI/AN) veterans. The MOU encourages VA and IHS programs to collaborate and improve beneficiaries' access to health care services, improve communications between IHS and VHA and to create opportunities to develop strategies for sharing information, services, and information technology. In some areas, this coordination between IHS and VHA has improved while in other areas, such coordination needs improvement.

A recent study examined AI/AN veterans' utilization of the IHS and VA health services. Based on the study's survey, 25 percent of AI/AN veterans receive care through both IHS and VA, while over 25 percent of AI/AN veterans accessed care through VA only and nearly 50 percent of AI/AN veterans accessed care through IHS only.[5] Those AI/AN veterans who used both VA and IHS for medical care actively matched health care resources to their medical needs, generally use IHS for primary care and VA for specialty care, thus using VA as a form of supplemental coverage. The report also indicates that AI/AN veterans report a high rate of unmet health care needs and experience a lack of coordination of health care.

Another study concluded fostering closer alignment between VHA and IHS would reduce care fragmentation and improve accountability for patient care.[6] This study found coordination between VA and IHS providers occurred on an ad hoc basis. Although both VA and IHS could share information through medical releases, veterans were dissatisfied with the burdensome process when it was made available as an option. Since medical information was not routinely shared, treating chronic health conditions was challenging, especially when providers were unaware of their counterpart's recommendations of treatments, including medications and dosage. Appropriate referrals to VHA from the IHS would be a significant step toward resource sharing that would benefit both organizations financially. By displaying leadership in coordination of care, VHA and IHS can demonstrate how to overcome technical, policy and administrative challenges in implementing the Institute of Medicine recommendations to enhance quality through data sharing and care coordination.[7]

As with Section 7 of H.R. 2879, the Rural Veterans Health Care Improvement Act of 2009, DAV supports this measure based on DAV Resolution No. 247 (supporting improved access to rural health care services for veterans residing in those areas), adopted by our membership at DAV's 2009 National Convention. We are aware that better collaboration between VA and IHS is critical, particularly in the behavioral health understanding and accommodation of the cultural needs of American Indian, Alaska Native and Pacific Islander veterans—and that culturally traditional treatments should be considered as an option for tribal veterans.

Draft Bill—To amend title 38, United States Code, to make certain improvements in the laws relating to performance pay and collective bargaining rights for certain employees of the Department of Veterans

This measure would amend section 7431(d)(2) of title 38 by inserting "individual" after "dentist's" and by inserting "in accordance with regulations" after "objectives," in addition to editing section 7422 by inserting "rates" after "employee compensation." Further, "patient care" would be inserted in subsection (c)(1) after "not including procedures or appropriate arrangements as such terms are used in section 7106(b) of title 5l and in subsection (d) by inserting "rates" after "employee compensation."

Section 1 of this bill would clarify Congressional intent in establishing performance pay elements for VA physicians and dentists in Public Law 108-445, the VA Health Care Personnel Enhancement Act of 2004, by sharpening its intent to measure performance of individual physicians and dentists, rather than groups of these key

[5] B.J. Kramer, M. Wang, et al; *Veterans Health Administration and Indian Health Service – Healthcare Utilization by Indian Health Service Enrollees*, Medical Care Vol. 47, No. 6. June 2009
[6] B.J. Kramer, R.L. Vivrette, MA, et al; *Dual Use of Veterans Health Administration and Indian Health Service: Healthcare Provider and Patient Perspectives*, Gen Intern Med. 24(6): 758–764. Published online April 18, 2009
[7] Institute of Medicine, Committee on Enhancing Healthcare Quality Programs. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*; National Academy Press. 2002

VA professionals in establishing performance pay. The bill would also require the Secretary to establish by published regulation (presumably in the *Federal Register*) in advance the performance objectives that VA would use to justify awarding performance-based salary increments, or performance bonuses, to VA physicians and dentists who chose to function under those performance objectives. Under the bill, such regulations would be required to be published within 60 days post-enactment of this bill.

The DAV has no adopted resolution on these particular matters, but we again refer the Subcommittee to the FY 2011 IB discussion on the need for VA to improve human resources programs. Publishing performance objectives for VA physicians and dentists in the *Federal Register* in advance of their use would be a novel but probably effective way to guarantee VA would be required to consider their views before adopting new procedures that impacted their conditions of employment. We believe this bill's enactment would be consistent with our views in the IB. Thus, we would have no objection to passage of this section.

Section 2 of the bill would make a series of amendments to section 7422 of title 38, USC, in subsections (b), (c) and (d), to narrow the definition of exclusions from collective bargaining dealing with the interests of certain health professional employees of the Department. Again, DAV refers the Subcommittee to our human resources discussion in the IB for FY 2011. These changes would afford recognized employee units more ability to bargain with VA on policies that would make VA a preferred workplace for clinical professional staffs. DAV would offer no objections to enactment of this section of the bill. However, we remind the Subcommittee of our comments on H.R. 949, a bill that would repeal each of the subsections of title 38 that this bill would amend.

Draft Bill—To amend title 38, United States Code, to improve the continuing professional education reimbursement provided to health professionals employed by the Department of Veterans Affairs

This bill would expand from VA physicians and dentists to a wider group of VHA professional employees who are eligible for annual continuing education allowances, and would increase such allowances from $1,000 to $1,600 per annum per employee. Amendments to effect this change would be made to section 7411(1) of title 38, USC, by striking "physician or dentist" and replacing it with "health professional" employees appointed under paragraph (1) or (3) of section 7401 of the title. The bill would also specify that no health professional could receive reimbursement under this section in addition to any other reimbursement for expenses incurred for education provided by a Department medical center.

While we have no resolution adopted on this specific matter from our membership, the purpose of the bill is consistent with VA's maintaining technical proficiencies of VA clinical professionals. On that basis, DAV would offer no objection to its enactment into law.

Draft Bill—To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to waive certain requirements relating to mental health counselors

This bill would amend section 7202(b)(11)(B) by inserting "except that the Secretary may waive the requirement of licensure or certification for an individual licensed professional mental health counselor for a reasonable period of time recommended by the Under Secretary for Health" before the period where it appears. We noted a technical error in the text in that it refers to "section 7202," a section that does not exist in title 38, rather than section 7402, a section that refers to "Qualifications of appointees" in the VHA.

Assuming it would apply to section 7402, this bill would grant the VA Secretary a temporary period to retain VA mental health professional employees while they sought professional certifications and state licensures within their fields. Given the shortage of mental health professionals today in general, and given VA's need to continue to prepare for a major growth of mental health workloads due to the anticipated end of wars in Iraq and Afghanistan and the mental health legacy associated with these wars, this proposal seems reasonable as a needed human resources flexibility. Also, given VA's massive academic programs in which tens of thousands of professional and technical students rotate in VA facilities each year as a part of their *practica*, this tool might help VA with a number of its chronic recruitment challenges. Thus, while DAV has no adopted resolution from our membership on this particular issue, we would not object to enactment of this bill.

Mr. Chairman, this concludes DAV's testimony. Again, we thank the Subcommittee for its leadership, and for requesting our views on the legislation under consideration by the Subcommittee at this hearing. I would be pleased to respond to any questions from you or other members of the Subcommittee on these issues.