

**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 8, 2011**

Chairman Murray, Ranking Member Burr and Members of the Committee:

On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to present our views on 34 bills under consideration today.

S. 277 – Caring for Camp Lejeune Veterans Act of 2011

Section 2 of this bill would furnish Department of Veterans Affairs (VA) hospital care, medical services, and nursing home care to veterans who were stationed at Camp Lejeune, North Carolina during a period, determined by the VA Secretary in conjunction with the Agency for Toxic Substances and Disease Registry of the Department of Health and Human Services, in which the water at Camp Lejeune was contaminated by volatile organic compounds, including known human carcinogens, notwithstanding that there is insufficient evidence to conclude such illness is attributable to such contamination.

Section 3 of this measure would create a new section 1786 under subchapter VIII of title 38, United States Code. Specifically, this bill would require a family member of the above described veteran who resided at Camp Lejeune during the same period, or who was in utero during such period, to be eligible for the same VA hospital care, medical services and nursing home care furnished by the Secretary for any condition, or any disability that is associated with such condition. The Secretary shall prescribe regulations that specify which conditions and disabilities are associated with said exposure.

The delegates to our most recent National Convention in Atlanta, Georgia, July 31-August 3, 2010, adopted two resolutions related to this bill. Resolution No. 298 urges congressional oversight and federal vigilance to provide for research, health care and improved surveillance of disabling conditions in veterans resulting from military toxic and environmental hazards exposure. Resolution No. 278 calls for supporting legislation to provide for service connection of veterans for disabling conditions resulting from toxic and environmental exposures.

Accordingly, we support section 2 of this measure; however, we recommend any medical care provided to veterans' dependents under section 3 of this bill should be provided either under the military TRICARE program, or if in VA, in the Civilian Health and Medical Program of VA (CHAMPVA). We do not believe providing direct eligibility for these dependents in VA health

care facilities would be in the best interest of either the VA system of care, or of the veterans who must rely on that system. Without a significant infusion of new funding – which this bill would not authorize – introducing a large, new treatment population into direct VA health care would cause rationing of care for those already enrolled in order for VA to generate the considerable additional resources that would be needed for the care of a new, unanticipated population. We would prefer that TRICARE be assigned this responsibility as a more appropriate source of continuing federal care for this dependent population.

S. 396 – Meeting the Inpatient Health Care Needs of Far South Texas Veterans Act of 2011.

If enacted, this measure would require the Secretary of Veterans Affairs to ensure that the South Texas Veterans Affairs Health Care Center in Harlingen, Texas includes a full-service VA inpatient health care facility—and, if necessary, shall modify the existing facility to meet this requirement.

The author of the measure argues that given the veteran population in the area, there is a high demand for VA medical services and that VA is not meeting the current health care needs of veterans residing in far south Texas. Additionally, it was noted that travel times in that area can exceed six hours for certain veterans in need of acute inpatient health care from VA, and they must seek that care in distant cities such as San Antonio, Houston and Dallas.

DAV does not have a specific resolution from our membership on this issue, nor does the national organization get involved in the placement of VA medical facilities. However, we acknowledge that access to inpatient services is a challenge for many veterans living in more rural and remote areas and certain areas of the country where there is only a minor community-based outpatient clinic (CBOC) available to deal with primary health care needs. We note that in Public Law 108-170, sections 223 and 224, Congress directed VA to establish a defined plan to provide inpatient hospital care to veterans residing in far south Texas and other rural, frontier and remote regions in need of a greater VA bed presence. This act also gave VA a variety of new statutory tools to accomplish that goal.

We believe that the Veterans Health Administration (VHA) Office of Rural Health (ORH) is deeply engaged today in establishing better access to care for rural and remote veterans. Since its inception, the ORH has funded well over 500 projects/programs across the VA health care system to accomplish its mission of increasing access and improving the quality of health care for enrolled rural and highly rural veterans. In the 2010-2014 ORH strategic plan, six major goals are outlined:

- 1) **Improve access and quality of care** through the establishment of new access points, by supporting new and ongoing transportation solutions to VA facilities and by supporting initiatives such as the home based primary care program
- 2) **Optimize the use of available and emerging technologies** such as telemedicine, web-based networking tools, and the use of mobile devices to deliver care to and monitor the health of rural and highly rural veterans
- 3) **Maximize utilization of existing and emerging studies and analyses** to impact care delivered to rural and highly rural veterans

- 4) **Improve availability of education and training** for VA and non-VA health care providers to rural and highly rural veterans by supporting initiatives such as the Graduate Medical Education Enhancement Initiative for residents, nurse practitioners and social workers who want specialized training in Rural Health
- 5) **Enhance existing and implement new strategies to improve collaborations and increase service options** for rural and highly rural veterans such as the recent Indian Health Service-VA Memorandum of Understanding, which will improve health care delivery by sharing programs, improving coordination of care, and increasing efficiency through sharing contracts and purchasing agreements
- 6) **Develop innovative methods to identify, recruit and retain medical professionals and requisite expertise** in rural and highly rural areas.

In fiscal year (FY) 2011, ORH is supporting over 275 individual projects across the country at a cost of over \$500 million (this does not include ORH-funded projects overseen by three Veterans Rural Health Resource Centers). Many of these are in collaboration with other VA program offices such as the Office of Mental Health, Geriatric and Extended Care Office, and the Office of Telehealth Services.

We strongly concur that VA must work to improve access for veterans that are challenged by long commutes and other obstacles in gaining reasonable access to the full continuum of health care services at VA facilities and explore practical solutions when developing policies in determining the appropriate location and setting for providing VA health care services. At a minimum, VA should include experts and veterans service organization representatives from the areas in question in decisions made regarding access to inpatient care services to help VA consider alternative program and policy decisions that would have positive effects on veterans who live in these areas.

DAV recommends the sponsors of this bill ask VA to provide them with a current assessment of the veteran population in far south Texas including the need for hospital services to see if adding an inpatient capability is feasible and what methods if any VA intends to pursue to achieve that goal.

S. 411 – Helping our Homeless Veterans Act of 2011

Veterans living in rural areas, underserved metropolitan areas, or Indian lands require an adequate share of targeted housing vouchers. This legislation instructs the VA to ensure appropriate Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) vouchers are distributed to these populated areas as well. Allowing these services to be administered by local community organizations will give underserved veterans greater access to this important program. Inclusion of other partners into housing as part of case management is an important step in moving forward on ending veteran homelessness.

This legislation supports our mission, which is to build better lives for disabled veterans, their families and survivors. We support this bill, in accordance with DAV Resolution No. 223, which calls for sustained sufficient funding to improve services for homeless veterans. It is projected that there will be a need for a significant increase in services over current levels to

serve veterans of all eras. The Secretary of Veterans Affairs' campaign to end homelessness among veterans through enhanced collaboration with other federal and state agencies, faith-based organizations, veterans' service organizations and other community partners is essential. This legislation addresses these issues by expanding case management services delivery through nonprofits and state entities.

Accordingly, DAV supports S. 411.

S. 423 – A bill to provide authority for retroactive effective date for the availability of compensation with the submission of a fully developed claim.

This bill would amend title 38, United States Code, section 5110(b) to allow for a retroactive effective date up to one year earlier than the date of submittal of a fully developed claim, based on the facts found.

Although DAV does not have a resolution on this specific issue, DAV Resolution No. 073 supports reform of the VA disability claims process. DAV supports passage of this legislation, as it is in the best interest of both the VA and veterans, it will improve the current claims process and provide for the timely delivery of claims.

S. 486 – Protecting Servicemembers from Mortgage Abuses Act of 2011

This bill amends the Servicemembers Civil Relief Act, extending the period of protection from the current nine months to 24 months after leaving military service against mortgage sale or foreclosure, as well as the stay of proceedings, in the case of an obligation on real property that originated before the period of military service. This bill also increases criminal and civil penalties for mortgage abuses, including felonies for unlawful eviction or distress or for unlawful sale, foreclosure, or seizure.

While DAV does not have a resolution on this matter, we would not be opposed to its favorable consideration.

S. 490 – A bill to increase the maximum age for children eligible for medical care under the CHAMPVA program.

This measure would amend title 38, United States Code, section 1781(c) to increase the maximum age for children eligible for medical care under CHAMPVA.

CHAMPVA was established in 1973 within the VA to provide health care services to dependents and survivors of our nation's veterans. CHAMPVA enrollment has grown steadily over the years and, as of FY 2009, covers more than 336,000 beneficiaries.

Under current law, a dependent child's eligibility, which otherwise terminates at age 18, continues to age 23 when such child is pursuing an approved full-time course of education.

The landmark health care reform act that was enacted into law last year includes a provision that requires private health insurance to cover dependent children until age 26.

This is in line with DAV Resolution No. 201, supporting legislation to extend eligibility for CHAMPVA until an eligible child's graduation from an approved course of full-time education.

DAV therefore strongly supports this measure.

S. 491 – Honor America's Guard-Reserve Retirees Act of 2011

This bill would amend Chapter 12 of title 38, United States Code, by conferring the designation of "veteran" on members of the Reserve component of the armed forces who retired due to age. While the bill does specify that these individuals are entitled to retired pay for their nonregular service, they would *not* be entitled to benefits provided to those who served on active duty.

DAV does not have a resolution on this matter. We are concerned, however, that measures such as this, if enacted, may then lead to a misunderstanding in the minds of the American public about those veterans who earned the designation of veteran by virtue of their active duty service, injury or deployment and those who have been honored with the title veteran and a misunderstanding of what benefits they receive or are entitled to receive.

S. 536 – A bill to provide that utilization of survivors' and dependents' educational assistance shall not be subject to the 48-month limitation on the aggregate amount of assistance utilizable under multiple veterans and related educational assistance programs.

This bill amends title 38, United States Code, to remove the 48-month limitation for survivors and dependents to use the aggregate amount of assistance utilizable under multiple veterans and related educational assistance programs.

DAV has no resolution, but is not opposed to its favorable consideration.

S. 572 – A bill to repeal the prohibition on collective bargaining with respect to matters and questions regarding compensation of employees of the Department of Veterans Affairs other than rates of basic pay.

This bill would restore some bargaining rights for clinical care employees of the VHA that had been eroded. The bill would amend subsections (b) and (d) of section 7422 of title 38, United States Code, by striking "compensation" both places where the term appears and inserting "basic rates of pay" in its place. The intent of the bill would be to authorize employee representatives of recognized bargaining units to bargain with VHA management over matters of employee compensation other than rates of basic pay.

We understand recently VA has given federal labor organizations some indication of additional flexibility in negotiating labor-management issues such as some features of

compensation, and we are hopeful that this change of heart signals a new trend in these key relationships that directly affect sick and disabled veterans under VA care.

DAV does not have an approved resolution from our membership on the specific issues addressed by this bill. However, we would not oppose its enactment, while continuing to hope that VA and federal labor organizations can find a sustained basis for compromise and resolution.

S. 666 – Veterans Traumatic Brain Injury Care Improvement Act of 2011

This bill would require VA to submit a report to Congress on the feasibility and advisability of establishing a Polytrauma Rehabilitation Center or Polytrauma Network Site for the VA in the northern Rockies or the Dakotas.

DAV does not have a resolution on this particular issue, and we therefore have no position.

S. 696 – A bill to treat Vet Centers as Department of Veterans Affairs facilities for purposes of payments or allowances for beneficiary travel to Department facilities.

The legislation would amend title 38, United States Code, section 111, to allow for beneficiary travel benefits to eligible veterans who receive care at Vet Centers as those who travel to VA health care facilities.

Under current law, readjustment counseling authorized under title 38, United States Code, section 1712A is not considered part of VA's medical benefits package under title 38, Code of Federal Regulations, section 1738.

DAV believes adequate travel expense reimbursement is directly tied to access to care for many veterans, and is not a luxury. DAV supports this legislation based on DAV Resolution No. 214, and urge its favorable consideration.

S. 698 – A bill to codify the prohibition against the reservation of gravesites at Arlington National Cemetery.

This bill would amend title 38, United States Code, to codify the prohibition against the reservation of gravesites at Arlington National Cemetery, and for other purposes. It stipulates that no more than one gravesite shall be provided at Arlington to a veteran or member of the Armed Forces or family member who is eligible for burial. Additionally, it specifies that no gravesite shall be reserved at Arlington before an individual's death, except in the case of a request submitted to the Secretary of the Army before January 1, 1962.

DAV does not have a resolution on this matter and, therefore, we have no position on this measure.

S. 745 – A bill to protect certain veterans who would otherwise be subject to a reduction in educational assistance benefits.

This bill would amend title 38, United States Code, to protect certain veterans who would otherwise be subject to a reduction in educational assistance benefits, and for other purposes. This bill would allow veterans who are using the Post 9/11 GI Bill and enrolled at nonpublic institutions of higher education from August 1, 2011 through December 31, 2014, the lesser of: (1) the established charges for that program; (2) the established charges payable under the VA's maximum payments table published on October 27, 2010; or (3) the amount for the previous academic year, increased by the authorized annual percentage increase.

While DAV does not have a resolution on this matter, we are not opposed to its favorable consideration.

S. 769 – Veterans Equal Treatment for Service Dogs Act of 2011

This bill would ensure that the VA Secretary not prohibit the use of service dogs provided by VA for veterans with a hearing impairment, spinal cord injury/dysfunction or any other chronic impairment that limits mobility in any facility or on any property of the Department or in any facility or on any property that receives funding from the Secretary.

Congress found that the usage of medical service dogs among veterans is increasing. Likewise, VA currently allows seeing-eye dogs in Department facilities and does not place any limitations on the access of seeing-eye dogs to Department facilities. This legislation would amend Section 1714 of title 38, United States Code, by adding a new subsection—aimed to ensure that veterans with service dogs have the same access in VA facilities as guide dogs for the blind.

The VHA published VHA Directive 2011-013 on March 10, 2011, related to its policy on access of guide dogs and service dogs on VHA property. The directive acknowledges that trained guide dogs and other trained service dogs can play a significant role in maintaining functionality and promoting maximal independence of individuals with disabilities. Therefore, individuals with disabilities are authorized to enter VHA facilities accompanied by their guide dogs or *trained* service dogs consistent with the same terms and conditions, and subject to the same regulations, that govern the admission of the general public to the property.

VA does note that therapy animals, companion animals, emotional support animals, and pets are not covered by this directive. The directive further notes that VHA facility directors do have the authority to make determinations regarding the entry of dogs into VHA facilities or on VHA property. Furthermore, each facility director is required to ensure there is a written published policy that addresses the issue of VHA access for guide and service dogs. The policy states that dogs are not permitted to roam free in VHA facilities and must be on a leash, in a guide harness or under control at all times.

Although VA's directive on this issue is clear and addresses the issue specifically—DAV has received information over the past year that this policy directive may not be consistently

applied at all VA facilities. DAV has no specific resolution from our membership in support of this measure; however, it appears the bill would clarify current VHA policy on this matter and would be beneficial to a number of service-disabled veterans. Therefore, we would not object to its passage. We are aware that VA is engaged in a formal research project dealing with the use of service dogs for patients with certain mental health conditions. We believe the results of this research will better inform VA policy on the management of service and guide dogs on VA premises.

S. 780 – Veterans Pensions Protection Act of 2011

This bill would amend title 38, United States Code, to exempt reimbursements of expenses related to accident, theft, loss, or casualty loss from determinations of annual income with respect to nonservice-connected pension benefits.

Because this is outside of our mission, we do not have a resolution on this matter; however, we would not oppose passage of this legislation.

S. 815 – Sanctity of Eternal Rest for Veterans Act of 2011

This measure would amend the federal criminal code prohibition of disrupting funerals, including those at national cemeteries, of members of the Armed Forces or veterans, changing the time from one hour to two hours before and after the burial. Such unlawful conduct would include any disturbance or disruption occurring within 500 feet of the residence of a surviving member of a deceased's immediate family. The bill also provides civil remedies to include actual and statutory damages.

While DAV does not have a resolution on this matter, we are not opposed to its favorable consideration.

S. 873 – A bill to provide benefits to children with spina bifida

This bill would amend title 38, United States Code, to provide benefits for children with spina bifida of veterans exposed to herbicides while serving in the Armed Forces during the Vietnam era outside Vietnam.

Although we do not have a resolution on this, DAV would not oppose passage of this legislation, since this benefit is currently provided to children of veterans exposed to Agent Orange during service in the Republic of Vietnam.

S. 874 – A bill to modify the month of death benefits for surviving spouses

This bill would amend title 38, United States Code, to modify the month of death benefit for surviving spouses of veterans who die while entitled to compensation or pension; expands the eligibility for the Presidential Memorial Certificates to include those individuals who die while on active duty; and to improve housing loan benefits.

DAV does not oppose passage of this legislation.

S. 894 – Veterans’ Compensation Cost-of-Living Adjustment Act of 2011

This bill would amend title 38, United States Code, to provide for an increase, effective December 1, 2011, in the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation. DAV supports passage of this legislation; however, we oppose the rounding down to the next whole dollar amount of the cost-of-living adjustment.

S. 910 – Veterans Health Equity Act of 2011

This measure would require availability of at least one full-service VA hospital or comparable services through contract, in each of the 48 contiguous states.

Arguments have been made that New Hampshire was the only state that did not have access to a VA full-service medical center and that the most ill veterans in that state routinely had to drive or be transported to Boston for more comprehensive health care services. Members of Congress have stated they are particularly concerned that the sickest and generally very elderly veterans with complex and chronic health problems were subjected to having to first report to the VA’s Manchester facility—which could be up to a three-hour drive—and then continue on for another hour to the Boston VA Medical Center (VAMC) or other VA provider sites, in order to receive their care. It was also noted by former Congresswoman Shea-Porter of New Hampshire, that it may not be fiscally responsible, given the veteran population in New Hampshire, to have VA provide a full continuum of hospital services and that contracting for such services may be a better option.

Convenient access to comprehensive VA health care services remains a problem for many of our nation’s sick and disabled veterans. While VA must contract or use fee basis to provide care to some veterans, it maintains high quality care and cost effectiveness by providing health services within the system. According to VA, the Manchester VAMC in New Hampshire provides urgent care, mental health and primary care services, ambulatory surgery, a variety of specialized clinical services, hospital based home care and inpatient long-term care. In addition, CBOCs are located in Somersworth, Tilton, Portsmouth, Littleton and Conway.

In light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of providing high quality care and holding down costs by effectively managing in-house health programs and services for veterans. However, outside care coordination is poorly managed by VA. When it must send veterans outside the system for care, those veterans lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health records, and bar code medication administration program (BCMA). The proposal in S. 910 to use broad-based contracting for necessary hospital services in the New Hampshire area concerns us because these unique internal VA features noted above culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector health systems, equate to diminished oversight and coordination of care, and, ultimately, may result in

lower quality of care for those who deserve it most. However, we agree that VA must ensure that the distance veterans travel, as well as other hardships they face in gaining access, be considered in VA's policies in determining the appropriate locations and settings for providing VA health care services.

In general, current law places limits on VA's ability to contract for private health care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits and outside certain ongoing rural health initiatives by VHA, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban.

DAV believes that VA contract care for eligible veterans should be used judiciously and only in these authorized circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans. VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with complex health problems such as blindness, amputations, spinal cord injury, traumatic brain injury or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new VA health care programs would only exacerbate the problems currently encountered.

Nevertheless, after considerable deliberation, and in good faith to be responsive to those who have come forward with legislative proposals such as S. 910, to offer alternatives to VA health care, we have asked VA to develop a series of tailored demonstration projects and pilot programs to provide VA-coordinated care (or VA-coordinated care through local, state, or other federal agencies) in a selected group of communities that are experiencing access challenges, and to provide to the Committees on Veterans' Affairs reports of the results of those programs, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstration pilots with interested health professions' academic affiliates. We suggest the principles of our recommendations from the "Contract Care Coordination" section of the FY 2012 *Independent Budget* be used to guide VA's approaches in this effort. Also, any such demonstration pilot projects should be funded outside the Veterans Equitable Resource Allocation (VERA) system, and their expenditures should be monitored in comparison with VA's historic costs for care.

Veterans service organization representatives from the local areas involved, and other experts need a seat at the table to help VA consider important program and policy decisions, such as those described here, that would have positive effects on veterans who live in these areas. VA must work to improve access for veterans that are challenged by long commutes and other obstacles in getting reasonable access to a full continuum of health care services at VA

facilities and explore practical solutions when developing policies in determining the appropriate location and setting for providing VA health care services.

As a final note, we believe VA must fully support the right of all enrolled veterans to have reasonable access to health care and we insist that funding for alternative care approaches and outreach be specifically appropriated for this purpose, and not be the cause of reductions in highly specialized VA medical programs within the health care system.

S. 914 – A bill to authorize the waiver of the collection of copayments for telehealth and telemedicine visits of veterans.

This measure would amend title 38, United States Code, section 1722A to provide VA the discretionary authority to waive collection of copayments for VA telehealth and telemedicine.

The VA is recognized as a national leader in developing and using telehealth and we applaud VA for publicly stating its intent to expand use of cutting edge telehealth technology to broaden access to care while improving the quality of health care services. Since its implementation in 2003, VA's home telehealth includes monitoring of patients with diabetes, heart conditions, hypertension, and depression. Plans for this program include a doubling of unique veterans served in FY 2010 from about 46,000 to 92,000 by FY 2012. Telehealth is also a key initiative in collaboration with the Office of Rural Health to meet the needs veterans residing in rural and remote areas.

Aided by the required expansion of telehealth services in VA's CBOCs and readjustment counseling centers as authorized under Public Law 109-461, the Department also uses clinical videoconferencing to counsel patients suffering from mental health issues and polytrauma injuries, and patients in need of rehabilitation. VA also has the capability of store-and-forward telehealth for diabetic retinal imaging and dermatology to provide a connection between patients and doctors to distant specialists. However, we note the limited use of VA's store-and-forward telehealth for diabetic retinal imaging and dermatology is primarily used for the latter in cases such as wound care and lesion diagnosis.

General outcomes of VA's telehealth programs indicate a reduction in hospital admissions and increased patient satisfaction. Last fiscal year alone, VA invested \$121 million in telehealth and treated over 300,000 veterans.

However, while VA faces many issues to improve and further expand telehealth, the success of these programs is contingent upon the adoption of this type of care by the veteran patient population. Eliminating copayments is one important tool that could facilitate VA's success.

Accordingly, and with DAV Resolution No. 208 calling for the repeal of medical copayments, DAV supports this legislation and looks forward to its favorable consideration.

S. 928 – A bill to limit the authority of the Secretary of Veterans Affairs to use bid savings on major medical facility projects of the Department of Veterans Affairs to expand or change the scope of a major medical facility project of the Department.

This bill, if enacted, would provide for more efficient but controlled use of bid savings from major medical facility construction project contract awards by the Secretary of Veterans Affairs.

While we have no resolution from our membership dealing with this specific issue, we would not object to enactment of this bill.

S. 935 – Veterans Outreach Enhancement Act of 2011

This bill would require the Secretary of Veterans Affairs to carry out a program of outreach for veterans to increase the access and use by veterans of Federal, State, and local programs providing compensation for service in the Armed Forces and the awareness of such programs by veterans and their eligibility for such programs.

Although we do not have resolution on this particular matter, DAV currently provides such outreach to veterans and, therefore, we would not oppose passage of this legislation.

S. 951 – Hiring Heroes Act of 2011

This bill provides enhancements to several programs impacting veterans. Section 10 modifies federal hiring practices to encourage the hiring of separating servicemembers and would allow them to begin the federal employment application process prior to separation. This is in line with DAV Resolution 305, which supports veterans' preference in public employment. The current federal hiring process is slow and cumbersome and the total number of federal employees hired under veterans' preference categories has shown only incremental increases over the years. This legislative change could result in the substantive improvement of recruitment and hiring of veterans generally and service-disabled veterans specifically.

Section 2 provides a two-year extension, from December 31, 2012 to December 31, 2014, of a program that provides rehabilitation and vocational benefits to severely wounded members of the Armed Forces under the Wounded Warrior Act.

This is line with DAV Resolution No. 307, which supports strengthening of the Vocational Rehabilitation and Employment (VR&E) program to meet the demands of disabled veterans.

Section 4 would provide up to an additional 24 months of vocational rehabilitation and employment services to veterans who have exhausted *both* these benefits *and* state-provided unemployment benefits.

Section 5 of the measure requires VA to engage, on a periodic basis, with each veteran who has participated in its VR&E Program, to determine whether the veteran is employed. This

provision is in line with DAV Resolution No. 307, which calls for VR&E to provide for placement follow-up with employers for at least six months.

Section 6 of this measure would make participation in the Transition Assistance Program (TAP) mandatory.

This provision is in line with DAV Resolution No. 230, which recognizes the importance of TAP and the Disabled Transition Assistance Program for those servicemembers transitioning to civilian status.

Section 8 creates a competitive grant program for nonprofit organizations that provide mentorship and job training programs that are designed to lead to job placements. Although DAV does not have a resolution on this matter, we are not opposed to its favorable consideration.

Section 9 requires that each servicemember receive an individualized assessment of jobs they may qualify for when they participate in TAP.

Although DAV does not have a resolution on this matter the provision would greatly benefit transitioning servicemembers. Therefore, we are not opposed to its favorable consideration.

Section 9 also requires the Department of Defense (DOD), the Department of Labor (DOL) and VA to jointly contract for a study to identify the equivalencies between certain military occupational specialty (MOS)-related skills and civilian employment, and to eliminate barriers between military training and civilian licensure or credentialing for several military occupational specialties. This provision is in line with DAV Resolution No. 100, which supports efforts to eliminate employment barriers that impede the transfer of military job skills to the civilian labor market.

Section 11 requires DOL to engage with each veteran on a periodic basis to determine whether the veteran is employed or whether the veteran might be interested in further assistance.

Although we have no applicable resolution regarding section 11, we have no objection to the efforts proposed.

DAV strongly supports the passage of S. 951.

S. 957 – Veterans’ Traumatic Brain Injury Rehabilitative Services’ Improvements Act of 2011.

This bipartisan and bicameral legislation would make improvements to the so-called “Wounded Warrior” provisions of the National Defense Authorization Act of 2008, Public Law 110-181, in that it would add specificity and emphasis to preexisting requirements of VA’s polytrauma centers and other VA facilities that are treating and rehabilitating brain-injured veterans from Iraq and Afghanistan. The language of this bill is fully consistent with DAV’s Resolution No. 215, which deals with VA’s treatment of traumatic brain injuries (TBI).

Section 1710C(a), title 38, United States Code, as amended by the Wounded Warrior provisions, requires VA to develop a rehabilitation plan for each veteran being treated for TBI. If this bill is enacted, that existing plan would need amendment to address expanded and redefined rehabilitation, improved quality of life, and expressed methods for the sustainment of improvements from rehabilitative services provided by VA for TBI.

A new subsection (h) in section 1710C would redefine “rehabilitative services” for the purpose of sustaining these improvements, promoting independence and advancing quality of life in this severely injured population. While these concepts could be the assumed or inherent goals of any physical rehabilitation plan, the bill would make them explicit in the law, and would address cognitive and mental health rehabilitation as well.

DAV strongly supports this bill, commends the sponsors in both Congressional Chambers, and urges the immediate enactment of this important legislation.

S. 1017 – Disabled Veteran Caregiver Housing Assistance Act of 2011

This measure provides increased assistance for the Temporary Residence Allowance (TRA) Grant program for disabled veterans living in housing owned by a family member, and expands eligibility for Specially Adapted Housing (SAH) grants for veterans with vision impairment from blindness in both eyes, having only light perception, to those having central visual acuity of 20/200 or less in the better eye with the use of a standard correcting lens.

While the TRA Grant program has the potential to be an important tool, a continued problem is that, should an eligible veteran choose to participate in this program, the amount used is deducted from the overall amount of the SAH Grant. The aggregate amount of assistance available for SAH grants made pursuant to title 38, United States Code, section 2101(a) is \$63,780 throughout FY 2011. The aggregate amount of assistance available for SAH grants made pursuant to section 2101(b) is \$12,756 during FY 2011. The TRA grant amounts are not indexed and remain unchanged at \$14,000 for grants administered under section 2101(a) and \$2,000 for grants administered under section 2101(b).

The deduction of the TRA Grant from the overall SAH Grant alone may cause many veterans to bypass this program and instead wait until they have recuperated and use the SAH Grant to adapt their permanent residence. While DAV does not have a resolution on this matter, we believe Congress should decouple the TRA Grant from the SAH Grant so the grant amount would not count against the overall grant for permanent housing. The TRA grant amounts should also be indexed in the same manner as the SAH Grant.

DAV supports the favorable consideration of this bill, since it benefits severely disabled veterans living with their family members.

S. 1060 – Honoring All Veterans Act of 2011

This bill would improve education, employment, independent living services, and health care for veterans, improve assistance for homeless veterans, and improve the administration of the VA.

Title I, *Education, Employment, and Independent Living Services for Veterans*, addresses a number of topics within our area of interest. Section 101 increases the cap on the VA's Independent Living program and Section 102 authorizes veterans to attend DOD TAP within their first year of military separation. Section 103 requires the VA to conduct a study on the recognition of military training and qualifications of veterans by civilian employers and educational institutions.

Section 103 requires the VA to conduct a study on the recognition of military training and qualifications of veterans by civilian employers and educational institutions. This is a critical area that has been addressed on many occasions and numerous forums.

The provision is in line with DAV Resolution No. 100, which supports efforts to eliminate employment barriers that impede the transfer of military job skills to the civilian labor market. Based on a review of both bills, DAV would encourage passage of S. 951, the Hiring Heroes Act of 2011.

TITLE II, *Assistance for Homeless Veterans*, addresses repeal of sunset on extension of enhanced protections for servicemembers relating to mortgages and mortgage foreclosure under Servicemembers Civil Relief Act in Section 201, and the modification for payment of services to those providing services to homeless veterans in Section 202.

DAV has no resolution on these matters. We are not opposed to their favorable consideration.

TITLE III, *Health Care and Mental Health Services for Veterans*, addresses three areas of interest for the DAV.

Section 301 of this bill would require VA and DOD to establish a mechanism for monitoring and reviewing the referral process of veterans and servicemembers who are identified as having a potential mental health condition based on DOD's post-deployment health assessment. The review is to include identification and comparison of the number of individuals who were referred to those who complete a course of mental health treatment based on such referral.

Because VA and DOD share a unique obligation to meet the health care needs, including mental health care and rehabilitation needs, of veterans who are suffering from readjustment difficulties as a result of wartime service, DAV supports this section based on DAV Resolution No. 217, which supports program improvement and enhanced resources for VA mental health programs, including its Vet Centers, to achieve readjustment of new war veterans and continued effective mental health care for all enrolled veterans needing such services.

Section 302 would amend title 38, United States Code, section 1710C to require the individualized rehabilitation and reintegration plan developed with the veteran or servicemember suffering from traumatic brain injury to include consideration for participation in the Department's Independent Living Program and use of VA's employment services provided through its Compensated Work Therapy Supported Employment Services (CWT-SE) program. We also note that Section 101 of this bill calls for an increase in the cap of the Independent Living program.

The Independent Living program is aimed at veterans whose service-connected disabilities are so severe they are currently unable to pursue an employment goal under Chapter 31. The CWT-SE program has been demonstrated to substantially increase competitive employment outcomes for people who have severe disabilities and a demonstrated inability to gain and/or maintain competitive employment.

Because the primary focus of the CWT-SE implementation is to provide services to veterans diagnosed with Serious Mental Illness (SMI), who, because of the severity of their disabilities, would not be able to function independently in employment without intensive ongoing support services, SMI veterans with psychosis constitute the majority of participants in these programs. If this section is to be favorably considered, we urge strong oversight by this committee to ensure programs services are adjusted to veterans suffering from the cognitive and other adverse effects of traumatic brain injury.

While DAV does not have a resolution on this matter, we are concerned about the adequacy of the authorized participation rate for the Independent Living program given the potential for expansion of service to those suffering from traumatic brain injury as well. The solution is for Congress to eliminate the statutory cap. Otherwise, the effect of the cap, with this anticipated increase in veteran demand for services, is a delay in access to the Independent Living program by severely disabled veterans.

Section 303 would authorize VA to provide the immediate family members of a deployed servicemember consultation, professional counseling, marriage and family counseling, training, and mental health services necessary in connection with that deployment.

We are cognizant of and sensitive to the stresses on dependents of servicemembers who are deployed; however, we question why such authority should be afforded to the VA when such dependents have access to mental health services under TRICARE.

TITLE IV, *Administration of the Department of Veterans Affairs*, addresses two issues within our area of interest in Section 401 and 403.

Section 401 calls for monitoring of the DOD/VA Integrated Disability Evaluation System (IDES). Specifically, it requires the Secretaries of Defense and Veterans Affairs to jointly develop an IDES-wide monitoring mechanism to identify and address issues following collection and analysis of data on staffing levels at DOD and VA, sufficiency of exam summaries and diagnostic disagreements. In addition, they are to monitor data on caseloads and case processing time by individual rating offices of the VA and the Physical Evaluation Boards of the DOD as

well as create a formal mechanism for agency officials at local facilities to communicate challenges and best practices to DOD and VA headquarters.

The President's Commission on Care for America's Returning Wounded Warriors recommended that DOD and VA create a single, comprehensive, standardized medical examination that the DOD administers. It would serve DOD's purpose of determining fitness and VA's of determining initial disability level. The Disability Evaluation System (DES) pilot project premised on the commission's recommendation was launched by the DOD and the VA in 2007. Using lessons learned from that pilot, the legacy DES is transitioning to IDES in 2011 in a total of 140 locations, with the goal of expediting the delivery of VA benefits to all out-processing servicemembers. Issues such as the sufficiency of staffing levels and their training, adequacy of medical and mental health exam summaries, the resolution of diagnostic disagreements, caseloads and case processing time have been reported as having a negative impact on the rollout of this program.

Initially, DOD and VA had indicated in their planning documents that they had a target of delivering VA benefits to 80 percent of servicemembers within the 295-day (active component) and 305-day (reserve component) targets. The various rollout problems noted above, however, have resulted in a reduction from the 80 percent to a 50 percent target.

DAV does not have a specific resolution on this matter, although DAV Resolution No. 073 does address improvements in the VA claims process. The steps laid out in Section 401 of the legislation are essential to improving the IDES so benefits can be delivered closer to the time veterans leave military service. Therefore, we support the favorable consideration of this section of the bill.

Section 403 of this bill addresses treating certain misfiled documents as "motions for reconsideration" of decisions by the Board of Veterans' Appeals (Board). If an individual disagrees with a Board decision, and has not filed a notice of appeal with the United States Court of Appeals for Veterans Claims (Court) within the 120-day period allowed, but files a document with the Board or the agency of original jurisdiction not later than 120 days after the date of such decision, which expresses disagreement with the Board's decision, such document shall be treated as a "motion for reconsideration." However, if the Board or agency of original jurisdiction receives a document from an appellant, which expresses the intent to appeal the Board's decision to the Court, and the Board or agency of original jurisdiction must forward such document to the Court within the 120-day appeal period allowed, and it will be treated as a proper notice of appeal to the Court

Section 403 of this bill is in line with the intent of DAV Resolution 287, which supports legislation to ensure all veterans are not prevented from filing timely appeals with the Court as a result of sending the request for appeal to the wrong office or other good cause reasons.

S. 1089 – A bill to provide for the introduction of pay-for-performance compensation mechanisms into contracts of the Department of Veterans Affairs with community-based outpatient clinics for the provision of health care services, and for other purposes

Madam Chairman, we have not been afforded an opportunity to date to examine the language specific to this bill; thus, we offer no evaluative or definitive testimony on it during this hearing. Nevertheless, we caution the Committee that “pay for performance” has a mixed record of success in both the private and public sectors (including in primary and secondary education), so we would be keenly interested in closely examining this bill if its intent is to instill similar incentives into VA’s nearly 150 contract CBOCs. We understand that historically, many of these mostly-rural and remote clinics (including clinics in the Commonwealth of Kentucky) have expressed concerns that they are significantly underpaid for the work they are required to do under their variable contracts with VA Veterans Integrated Service Networks (VISN) or individual VA medical centers. While improving their contract pay rates would not necessarily be objectionable to DAV on its face, any unintended effects of such a policy (on supervising VA medical centers, other CBOCs within the region or VISN, on labor relations, on cost control, and on veteran patients themselves) need further scrutiny. Also, it should be noted that VA’s contractual methods for obtaining CBOCs are not uniform throughout the VA system. As a partner organization of the Independent Budget for Fiscal Year 2012, we have commented on this contract variability and recommended the VISNs use a more uniform approach in addressing their contract CBOC relationships. On this basis, and since we have not examined the bill itself prior to today’s hearing, we ask that the Committee defer further consideration at this time on this particular proposal.

S. 1104 – Veteran Transition Assistance Program Audit Act of 2011

This bill requires the Secretary of Labor to conduct regular audits of TAP, not less often than once every three years. These audits would be done via a contractual relationship with a private organization not affiliated with the program and the contractor would measure the effectiveness of TAP, and identify any measures needed to improve the effectiveness of the program.

The contractor will be required to submit its report to the Secretary of Labor in conjunction with the Secretary of Defense, the Secretary of Homeland Security, and the Secretary of Veterans Affairs, as well as the Committees on Armed Services and the Committees on Veterans’ Affairs of the House and Senate. The Secretary of Labor, in conjunction with the other Secretaries, will review the report and implement any measures needed to improve the effectiveness of TAP.

This legislation is in keeping with the intent of DAV Resolution 230, by ensuring the TAP and Disabled Transition Assistance Program are viable, up to date programs, helpful in the difficult task of transitioning from military service to civilian life as well as overcoming the many obstacles to successful employment.

DAV supports this bill.

S. 1123 – Assistance to Veterans Affected by Natural Disasters Act

This bill would amend title 38, United States Code, to improve the provision of benefits and assistance under laws administered by the Secretary of Veterans Affairs to veterans affected by natural or other disasters, and for other purposes.

Section 1, *Assistance to Veterans Affected by Natural Disasters*, would amend chapter 21 of title 38, United States Code, to allow the Secretary of Veterans Affairs to award a grant to a veteran whose home was previously adapted with assistance of a grant under this chapter in the event the adapted home that the veteran occupied was destroyed or substantially damaged in a natural or other disaster, as determined by the Secretary. The amount of the grant that could be awarded may not exceed the lesser of either the reasonable cost, as determined by the Secretary, of repairing or replacing the damaged or destroyed home in excess of the available insurance coverage on such home; or the maximum grant amount the veteran would have been entitled under the applicable section 2102 of this title had the veteran not obtained the prior grant.

Grants should be available for special adaptations to homes veterans purchase or build to replace an initial specially adapted home. Further, an initial home may become too small when the family structure changes or the nature of the veteran's disability changes, necessitating a home configured differently and/or changes to the special adaptations. In addition, technological changes occur rapidly and additional modifications, after the initial housing grant, may maximize the veteran's independence as well as improve the ability for caregivers to provide medically necessary care. These evolving requirements merit a second grant to cover the costs of adaptations to a new home.

While DAV does not have a resolution on this matter, we are not opposed to favorable consideration of this legislation.

This bill also provides for a two-month extension of subsistence allowance for veterans completing vocational rehabilitation program. Specifically, when the Secretary determines that a veteran participating in VA's Vocational Rehabilitation program is displaced as the result of a natural or other disaster, two months of additional payments of subsistence allowance may be granted.

This measure would waive the cap on the Independent Living program by amending Section 3120(e) of such title 38, United States Code, so that such a cap shall not apply when the Secretary determines that a veteran participating in the Independent Living program has been displaced or otherwise been adversely affected by a natural or other disaster.

This legislation also seeks to modify covenants and liens created by public entities in response to disaster-relief assistance. Specifically, the Secretary, in determining whether a loan is so secured, may either disregard or allow for subordination to a superior lien created by a duly-recorded covenant running with the realty in favor of either a public entity that has provided or will provide assistance in response to a major disaster as determined by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance; or a private entity to secure an obligation to such entity for the homeowner's share of the costs of the management, operation, or maintenance of property, services, or programs within and for the benefit of the development or community in which the veteran's realty is located, if the Secretary determines that the interests

of the veteran-borrower and of the government will not be prejudiced by the operation of such covenant.

Lastly, this bill proposes modification to section 3903 of title 38, United States Code, covering automobiles and other conveyances for certain disabled veterans and members of the armed forces. If enacted, the Secretary would have the option of providing or assisting eligible veterans with a second automobile or other conveyance. The Secretary would require satisfactory evidence that the automobile or other conveyance previously purchased with assistance under this chapter was destroyed as a result of a natural or other disaster, as determined by the Secretary. The loss of the vehicle would be no fault of the eligible person; and the eligible person would not otherwise receive compensation from a property insurer for the loss.

DAV has no resolution on these matters. However, we would not oppose the favorable consideration of this legislation.

S. 1124 – Veterans Telemedicine Act of 2011

This measure would require VA to provide teleconsultation for mental health and traumatic brain injury assessments and require VA ensure each VISN has a teleretinal imaging program. VA would also be required to increase the number of enrolled veterans in both programs by five percent annually from FY 2010 to 2015.

DAV has no resolution to support this measure; however, we would like to highlight those provisions we believe would be beneficial to service-connected disabled veterans. This measure would require each VA medical facility with an affiliate agreement to develop an elective rotation to train in telemedicine. The bill would also require VA to address its resource allocation system to act as an incentive for using telehealth. DAV believes this is a critical component of this measure. How health services are funded, whether through allocation or reimbursement systems, plays a major role in determining how the service delivery is organized. The VHA is no different in this respect. VHA resources are allocated by a system known as VERA. This funding mechanism has features that encourage the development of certain services such as for non-institutional care and serious mental illness. To ensure funding arrangements such as these are targeted to the intended patient populations, there are eligibility criteria for patients and requirements that must be met.

The evolution of VERA over the years did not reflect the growing access and utilization of telehealth services. Since at least 2008, telehealth workload is reported for program evaluation and meeting performance standards but there is no VERA credit to allow for proper allocation of resources. DAV is concerned that little has been done to address this glaring flaw.

While it is not clear whether correcting VERA to give credit to telehealth would increase telehealth workload, increasing resources to those facilities providing telehealth, and thus providing the means to provide greater access, DAV believes it would at minimum address the resistance to telehealth by VA providers.

S. 1127 – Veterans Rural Health Improvement Act of 2011

This bill would establish authority for the Secretary to form and operate from one to five new “Centers of Excellence for Rural Health Research, Education, and Clinical Activities,” modeled on legislation that authorizes VA Mental Illness Research, Education and Clinical Centers (MIRECC) and Geriatric Research, Education and Clinical Centers (GRECC). Based on DAV Resolution No. 221, calling for improvements in rural health, we support this bill and urge its enactment. We believe both the MIRECC and GRECC model programs are effective in organizing resources and concentrating energy to solve myriad issues in mental illness, geriatrics and gerontology, and we would anticipate similar results from implementation of this new authority to address deficits in rural health. We appreciate the sponsor’s intentions and strongly endorse the bill.

Draft bill – Veterans Programs Improvements Act of 2011

Draft legislation entitled the “Veterans Programs Improvement Act of 2011” would amend title 38, United States Code, to improve the provision of assistance to homeless veterans and the regulation of fiduciaries who represent individuals for purposes of receiving benefits under laws administered by the Secretary of Veterans Affairs, as well as other administrative and benefit matters.

Title I, *Homeless Veterans Matters*, addresses a number of issues, including an update on the campaign to end homelessness among veterans through enhanced collaboration with other federal, state, faith-based, veterans service organization and community partners that was launched by the Secretary of Veterans Affairs in 2009.

This provision is in line with DAV Resolution 223, which supports strengthening the capacity of the VA Homeless Veterans program.

Title II, *Fiduciary Matters*, focuses on appointment of caregivers and persons named under durable power of attorney as fiduciaries for purposes of benefits and access to financial records of individuals represented by fiduciaries and receiving benefits under laws administered by VA and other issues.

DAV has no resolution on these matters, and therefore, we take no position.

Title III, *Other Administrative and Benefits Matters*, touches on several areas. Of interest to DAV is Section 302, which would provide a waiver of loan fees for individuals with disability ratings issued during pre-discharge programs. This section would partially fulfill DAV Resolution 074, which supports repeal of funding fees for VA home loans for all veterans.

DAV also supports Section 306, automatic waiver of agency of original jurisdiction review of new evidence. This is in line with DAV Resolution No. 073, which calls for reform of the Veterans Benefits Administration disability claims process to significantly reduce the claims backlog.

Draft bill – Alaska Hero’s Card Act of 2011

This bill would establish a new pilot program under which, in the most remote locales in Alaska, service-disabled veterans (at any level of disability) would be issued an “Alaska Hero Card” by the Department of Veterans Affairs. Issuance of the card would entitle the possessor to obtain unlimited health care (hospital care and medical services) at no out-of-pocket cost for any condition from a private provider, if the private provider were eligible to receive payments under Medicare or the military TRICARE program. The Secretary would be required under the bill to take measures to ensure care received under the pilot program was of equal quality to that which would be obtained directly from VA; and that providers were qualified, accredited and credentialed to provide the care needed by these veterans.

We have long been concerned about the use of non-VA purchased health care. While our members are major users of both the fee-basis and contract hospitalization programs under current statutory authority, we have criticized those programs as expensive, uncoordinated, and even of questionable quality, safety and value to these disabled veterans. Despite those problems we continue to believe that current legal authorities are sufficient to meet most needs of service-disabled veterans if certain improvements were made by VA in how these programs are administered. We have discussed these concerns and needs for improvement on multiple occasions in testimony and in the *Independent Budget* for Fiscal Year 2012.

In good conscience we could not support this proposal for Alaska veterans without also advocating a similar program for veterans in all rural and remote regions. We have noted in prior testimony our concern that there must be a balance in using non-VA services to avoid the slippery slope of replacing VA as a direct provider and substitutes an insurance function in its place. Absent exclusive funding outside the Medical Services appropriation, this shift has the potential to erode VA’s congressionally mandated specialized medical programs, and may diminish care for all veterans. Thus, we cannot offer our support for this pilot program.

We note that the Office of Rural Health is conducting multiple pilot programs (funded separately by Congress) to extend access to care for veterans who live in frontier areas, including in Alaska. We urge the sponsor of this measure to work closely with that office to address the problem identified by the purposes of this bill.

Madame Chairman and Members of the Committee, this concludes my statement and I would be happy to answer any questions you may have.