S. HRG. 111–264

HEARING ON PENDING HEALTH AND BENEFITS LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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C O N T E N T S

OCTOBER 21, 2009

SENATORS

WITNESSES

Page

APPENDIX

HEARING ON PENDING HEALTH AND BENEFITS LEGISLATION

WEDNESDAY, OCTOBER 21, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Begich, Burr, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order. Good morning and welcome to today's hearing. Our legislative agenda reflects the work and commitment of Members on both sides of the aisle, all of whom are looking for solutions in areas of veterans health and veterans benefits. I want to mention for everybody's information that we are glad to have Mr. Mayes here. I think this is the fourth hearing you are attending. That is great.

Before we begin, I want to speak briefly about some of the progress this Committee has made since our legislative hearings in April. Earlier this year, I sponsored the Veterans Health Care Budget Reform and Transparency Act of 2009. This measure would provide timely and predictable funding for the veterans health care system. I am delighted to note that the President will sign this legislation into law tomorrow. I am grateful to all who worked on this, including the Committee's Ranking Member and the Veterans Service Organizations who made this one of their priorities.

Other vital legislation reported out of this Committee is progressing to final passage, as well. The Veterans Benefits Enhancement Act of 2009 was unanimously approved by the Senate just 2 weeks ago and we are beginning to work with the House on the final benefits legislation. This bill would enhance a number of benefits for veterans and their families, including compensation, housing, employment, education, burial, and insurance benefits.

Despite these successes, we as a Committee have not been able to achieve full support for two large health measures. The Veterans Health Care Authorization Act of 2009 has been held up by one Member of the Senate. This is very unfortunate, as it means vital changes to help women veterans and VA health workers are being delayed.

Likewise, a single Member is holding up the Caregiver and Veterans Health Services Act of 2009. This important legislation provides long-overdue assistance to the caregivers of the most seriously injured veterans, including health care, counseling, support, and a living stipend. We are working on an agreement to bring the bill to the full Senate. Caring for wounded veterans is simply a cost of war and should be treated as such.

So now let us turn to the agenda before us. I thank you all for joining us this morning and look forward to hearing from our witnesses. So let me call on our Ranking Member, Senator Burr, for his opening statement.

Senator Burr?

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. Aloha.

Chairman AKAKA. Aloha.

Senator BURR. Welcome to our witnesses.

We do have an extensive legislative agenda before us today, so in the interest of time, I will be brief. I am going to focus on a bill I introduced with Senator Hagan, S. 1518, the Caring for Camp Lejeune Veterans Act of 2009.

Two weeks ago, we held a hearing on the water contamination that existed for three decades at Camp Lejeune. We heard the personal stories of Michael Partain, who is the son of a Marine and was one of over 20 former Camp Lejeune residents diagnosed with a rare male breast cancer at an unusually young age. He was just 39 years old. To show how rare it is, the condition usually strikes fewer than 2,000 men each year in the United States and typically strikes those at an age of 55 or over.

As I stated at the hearing, we have an obligation to figure out how much of these dangerous chemicals veterans and their families were exposed to and what impact these exposures might have had on their health. But while we wait for the science, we must deal with the fact that many continue to suffer from devastating conditions. We shouldn't ask sick veterans and family members to hold on while we wait for more studies. They have already waited two decades. We owe them much more than that.

That is why I have introduced the Caring for Camp Lejeune Veterans Act, which would allow veterans stationed at Camp Lejeune while the water was contaminated to get the medical care from VA. It would also allow VA to treat their families for conditions associated with exposure to contaminated water. Providing health care to veterans and their families would be one step toward meeting, I think, our moral obligation to those who we put at risk.

There are other bills on today's agenda I am anxious to hear testimony on. Two bills in particular propose additional assistance for homeless veterans, an important priority of mine. In fact, I have already drafted an amendment to the MILCON VA Appropriations Bill to increase funding for homeless programs by over $40 million. I would ask the Committee Members for their support on that amendment and I look forward to learning more about the bills before us today.

I thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr.

I would like to call for opening statements from Senator Brown, Senator Murray, and then I will introduce Senator Reed. So at this time, Senator Brown.

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Aloha. I want to thank the Chairman for his leadership on the wide range of legislation we are discussing today. The variety of today's discussion spans issues from homelessness to chiropractic care.

I welcome our colleague, Senator Reed from Rhode Island, to talk about his Zero Tolerance for Homeless Veterans Act of 2009. I thank Senator Murray for her work on S. 1204, the Chiropractic Care Available to All Veterans Act, which is one of the bills we will be discussing today. Her work on our Nation's health reform in this Committee and on the HELP Committee has been so valuable.

Veterans coming home have serious muscular-skeletal problems. Chiropractors can help, but only if we increase access to care. Many of our Vietnam-era veterans have suffered from these same problems for decades. We should not be shutting the door on one type of care. The backlogs, the wait lists, the need for chiropractic care at the VA is clear. I can see it in my State in the uneven availability of care. We see this with the number of outside referrals at VA medical centers all over the country, like I said, in my State in Chillicothe, Columbus, and Cleveland.

I look forward to working on the legislation we are discussing. I appreciate today's witnesses being here and want to welcome Dr. Rick McMichael, who is President of the American Chiropractic Association. We talked yesterday about this legislation. He is from Canton, Ohio.

Mr. Chairman, I regret I cannot stay very long today because we have confirmation proceedings in the HELP Committee in a few minutes, but I thank the Chairman for moving forward.

Chairman AKAKA. Thank you very much, Senator Brown.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Akaka and Senator Burr, for holding today's hearing on the legislation before us to help improve veterans health care and benefits. I also want to thank all of our witnesses for joining us today. I look forward to hearing your comments on the legislation we are considering.

Mr. Chairman, I have introduced three bills that are being discussed today. Each of those bills deals with a different area of veterans care, but they all share a common thread. Each of them will give the VA better tools to provide our veterans with the care and benefits that they have earned through their selfless service to our Nation.

One of my bills would expand grant programs for homeless women veterans and homeless veterans with children. Another would increase benefits for former POWs. And a third, as Senator Brown alluded to, would improve chiropractic care at VA hospitals.

Mr. Chairman, I just want to take a few minutes to talk about these bills and why it is so important that we pass them.

The first bill is designed to help homeless veterans. In particular, it will address the problems faced by homeless women veterans and homeless veterans with children—two very vulnerable groups that are growing by the day. We are seeing more and more homeless veterans with children coming to the VA and to Veterans Service Organizations looking for help. Women now make up about 5 percent of our homeless veterans, which is up from 3 percent just a decade ago. And about 10 percent of these homeless are Iraq and Afghanistan veterans. In fact, female veterans are between two and four times as likely to be homeless as their civilian counterparts, plus they have unique needs and require special services.

That is why I introduced the Homeless Women Veterans and Homeless Veterans with Children Act with Senator Jack Reed and Senator Tim Johnson. This legislation will take three steps toward tackling the problem. It will make more front-line homeless service providers eligible to receive special needs grants. It will expand the special needs grants to cover homeless male veterans with children, as well as dependents of homeless veterans themselves. And it will extend the Department of Labor's Homeless Veterans Reintegration Program to provide workforce training, job counseling, child care services, and placement services to homeless women veterans and homeless veterans with children.

Mr. Chairman, I think it is our duty to give every veteran the resources he or she needs to keep themselves and their families off the streets and in safe and stable housing. My bill would help provide an open door and a helping hand to homeless women and their families who have made a lot of great sacrifices and deserve more than just a thank you from a grateful Nation. I hope my colleagues will support it.

I also introduced the Prisoner of War Benefits Act of 2009. This bill will provide former POWs with expanded health care benefits for conditions like Type 2 diabetes. It would also eliminate the minimum time held requirement in order to qualify for those benefits. Currently, former POWs have to be detained for at least 30 days to qualify for the presumption of service connection for some diseases. I think a veteran who endured 29 days of captivity should be entitled to the same benefits as one who was a prisoner for one more day. And no veteran should have to fight to cut through bureaucratic red tape to receive the benefits they earned and deserve. To me, this is just common sense and fair play, and for those reasons, I hope that we can all support this legislation.

And finally, as Senator Brown mentioned, we have before us the Chiropractic Care Available to All Veterans Act. I introduced this bill with Senator Sam Brownback and a number of others to expand chiropractic care at VA facilities in my home State and across the country. Of the more than 150 VA medical centers, less than one-third of them today offer chiropractic care and services. So our bill will address that shortfall by mandating chiropractic care and services at all of our VA medical centers. Again, I hope my colleagues will support that legislation, as well.

So, thank you very much, Mr. Chairman. I look forward to the hearing.

Chairman AKAKA. Thank you very much, Senator Murray.

Before I call on Senator Jack Reed, let me ask for an opening statement from Senator Johanns.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Thank you very much, Mr. Chairman. I appreciate the opportunity to be here today.

Many good things have happened in the short time that I have been on this Committee, and, of course, many good things predated my arrival. I would like to focus, if I could, on one thing that I think we are going to be talking about today, S. 1427, which I introduced with Senator Wyden and I hope there will be broad support on.

Basically, what this bill would do would be to direct the VA to rate the different services of its medical centers with a straightforward, very easy to understand A to F grade and make those ratings public and simple to compare. The information would allow veterans to assess how the VA hospital in their region stacks up against other VA facilities. My hope is that by rating them, it will lead to improvements in areas that would otherwise be regarded as deficient. Now, I do know if there are some comparative data already provided by the VA. I am appreciative of that. VA is also working on grading its hospitals internally, as is noted in the testimony today by one of the witnesses.

As you also say, VA is focused this year on health care transparency. I really applaud that effort. I think that we can work together on this to achieve a goal where veterans can simply look up how health care stacks up. You shouldn't have to be a medical care specialist to be able to do that. And some of these veterans, especially the elderly or the seriously disabled, might have difficulty pursuing the data as it stands now. So I am hoping we can take a step toward increased transparency.

Let me, if I might, just wrap up my comments today by once again expressing my appreciation to the Chairman and to the Ranking Member for allowing me to have a hearing at the Omaha facility this summer. To all those who participated in it, I thought it was a great hearing. It certainly underscored the need we have in terms of that facility and trying to bring it up to date. So, Mr. Chairman, I thank you for that. I hope we established a very good record to move forward on that issue.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Johanns.

I am delighted to welcome my friend, Jack Reed from Rhode Island, here to join us, and ask Jack for his opening statement.

STATEMENT OF HON. JACK REED,
U.S. SENATOR FROM RHODE ISLAND

Senator REED. Well, thank you very much, Mr. Chairman. Aloha.

Chairman AKAKA. Aloha.

Senator REED. If I knew the Hawaiian word for thank you, I would say that, too. I appreciate your hospitalities, Senator Burr and all my colleagues.

I want to spend a moment talking about S. 1547, the Zero Tolerance for Veterans Homelessness Act. I am very pleased that Senator Murray is an original cosponsor, along with Senator Bond and Senator Tim Johnson, and we have been joined by Senators Kerry, Durbin, Begich, Mikulski, Burris, Leahy, Whitehouse, Baucus, and Udall.

This legislation would address one of the most, I think, difficult problems that we recognize in the country when it comes to veterans. I was with the Chairman of Joint Chiefs of Staff, Admiral Mike Mullen, and one would expect in a conversation with him, it would all be about new systems and budgets, et cetera. His point to me was he was in San Diego meeting with homeless veterans—homeless veterans of Iraq and Afghanistan. These were individuals in their 20s and 30s who couldn't find work, couldn't find housing, et cetera. That is a shame, to be blunt. We have to do more.

This bill proposes to do more. It will essentially try to support at-risk veterans by providing short-term rental assistance and housing relocation services. It also will support existing programs, like the HUD-VASH program, which provides vouchers for veterans who can rent in areas which require that type of assistance. Presently, there are 20,000 of these vouchers. This bill would increase those by 10,000 each year up to a total of 60,000, so we could be reasonably assured that we wouldn't be seeing young veterans, or any age veteran, without access to housing. It would also make it easier for nonprofits to apply for grants from the VA to go ahead and participate in developing housing for veterans.

There are other features of the legislation, and I would like to submit for the record my statement, together with letters of support from the National Alliance to End Homelessness and the Veterans of Foreign Wars.

And again, Mr. Chairman, thank you very, very much.

[The prepared statement of Senator Reed follows:]

PREPARED STATEMENT OF HON. JACK REED, U.S. SENATOR FROM RHODE ISLAND

Mr. Chairman, Senator Burr, and distinguished Members of this Committee, thank you for the opportunity to speak today regarding legislation I have introduced to help homeless veterans—S. 1547, the Zero Tolerance for Veterans Homelessness Act. This comprehensive bill enhances and expands the assistance provided by the Department of Veterans Affairs and the Department of Housing and Urban Development to homeless veterans and veterans at risk of becoming homeless.

It is one of our Nation's great tragedies that on any given night, an estimated 131,000 veterans are homeless. The VA estimates that more than 200,000 veterans experience homelessness each year and that nearly 1/5 of all homeless people in the United States are veterans. These numbers are expected to climb as our servicemembers fighting in Iraq and Afghanistan return home to face tough economic conditions.

Unfortunately, we know that veterans are often at a greater risk of becoming homeless. Some return from deployments to discover that the skills they have honed in the military are difficult to transfer to jobs in the private sector. Others struggle with physical or mental wounds of war. Still others return to communities that lack safe, affordable housing.

Our veterans have made great sacrifices to serve our country, and we have an obligation to honor our commitment to them. Many programs through HUD and the VA are already helping homeless veterans with transitional housing, health care and rehabilitation services, and employment assistance. This legislation recognizes these efforts by building on the existing structures to provide a more comprehensive and coordinated approach.

First, this bill would create a new Homelessness Prevention program that would enable the VA to keep at-risk veterans in stable housing and offer increased assist-

ance to veterans who have fallen into homelessness. Specifically, the VA could provide short-term rental assistance, housing relocation and stabilization services, services to resolve personal credit issues, payments for security deposits or utility costs, and assistance for moving costs. These up-front expenses can be the major obstacle that puts low-income or unemployed veterans at risk of becoming homeless. These homelessness prevention and rapid re-housing techniques have been successfully used in numerous communities to significantly reduce family homelessness, and this bill would provide the VA with resources to put these strategies into practice.

Second, this bill would expand the HUD-Veterans Affairs Supportive Housing program, also known as the HUD-VASH program. This collaborative program provides homeless veterans with vouchers to rent apartments in the private rental market, as well as case management and clinical services at local VA medical centers. In this way, veterans receive the supportive housing they deserve and have earned.

The HUD-VASH program has grown in recent years, with 20,000 vouchers funded over the last two years. However, more homeless veterans should benefit from this important resource. As such, the Zero Tolerance for Veterans Homelessness bill authorizes up to 10,000 additional vouchers each year to reach a maximum of 60,000 vouchers by 2013.

Third, this legislation would make it easier for non-profits to apply for capital grants through the VA's grants and per diem program to build transitional housing and other facilities for veterans. This would streamline the process for non-profit organizations to use financing from other sources to break ground on new housing construction. This is particularly important in the current economy, when non-profits are stretched and have to be more creative than ever to fund new capital projects.

Among its other provisions, the Zero Tolerance for Veterans Homelessness Act would:

- create a Special Assistant for Veterans Affairs position within HUD to serve as a liaison between HUD and the VA to coordinate their services;
- establish a new data collection system for the VA to track the number of homeless veterans and the types of assistance they receive; and
- require the Secretary of Veterans Affairs to develop a comprehensive plan with recommendations on how to end homelessness among veterans.

I am proud to have introduced this bill with my colleagues, Senators Bond, Murray, and Johnson. Since this bill was introduced, nine additional Senators have joined as cosponsors, including Senators Kerry, Durbin, Begich, Mikulski, Burris, Leahy, Whitehouse, Baucus, and Tom Udall.

The bill is supported by many homelessness and veterans advocacy groups, including the National Coalition for Homeless Veterans, the National Alliance to End Homelessness, the VFW, the Local Initiatives Support Coalition, and Give Us Your Poor. I ask that letters of support from these organizations be entered into the record.

Our legislation also complements Senator Murray's bill, S. 1237, which I am cosponsoring, that will enable programs at the VA and the Department of Labor to better serve homeless women veterans and homeless veterans with children.

Only by working together, across the Federal Government and in partnership with non-profits and local housing authorities, will we be able to comprehensively help homeless veterans and reach those in danger of becoming homeless. We owe it to our veterans to ensure that they and their families have safe, affordable places to live and to provide the services and benefits they have earned. The Nation's brave veterans deserve nothing less.

I look forward to continue working with the Committee on this important legislation. Thank you for the opportunity to testify and for your leadership on behalf of our veterans.

Chairman AKAKA. Thank you very much, Senator Reed, for your statement. I am glad to hear of your support on some of our pending bills.

And now, I would like to introduce Senator Bayh. It is good to have you here with us this morning and we look forward to your statement.

STATEMENT OF HON. EVAN BAYH, U.S. SENATOR FROM INDIANA

Senator BAYH. Thank you, Mr. Chairman. I appreciate your hospitality and your leadership on these critically important issues. I want to thank you for your invitation to testify today and for all that you are doing to ensure that the VA has the tools and authority it needs to help our brave men and women returning from Iraq and Afghanistan nursing the wounds of war.

I am here today to testify about a tragedy that took place in 2003 on the outskirts of Basra in Iraq. I am here on behalf of LTC James Gentry and the brave men and women who served under his command in the First Battalion, 152nd Infantry of the Indiana National Guard. I spoke with LTC Gentry by phone just last week. Unfortunately, he is at home with his wife, Luanne, waging a valiant fight against terminal cancer.

The Lieutenant Colonel was a healthy man when he left for Iraq. Today, he is fighting for his life. Tragically, many of his men are facing their own bleak prognosis as a result of their exposure to sodium dichromate—one of the most lethal carcinogens in existence. The chemical is used as an anti-corrosive for pipes. It was strewn all over the water treatment facility guarded by the 152nd Infantry. More than 600 soldiers from Indiana, Oregon, West Virginia, and South Carolina were exposed. One Indiana Guardsman has already died from lung disease and the Army has classified it as a service-related death. Dozens of others have come forward with a range of serious respiratory symptoms.

The DOD Inspector General just launched an investigation into the breakdowns and gaps in our system that allowed this tragic exposure to happen. Neither the Army nor the private contractor, KBR, performed an environmental risk assessment of the site, so our soldiers were literally breathing in this chemical and swallowing it for months. Our country's reliance on military contractors and their responsibility to their bottom line versus our soldiers' safety is the topic for another day and for another hearing.

Mr. Chairman, today I would like to tell this Committee about S. 1779. It is legislation that I have written to ensure that we provide full and timely medical care to soldiers exposed to hazardous chemicals during wartime military service, like those on the outskirts of Basra. The Health Care for Veterans Exposed to Chemical Hazards Act of 2009 is bipartisan legislation that has already been cosponsored by Senators Lugar, Dorgan, Rockefeller, Byrd, Wyden, and Merkley. With a CBO score of just $10 million, it is a bill with a modest cost but a critical objective: to ensure that we do right by America's soldiers exposed to toxic chemicals while defending our country.

This bill is modeled after similar legislation that Congress approved in 1978 following the Agent Orange exposure in the Vietnam conflict. That bill ensured lifelong VA care for soldiers unwittingly exposed to the cancer-causing herbicide in the jungles of Vietnam. Some have called toxic industrial hazards "the Agent Orange of the wars in Iraq and Afghanistan."

My legislation would make soldiers eligible for medical examinations, laboratory tests, hospital care, and nursing services. It would ensure that soldiers receive priority health care at VA facilities. It

would recognize a veteran's own report of exposure and inclusion on a Department of Defense registry as sufficient proof to receive medical care, barring evidence to the contrary.

My legislation will help to ensure that we provide the best possible care for American soldiers exposed to environmental hazards during the reconstruction of Iraq and Afghanistan. At a bare minimum, Mr. Chairman, my bill will ensure compassionate care so families are spared the added grief of going from doctor to doctor in their loved ones' final days, searching for an accurate diagnosis.

The 1978 Agent Orange Registry only covered one chemical compound, but our bill is broader. It covers all members of the Armed Forces who have been exposed to any environmental chemical hazard, not just sodium dichromate. It recognizes a new set of risks that soldiers face today throughout the world.

Senate testimony last year identified at least seven serious instances of potential contamination involving different industrial hazards: sulfur fires; ionizing radiation; sarin gas; and depleted uranium, to name just a few. S. 1779 ensures that veterans who were exposed to these chemicals will be eligible for hospital care, medical services, and nursing home care. It allows the Secretary of Defense to identify the hazards of greatest concern that warrant special attention from the VA.

Our bill switches the burden of proof from the soldier to the government, where in such cases it rightfully belongs. Soldiers exposed to toxic chemicals will receive care presumptively, unless the VA can show their illness is not related to their service.

Exposure to toxic chemicals is a threat no servicemember should have to face. It is our moral obligation to offer access to prompt, quality care. We should cut the red tape for these heroes.

Mr. Chairman, I promised LTC Gentry that I would fight for his men here in Congress. I promised him I would use my position to get them the care they deserve and to make sure we protect our soldiers from preventable risks like these in the future. This tragedy will be compounded if we do not take the steps to provide the best medical care our country has to offer.

I want to thank you for this opportunity to offer testimony today. I urge this Committee to adopt S. 1779 to honor the sacrifice of LTC Gentry and all of our brave men and women doing the hard, dangerous work to keep America safe. It is the least we can do for them.

Chairman AKAKA. Thank you very much, Senator Bayh. Thank you for your statement and your legislation on exposures. Thank you.

Senator BAYH. Thank you, Mr. Chairman.

Chairman AKAKA. And now, I would like to welcome our principal witnesses. I want to welcome from VA Dr. Gerald M. Cross—it is good to have you back—who is the Acting Under Secretary for Health. Dr. Cross is accompanied today by Brad Mayes, the Director of the Compensation and Pension Service; Walter Hall, Assistant General Counsel; and Richard Hipolit, Assistant General Counsel.

I thank you all for being here this morning. VA's full testimony will, of course, appear in the record. So, Dr. Cross, will you please begin with your statement.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BRAD MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; WALTER HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Good morning, Mr. Chairman and Members of the Committee. I want to thank you for the opportunity to testify on a number of important pieces of legislation. I will be addressing legislation affecting health care, while my colleague, Mr. Mayes, will discuss benefits legislation.

I will focus on five bills that we believe touch upon particularly important issues for VA and the Committee, and these include a bill on homeless veterans, the Veterans Health Care Improvement Act of 2009, the Quality Report Card Act, the Caring for Camp Lejeune Veterans Act, and the reporting chain for physician assistants.

VA supports S. 1237, the Homeless Women Veterans and Homeless Veterans with Children Act of 2009, which would expand eligibility for entities to receive grant and per diem payments and would make available benefits to all homeless veterans with minor dependents. It would also authorize grant recipients to provide services directly to dependents of homeless veterans. VA supports all of these changes and recognizes them as important to complement VA's current efforts.

The Secretary and the President have announced an ambitious goal to end veteran homelessness within 5 years. We will assist all eligible veterans willing to accept our services. We will help them acquire safe housing, obtain needed medical and mental health treatment, and receive educational and employment assistance. We can't achieve this goal on our own. We will need the collaboration of Federal and State and community partners and, of course, Congress.

VA does not support S. 1302, the Veterans Care Improvement Act of 2009. VA is devoting significant efforts toward quality control and effective incentives that Community-Based Outpatient Clinics contracting, and that is a complex, multi-faceted endeavor. There is a great deal of emerging research in the medical field on pay-for-performance, and it is clear that programs must be carefully thought out to avoid unintended consequences. Prescribing a fixed set of tools would impair VA's flexibility. Moreover, the legislation would not provide any additional statutory authority to establish a CBOC performance-based quality care incentive contract beyond what is currently already available.

We agree with the intent of S. 1427, the Department of Veterans Affairs Hospital Quality Report Card Act of 2009. We agree with it quite strongly in terms of the intent. But we do not think the bill is actually necessary. Veterans in need of health care should know that they have access to the best services possible, which is why we have identified health care transparency as one of our

major strategic initiatives. We will publish more data about our facilities online than ever before, and we are working with the Centers of Medicare and Medicaid Services to support comparisons between VA and non-VA facilities. We believe that these efforts will fully achieve the objectives of the proposed legislation. We also have some technical concerns about the bill, as written.

VA also supports the intent of S. 1518, the Caring for Camp Lejeune Veterans Act of 2009, which would provide for treatment of veterans and their dependents who were exposed to contaminants at Camp Lejeune. We are very concerned about the health problems experienced by veterans who served at Camp Lejeune. However, we believe that S. 1518, as written, is too broad.

As a result of a recent National Research Council report, VA has convened a special work group. This work group will address the findings of the report and make recommendations to the Secretary about the need for any additional service connections.

VA currently provides veterans with information about this issue and offers referrals to the Navy's registry. My Office of Public Health and Environmental Hazards has already been contacted by the U.S. Marine Corps regarding VA's access to the registry. Affected veterans may already apply for health care enrollment and disability compensation based upon direct service connection. We recommend that any further priority for this group of veterans be established only in accordance with scientific evidence. Further, we strongly recommend that any care and treatment provided to eligible family members be coordinated with DOD and provided by DOD.

Finally, S. 1155 would require the establishment of the position of Physician Assistant Director and require this Director to report directly to the Under Secretary of Health. We value our Physician Assistants tremendously, as we do all of our professional groups who provide care to veterans. There already exists an equivalent position within VHA. It is called the Physician Assistant Advisor. We have already made several enhancements to the Physician Assistant Advisor's position, including making it a full-time position. It will also become a Washington, DC-based office at the end of the incumbent's tenure.

We believe that these measures give the Physician Assistant Advisor the status necessary to carry out all of the responsibilities needed. The proposed legislation would go a step further by elevating the reporting relationship of the Physician Assistant Advisor above nurse practitioners, surgeons, physical therapists, mental health staff, and other professional groups in VHA. For this reason, we oppose that bill.

Mr. Mayes is now available to discuss legislation affecting VBA, and after his remarks, sir, we will be pleased to answer any of your questions.

Mr. MAYES. Mr. Chairman and Members of the Committee, thank you for allowing me the opportunity to appear before you here today. In the interest of time, I will limit my oral statement to four bills of importance to the Veterans Benefits Administration. However, our full views have been submitted for the record.

VA does not support S. 977, the Prisoner of War Benefits Act of 2009, with the exception of the provision that would remove the re-

quirement that VA determine that a former prisoner of war has PTSD in order to extend the presumption of service connection for osteoporosis. We previously changed the regulation eliminating that predicate requirement for a diagnosis of PTSD. That rule was published in the Federal Register on August 28, 2009.

VA does not support extending the presumption of service connection for Type 2 diabetes because we are not aware of scientific evidence demonstrating that such a presumption is warranted. And we cannot support the elimination of the 30-day minimum internment period for disabilities resulting from nutritional deficiencies because these disabilities, by definition, are the result of deprivation or improper diet over a sustained period of time.

VA does not support an increase in the monthly dependency and indemnity compensation payment rate as proposed in S. 1118. In October 2007, the Veterans Disability Benefits Commission assessed the appropriateness of the level of dependency and indemnity compensation (DIC) payments and found the current level of DIC pay to a surviving spouse is comparable to or higher than the earnings of a widow or widower in the general population. In addition, 89 percent of the surviving spouses responding to a survey were satisfied with their DIC payments.

A May 2001 VA program evaluation of benefits for survivors indicated findings similar to those of the Veterans Disability Benefits Commission, specifically, that DIC is a competitive survivor benefit compared to employer-provided benefits for survivors of non-veterans. The report pointed out that DIC provides a benefit that is approximately twice as large as benefits for survivors of private-sector employees, State employees, and Federal employees covered by the Civil Service Retirement System.

However, VA would not be opposed to lowering the age from 57 to 55 at which a surviving spouse can remarry and retain eligibility for several VA benefits, including DIC paid under Section 1311, Chapter 35 educational assistance, and housing loans made under Chapter 37 of the title, provided Congress finds the offsets for the costs of these changes. By lowering the age, this change would make Title 38 provisions similar to those found in Title 10. Changing similar provisions in Title 38, we believe, is not only equitable, but would also simplify the administration of benefits under both titles.

Regarding S. 1444, the Combat PTSD Act, VA is concerned that the language of the bill is too broad, encompasses more than just PTSD claims, and may unduly complicate the adjudication process. While we cannot support the bill as proposed, we have taken a number of steps that we believe are consistent with the bill's intent to relax the evidentiary standard for veterans to prove their PTSD claim.

On August 24 of this year, VA proposed a rule that would liberalize the evidentiary standard for establishing the required in-service stressor for entitlement to service connection benefits for Post Traumatic Stress Disorder. The amendment to VA's adjudication regulations governing service connection for PTSD would eliminate the requirement for corroborating evidence that the claimed in-service stressor occurred if the stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity

and a VA psychiatrist or psychologist confirms that the claimed stressor is adequate to support a diagnosis of PTSD, provided that the claimed stressor is consistent with the places, types, and circumstances of the veteran's service, and that the veteran's symptoms are related to the claimed stressor.

Finally, VA supports the objective of S. 1752, which would add Parkinson's disease manifested to the degree of 10 percent or more to the list of diseases presumed service-connected for a veteran who served in Vietnam. Based on an independent study by the Institute of Medicine, the Secretary announced on October 13, 2009, that VA would add Parkinson's disease to the list of presumptive diseases associated with herbicide exposure. Therefore, we believe the legislation is unnecessary.

This concludes my testimony and we would be pleased to answer any questions you or any of the Members of the Committee may have. Thank you.

[The prepared statement of Dr. Cross follows:]

PREPARED STATEMENT OF GERALD M. CROSS, MD, FAAFP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning Mr. Chairman and Members of the Committee: Thank you for inviting me here today to present views on several bills that would affect Department of Veterans Affairs (VA) benefits and services. Joining me today are Mr. Brad Mayes, Director of the Compensation and Pension Service, Mr. Richard Hipolit, Assistant General Counsel, and Mr. Walter Hall, Assistant General Counsel. Unfortunately, we do not have views and estimates on several bills including S. 1109, S. 1467, S. 1556, S. 1753, and a draft bill regarding exposure to chemical hazards referred to in the list of bills provided in the Committee's witness letter of October 8. We will forward those as soon as they are available. We appreciate the opportunity to address these bills that would affect the Department's health care and benefits programs.

S. 977 "PRISONER OF WAR BENEFITS ACT OF 2009"

S. 977 would eliminate two current requirements for presuming service connection of certain diseases in a former prisoner of war (POW): (1) the requirement that a Veteran be detained or interned as a POW for at least 30 days; and (2) the requirement that VA determine that a former POW has Post Traumatic Stress Disorder (PTSD) for service connection of osteoporosis to be presumed. It would also add type II diabetes to the list of presumptive diseases. The bill would authorize the Secretary to add through rulemaking to the list of diseases that may be presumed service-connected in a former POW, by reason of having a positive association with the experience of being a POW, and would establish procedures, including taking into account the recommendations of the Advisory Committee on Former Prisoners of War, on how those diseases should be added. Finally, if a disease is removed from the presumptive list and a Veteran was awarded compensation for that disease or a Veteran's survivor was awarded dependency and indemnity compensation for the Veteran's death resulting from that disease before the removal effective date, the bill would protect entitlement to benefits for that disease.

VA does not support this bill. The presumption for some conditions currently requires a minimum internment period for good reason. Some presumptive conditions, such as avitaminosis, malnutrition, and other nutritional deficiencies, require a minimum period of deprivation to develop. The 30-day minimum internment period reflects the need for a period during which a person would be deprived of a proper diet. As a result, VA relied upon the 30-day timeframe established by Congress when it added osteoporosis to the regulatory list of presumptive diseases. VA already recognized that the presumption of service connection for osteoporosis for former POWs should not be limited to former POWs who have PTSD. Based on studies suggesting a link between osteoporosis and internment or detention as a POW for a period sufficient to result in nutritional deficiency, we amended our regulations to provide a presumption of service connection for osteoporosis independent of any determination regarding PTSD. VA cannot support the addition of type II di-

abetes to the list of presumptive diseases because we are not aware of scientific evidence demonstrating that such a presumption is warranted.

VA agrees that it should amend applicable regulations when sound medical and scientific evidence shows a positive association between the experience of being a former POW and the occurrence of a disease. VA already relies upon recommendations from its advisory committees, such as the Advisory Committee on Former Prisoners of War, to carefully study and recommend appropriate regulatory amendments, including additional POW presumptive conditions and has added by regulation new presumptions recommended by the Advisory Committee on Former Prisoners of War. However, because VA already has in 38 U.S.C. 501 sufficient statutory authority to prescribe necessary or appropriate regulations, additional statutory authority to authorize such rulemaking is unnecessary. Moreover, because VA already consults the Advisory Committee, requiring it to do so is unnecessary. VA intends to continue to review for possible regulatory amendment any recommendations from the Advisory Committee, as well as from other sources. Congress created the Advisory Committee to assess the needs of POWs with respect to compensation, health care, and rehabilitation. We welcome the opportunity to meet with the Advisory Committee at any time.

However, VA opposes mandatory timeframes within which to promulgate regulations in response to an Advisory Committee recommendation and any requirement to publish a notice of a decision that a presumption is not warranted for a disease. Under 38 U.S.C. 541, every two years the Advisory Committee is to submit a report to the Secretary on the programs and activities of VA that pertain to former POWs. Within 60 days of receipt of this report, VA is required to submit a copy to Congress along with appropriate comments. The Advisory Committee may submit any other reports or recommendations that it considers appropriate. These statutory provisions are clear that the Advisory Committee is to assist VA in making reports and recommendations regarding the needs of former POWs. The Advisory Committee is not and should not be a substitute for VA's regulatory efforts.

VA is unable to provide costs on this bill at this time because sufficient data are not yet available. With the Chairman's permission, we will provide a cost estimate in writing for inclusion in the record.

S. 1118 "INCREASE IN THE AMOUNT OF MONTHLY DEPENDENCY AND INDEMNITY COMPENSATION TO SURVIVING SPOUSES"

Section 1 of S. 1118 would increase the monthly amount of dependency and indemnity compensation (DIC) payable to a Veteran's surviving spouse. Instead of the current base amount, VA would pay 55 percent of the rate of monthly compensation in effect under 38 U.S.C. 1114(j), the rate of disability compensation for disability rated totally disabling. In the case of an individual who is eligible for DIC under section 1311 and for benefits under another provision of law by reason of the individual's status as a Veteran's surviving spouse, section 1 would also prohibit the reduction or offset in benefits under the other provision of law by reason of eligibility for DIC under section 1311. These changes would apply to DIC paid under 38 U.S.C. ch. 13 for months beginning after 180 days after the date of enactment.[1]

VA does not support section 1 of this bill because the current rates of DIC are appropriate. In October 2007, the Veterans' Disability Benefits Commission assessed the appropriateness of the level of DIC payments and found the current level of DIC paid to a surviving spouse is comparable to, or higher than, the earnings of a widow or widower in the general population. In addition, 89 percent of surviving spouses responding to a survey were satisfied with their DIC payments.[2] A May 2001 VA Program Evaluation of Benefits for Survivors indicated findings similar to those of the Veterans' Disability Benefits Commission—that DIC is a competitive survivor benefit compared to employer-provided benefits for survivors of non-Veterans. The report pointed out that DIC provides a benefit that is approximately twice as large as benefits for survivors of private sector employees, state employees, and Federal employees covered by the Civil Service Retirement System, and that VA provides a significantly broader array of non-income benefits for survivors of disabled Veterans.

DIC payments, unlike most other Federal benefits, are tax-free. Surviving spouses who are entitled to DIC are entitled to other non-income Federal benefits, such as care under the Civilian Health and Medical Program, Dependents' Educational As-

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[1] The bill language refers to ″compensation″ paid under chapter 13. We interpret the provision to apply to payments of DIC under chapter 13.

[2] Veterans' Disability Benefits Commission, ″Honoring The Call To Duty: Veterans' Disability Benefits in the 21st Century, October 2007, page 393.

sistance, burial expense reimbursement, and Servicemembers' or Veterans' Group Life Insurance. These additional benefits significantly increase the value of a surviving spouse's "benefit package" and help a surviving spouse to adjust during the critical transition period after a Veteran's death.

The language of the provision that would eliminate the offset between DIC and other benefits for a Veteran's surviving spouse is broad enough to include annuities under the Survivor Benefit Plan (SBP) and other Federal benefits, such as payments under the Radiation Exposure Compensation Act of 1990, the Federal Tort Claims Act, and the Federal Employees Compensation Act based on "death due to service in the Armed Forces." Current law generally prohibits payment of any other Federal benefit to a surviving spouse who is receiving DIC payments.

If the scope of the offset elimination is intended only for DIC and SBP payments, then VA defers to the Department of Defense (DOD) because DOD would incur the costs associated with enactment of the bill. VA pays the full amount of DIC regardless of whether a surviving spouse is entitled to SBP benefits. A provision of title 10, United States Code, which governs DOD programs, requires that SBP payments be offset.

If the offset elimination is intended to cover Federal benefits in general, not only SBP, there would again be no financial implications for VA. However, this provision could result in some circumstances in duplication of benefits for the same condition or event. If, for example, a surviving spouse receives DIC based on the Veteran's death, which was attributed to his service-connected bladder cancer due to radiation exposure, then the surviving spouse would also receive a lump sum payment for the same disability from the Department of Justice under the Radiation Exposure Compensation Act of 1990. In this hypothetical instance and others like it, the surviving spouse would receive duplicate payments for the same disability.

VA estimates the costs associated with section 1 of this bill would be $1.1 billion in the first year following enactment and $14.3 billion over ten years.

Current law authorizes the payment of DIC to the surviving spouse and children of a deceased Veteran who was entitled to receive compensation at the time death for a service-connected disability that was rated totally disabling for a minimum period of 10 years immediately preceding death. Section 2 of S. 1118 would reduce the amount of time required from 10 years to 5 years and would provide graduated rates of DIC depending on how long the disability was rated totally disabling. For example, if the disability was continuously rated totally disabling for at least five years but less than six years, DIC would be paid at the rate of 50 percent of the DIC otherwise payable. If the disability was continuously rated totally disabling for at least six years but less than seven years, DIC would be paid at the rate of 60 percent of the DIC otherwise payable.

VA needs additional time to evaluate section 2. We will forward views on this provision as soon as they are available.

Section 3 of S. 1118 would lower from 57 to 55 the age at which a surviving spouse can remarry and retain eligibility for several VA benefits, including DIC paid under section 1311, educational assistance paid under 38 U.S.C. ch. 35, and housing loans made under 38 U.S.C. ch. 37. The change would be effective on the later of the first day of the first month that begins after the date of enactment and the first day of the fiscal year that begins in the calendar year of enactment. Section 3 would prohibit the payment of any benefit for any period before the effective date. An individual who, but for having remarried, would be eligible for a VA benefit by reason of these amendments but who remarried before enactment and after attaining age 55, would be eligible for benefits under the amendment made by section 3, but only if the individual applies to VA not later than one year after enactment.

VA does not oppose enactment of this provision provided Congress finds savings to offset increased costs from its enactment. By lowering the age, this bill would make title 38 provisions similar to those already existing in title 10. Changing similar provisions in title 38 is not only equitable but would also simplify the administration of benefits under both titles.

VA is unable to provide a cost estimate for this provision at this time because sufficient data are not available. With the Chairman's permission, we will provide VA's estimate in writing at a later date.

S. 1155 "ESTABLISHING POSITION OF DIRECTOR OF PHYSICIAN ASSISTANT SERVICES"

S. 1155 would eliminate the Physician Assistant (PA) Advisor position established by Public Law 106–419, the Veterans Benefits and Health Care Improvement Act of 2000, and establish a Director of Physician Assistant (PA) Services within the Office of the Under Secretary for Health. VA does not support this bill.

The functions of the proposed Director of PA Services are already being performed by the PA Advisor. Moreover, the PA Advisor position was converted to full-time on April 14, 2008, and it will be based in VA Central Office at the expiration of the current incumbent's term in April 2010.

In addition, VA does not support the proposed organizational realignment of the Director of PA Services to the Office of the Under Secretary for Health. The position's current alignment within the Office of Patient Care Services is consistent with most other clinical program leadership positions and provides the PA Advisor access to the Under Secretary for Health for any issues that cannot be resolved within the current structure. The cost of implementing this bill is insignificant.

S. 1204 "CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2009"

S. 1204 would require VA to increase to not fewer than 75 the number of VA facilities directly providing chiropractic care through VA medical centers and clinics by December 31, 2009. In addition, S. 1204 would require that chiropractic care be provided at all VA medical centers by December 31, 2011.

VA opposes S. 1204. While musculoskeletal conditions are common in VA patients, and are increasingly prevalent among Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans, there is currently a facility with an in-house chiropractic care program in each of our geographic service areas. Specifically, VA has 28.5 chiropractors providing on-station care and services at 36 facilities. VA does not oppose eventually increasing the number of VA sites providing chiropractic care; however, the projected demand for chiropractic care is insufficient to justify mandating it at all VA medical centers by the end of 2011. Moreover, the requirement to increase the number of facilities in which VA provides chiropractic care from 36 facilities to 75 facilities by the end of the calendar year is unrealistic and unnecessary. Currently, 98 percent of VA patients are able to receive chiropractic care within thirty days of their desired date.

VA estimates that S. 1204 would cost $5.3 million in fiscal year (FY) 2010, $5.5 million in FY 2011, $29.8 million over 5 years, and $63.6 million over 10 years.

S. 1237 "HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009"

S. 1237 would expand those eligible to receive grants under 38 U.S.C. 2061 beyond grant and per diem providers to include those entities eligible to receive grant and per diem payments. It would also provide that both male and female homeless Veterans who are responsible for the care of minor dependents may qualify as Veterans with special needs. In addition, S. 1237 would authorize the use of funds for the provision of direct services to the dependents of homeless Veterans. Section 3 of S. 1237 would require the Secretary of Labor to award grants to eligible programs and facilities to provide services to reintegrate homeless women Veterans and homeless Veterans with children into the workforce. Grant recipients would provide job training, counseling, job placement services and child care. The law would be implemented by the Assistant Secretary for Veterans' Employment and Training, who would report through the Secretary of Labor on this program biennially. An additional $10 million, in excess of other appropriated funds, would be made available for fiscal years 2010 and 2014.

VA supports section 2 as it would allow any eligible entity providing services to special needs populations to apply for special needs grants by eliminating the requirement that recipients also be a grant and per diem recipient. VA also supports making the provision recognizing homeless Veterans with dependent children as a special needs population gender neutral because it would allow VA to directly provide equal services to all homeless Veterans with dependents.

VA estimates the cost of this section would be $8.9 million in FY 2010, $15.1 million in FY 2011, $91 million over 5 years, and $239.6 million over 10 years.

The Secretary of Labor is responsible for awarding grants under Section 3 of the bill. VA defers to the Department of Labor concerning this portion of the legislation.

S. 1302 "VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009"

S. 1302 would require VA to submit to Congress within one year a plan to introduce pay-for-performance measures into community-based outpatient clinic (CBOC) contracts. This plan would require VA to include measures to ensure contracts utilize pay-for-performance mechanisms including incentives for providing high-quality health care, patient satisfaction, and data collection on the outcomes of services provided by CBOCs. The plan would also require VA to impose penalties for substandard care, and to eliminate abuses by CBOCs that use capitated-basis compensation. Moreover, VA's plan would need to include mechanisms to ensure Vet-

erans are not denied care and do not face undue delays. VA would be required to implement this plan within 60 days of submitting it to Congress, though in implementing the plan the Secretary may initially carry out of one or more pilot programs to assess its feasibility and advisability. VA would be required to report to Congress every 6 months providing recommendations on the feasibility and advisability of utilizing pay-for-performance compensation in providing health care services through means other than CBOCs.

VA does not support S. 1302. VA is devoting significant effort into quality control and effective incentives in its CBOC contracting now, and that is a complex multifaceted endeavor. There is a great deal of emerging research in the medical field on pay-for-performance, and it is clear that programs must be carefully thought out to avoid unintended consequences. Prescribing a fixed set of tools would impair VA flexibility. Additionally the legislation would not provide any additional statutory authority to establish a CBOC performance-based patient quality care incentive contract than what is currently provided in the Federal Acquisition Regulations.

VA estimates there would be no additional costs associated with this legislation as it only requires VA to develop a different type of contract during the normal acquisition process.

S. 1394 "VETERANS ENTITLEMENT TO SERVICES (VETS) ACT OF 2009"

S. 1394, the "Veterans Entitlement to Service Act of 2009," would require the Secretary to acknowledge the receipt of any claim for medical services, disability compensation, or pension or other communication relating to those services or benefits within 30 days of receipt. The acknowledgment would have to specify the date of receipt and would be permitted to be communicated "via written or electronic means" including email.

VA does not support S. 1394. By requiring additional paperwork and administrative workload that would not materially advance the merits of a claim, the bill would be detrimental to VA's efforts to streamline and expedite claims processing. Moreover, the benefits of such a requirement are unclear; VA already contacts individuals who submit claims generally within 30 days. Individuals who submit claims electronically receive immediate acknowledgement. VA continues to communicate with claimants throughout the claims process.

In addition, the term, "or other communication" is too broad and could be interpreted to require VA to formally respond to an indefinite number of telephonic, written, or electronic contacts by Veterans to VA call centers, health care facilities, Regional Offices, Vet Centers and other locations. It is VA policy to respond as quickly as possible to any Veteran's request or inquiry but the legislation is too prescriptive in this regard. VA receives roughly 21 million telephone calls each year at the main Veterans Benefits Administration (VBA) call center; the Veterans Health Administration's (VHA) Pharmacy Customer Call Center is expected to receive in excess of 8 million calls per year, and VA estimates VHA, VISN, and medical center call centers receive in excess of 20 million calls per year.

Enactment of S. 1394 would not result in any mandatory costs. VA cannot estimate the cost for the proposed legislation as there is no central accounting system for the number of contacts made by Veterans to VA.

S. 1427 "DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT OF 2009"

S. 1427 would add section 1706A to title 38 and require VA, within 18 months of enactment, to establish and implement a Hospital Quality Report Card Initiative. This initiative would require the Secretary to publish a report at least twice a year on Department medical centers containing information on effectiveness, safety, timeliness, efficiency, patient-centeredness, patient satisfaction, health professional satisfaction, and equity of care for various populations (female, geriatric, disabled, rural, homeless, mentally ill, racial and ethnic minorities). VA would be required to grade facilities in these areas on a scale from A+ to F. VA would also be required to provide information, to the maximum extent practicable, on: staffing levels of nurses and other health professionals; rates of nosocomial infections; volumes of different procedures performed; hospital sanctions and violations; quality of care to various populations; availability of emergency rooms, intensive care units (ICUs), maternity and specialty services; quality of care in inpatient, outpatient, emergency, maternity and ICU; ongoing patient safety initiatives; use of health information technology; and other matters. S. 1427 would allow the Secretary to provide information in addition to or in lieu of the specific requirements identified in the bill by informing the Senate and House Committees on Veterans' Affairs at least 15 days before the report is to be published. S. 1427 would also allow Secretary to adjust

quality measures based upon risk, but it would require VA to establish procedures for making unadjusted data available to the public in a manner deemed appropriate by VA and to disclose its analysis methodology. These reports would need to be written for non-medical professionals and available electronically and in hard copy upon request at each medical center. The legislation is intended to ensure information VA provides is of a type and in a form that is conducive to comparisons with other local or regional hospitals. At least once a year, VA would be required to annually compare quality measures across years to identify and report any false or artificial improvements in quality measurements. In addition, VA would be required to develop and implement effective safeguards to protect against unauthorized use or disclosure of medical center data and to ensure that no identifiable patient data is released to the public.

VA does not oppose increasing transparency of quality measures for its facilities and agrees with the general premise of this legislation; however, the agency does not support S. 1427 as written because some of the requirements may not be possible or would require VA to develop its own data categories that could not be compared or benchmarked to other leading health care organizations.

VA has identified health care transparency as one of its major Strategic Transformation Initiatives this fiscal year and is working with the Centers for Medicare & Medicaid Services (CMS) to post VA comparable data on their "Hospital Compare" Web site (www.hospitalcompare.hhs.gov). CMS requires three data streams, each of which has different reporting periods based on assuring data validity. They post process data quarterly but outcome and patient satisfaction data annually. VA consequently believes that it is impractical to report data twice a year as the data may be invalid. VA is similarly exploring other public reporting programs, such as the Medicare Prescription Drug Plan Finder, Medicare Options Compare, CMS' Nursing Home Compare, Commonwealth Fund's WhyNotTheBest, and others.

Additionally, VA is developing composite metrics meaningful to both consumers and stakeholders. While seemingly simple, an incremental letter grade scale may not be the best way to communicate the quality of a particular hospital to consumers. For example, CMS uses a five star rating system for Nursing Home Compare. VA will be conducting focus groups with Veterans to determine how they would like to be provided quality information about medical facilities. VA has proposed an initiative to develop an internal VA Hospital Report Card prototype for internal measurements and comparison at all organizational levels. The data elements are similar but not exactly the same as the elements identified in this legislation. VA proposes to include: structure and volume; workforce productivity; population and disease burden; care delivery utilization; quality, efficiency and outcomes; and trends and benchmarks. This approach offers VA the flexibility to provide meaningful measures that may be benchmarked with other hospitals and develop new measures through consensus-based processes involving all stakeholders. Measures should focus on areas with the greatest potential for making care safe, effective, timely, efficient or equitable, and patient-centered. Primarily, these data will be used to identify areas where VA can improve the most.

VA estimates S. 1427 would cost $2 million in FY 2010, $2.1 million in FY 2011, $10.8 million over 5 years, and $24.0 million over 10 years.

S. 1429 "SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT"

S. 1429 would establish a 12 member commission, jointly appointed by VA and DOD, responsible for overseeing the monitoring and treatment of Veterans and servicemembers with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and other mental health disorders caused by service in the Armed Forces. The Commission would consist of at least one of each of the following: active duty servicemembers, Veterans retired from armed services, VA employees, DOD employees, recognized medical or scientific authorities in related fields, non-physician mental health professionals, and Veterans who have undergone treatment for PTSD, TBI or other mental health disorders. VA and DOD would be required to consult with Veterans Service Organizations (VSO), members of the Armed Forces, and family members of Veterans and servicemembers when identifying members of the Commission. The Commission would conduct a thorough study of all matters relating to the long-term adverse consequences of these conditions. This would include analyzing information gathered from post-deployment interviews, effective treatments, effects on military careers for those seeking care, and continuity and effectiveness of care provided individuals during transition from DOD to VA. The Commission would make recommendations to mitigate any adverse consequences identified in the study and reduce the cultural and professional stigmas associated with treatment. The Commission would, not later than September 30 of each year, sub-

mit a report to Congress on their findings, conclusions, and recommendations of the Commission. The Commission would be authorized to conduct site visits, secure information from any Federal department or agency, and solicit testimony from servicemembers, Veterans, caregivers and other sources. The Commission would be terminated at the joint discretion of the Secretaries of DOD and VA.

VA does not support S. 1429 because it is unnecessary. The Commission would review and advise on PTSD in current and former servicemembers who developed this condition as a result of service, regardless of era, but would not have oversight responsibilities for the care of Veterans with mental health conditions that were not determined to be service-connected. VA's mental health program provides care for enrolled Veterans with mental health conditions regardless of the origin of their conditions. Consequently, this Commission would be overseeing part of VA's mental health program, but not the entirety. The charge to address care in both Departments, and to address VA care across the lifespan, but only for those with service-connected conditions, is likely to limit its impact in either setting.

Additionally, the Federal Advisory Committee on Prosthetics and Rehabilitation already addresses care for Veterans with TBI. Care for Veterans with mental health conditions is being address by two congressionally authorized committees: the Special Committee on Serious Mental Illness, and the Special Committee on PTSD. Membership for both committees is determined by the Under Secretary for Health, and each submits an annual report to Congress. The Commission proposed by this legislation would duplicate these existing and effective mechanisms for oversight.

VA estimates the bill would cost $1 million in FY 2010, $1 million in FY 2011, $5 million over 5 years, and $10 million over 10 years.

S. 1444 "COMBAT PTSD ACT"

S. 1444 would clarify the meaning of the term "combat with the enemy" in 38 U.S.C. 1154(b) for the purpose of determining service connection. For Veterans who engaged in "combat with the enemy," section 1154(b) provides a relaxed evidentiary standard for proving service connection. Under this legislation, the term "combat with the enemy" would include active duty in a theater of combat operations (as determined by VA in consultation with DOD) during a period of war and active duty in combat against a hostile force during a period of hostilities. The clarification would apply to any disability compensation claim pending on or after the date of enactment.

VA opposes this bill. While we understand and support the intent to give every benefit of the doubt to combat Veterans, S. 1444 is too broad, encompasses more than just PTSD claims, and may unduly complicate the adjudication process.

Section 1154(b) provides a relaxed evidentiary standard that facilitates a combat Veteran's establishment of service connection for disease or injury alleged to have been incurred in or aggravated by certain active service. Specifically, section 1154(b) provides that, in the case of any Veteran who engaged in combat with the enemy in active service during a period of war, campaign, or expedition, VA shall accept as sufficient proof of service connection of any claimed disease or injury satisfactory lay or other evidence of service incurrence or aggravation, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding the absence of an official record of such incurrence or aggravation. In short, section 1154(b) allows a combat Veteran to establish the incurrence or aggravation of a disease or injury in combat service by lay evidence alone. However, to be afforded this relaxed evidentiary standard, the Veteran must have "engaged in combat with the enemy." Furthermore, the relaxed evidentiary standard does not apply to the predicate fact of engagement in combat with the enemy.

Historically, evidence of combat engagement with the enemy required evidence of personal participation in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality. Presence in a combat zone or participation in a campaign alone did not constitute engagement in combat with the enemy for purposes of the relaxed evidentiary standard.

The reason for relaxing the evidentiary requirements for combat Veterans was that official documentation of the incurrence or aggravation of disease or injury was unlikely during the heat of combat. Combat Veterans should not be disadvantaged by the circumstances of combat service in proving their benefit claims. Under the relaxed requirements, satisfactory lay or other evidence, if consistent with the circumstances, conditions, or hardships of the Veteran's service, is sufficient to establish that a disease or injury was incurred in or aggravated by combat service.

S. 1444 would extend the relaxed evidentiary standard to certain Veterans who did not engage in combat with the enemy during a period of war. It would require that a Veteran who served on active duty in a theater of combat operations during

a period of war or in combat against a hostile force during a period of hostilities be treated as having "engaged in combat with the enemy" for purposes of establishing service connection for disease or injury alleged to have been incurred in or aggravated by such service. S. 1444 would also require that VA, in consultation with DOD, determine what constitutes a theater of combat operations. DOD defines theater of operations broadly to encompass geographic operational areas of significant size defined for the conduct or support of specific military operations. An area designated as a theater of combat operations in consultation with DOD would encompass all Veterans who served on active duty in that theater during a period of war, whether or not they were actually involved in combat.

Service in a theater of combat operations does not necessarily equate to engaging in combat with the enemy and does not in many cases present the same difficulties encountered by combat Veterans when later pursuing compensation claims. So, although we share the goals of this bill to improve the processing of compensation claims, we are concerned that it would extend the relaxed evidentiary standard to Veterans who served in a theater of combat operations regardless of whether their service involved combat or was even near actual combat and regardless of whether the circumstances of their service were of the kind that would inhibit official documentation of incurrence or aggravation of injury or disease.

We also are uncertain of the scope of S. 1444, which is broader than just PTSD claims and would provide a relaxed evidentiary standard for all types of physical and psychological diseases and injuries allegedly incurred in or aggravated by service in a theater of combat operations. In this regard, the subjective psychiatric symptoms associated with a traumatic experience are not always immediately manifested or apparent and thus are not subject to ready documentation. For example, a Veteran who witnesses a traumatic event may show no immediate observable signs of the mental trauma resulting from the in-service incident. On the other hand, a physical injury is more readily observable to lay witnesses and more likely to have been documented even in a combat theater.

In addition, this bill may unduly complicate the adjudication process by requiring separate determinations of whether a Veteran served on active duty in a theater of combat operations during a period of war or served on active duty in combat against a hostile force during a period of hostilities, questions that VA typically does not address. The need to make such determinations may delay claim processing for all Veterans.

Furthermore, on August 24, 2009, VA proposed a rule that would liberalize the evidentiary standard for establishing the required in-service stressor for entitlement to service connection for PTSD. The amendment to VA's adjudication regulations governing service connection of PTSD would eliminate the requirement for corroborating evidence that the claimed in-service stressor occurred if the stressor claimed by a Veteran is related to the Veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist confirms that the claimed stressor is adequate to support a diagnosis of PTSD, provided that the claimed stressor is consistent with the places, types, and circumstances of the Veteran's service, and that the Veteran's symptoms are related to the claimed stressor. This proposed rule has been lauded by many Veterans service organizations and Congress and would improve in the same area as this bill.

VA is unable to provide a cost estimate for this bill because we cannot estimate the number of Veterans who would be granted service-connection based on the provisions of this bill.

S. 1483 "DESIGNATING THE ALEXANDRIA, MINNESOTA OUTPATIENT CLINIC"

S. 1483 would designate the Department of Veterans Affairs Outpatient Clinic in Alexandria, Minnesota as the "Max J. Beilke Department of Veterans Affairs Outpatient Clinic." Mr. Beilke died in service to his country at the Pentagon on September 11, 2001. The Department has no objection to this proposal and defers to Congress in the naming of Federal property.

S. 1518 "CARING FOR CAMP LEJEUNE VETERANS ACT OF 2009"

S. 1518 would amend title 38 to extend eligibility for hospital care, medical services and nursing home care for certain Veterans stationed at Camp Lejeune during a period in which well water was contaminated notwithstanding that there is insufficient medical evidence to conclude that a particular illness is attributable to such contamination. It would also make family members of those Veterans who resided at Camp Lejeune eligible for the same services, but only for those conditions or disabilities associated with exposure to the contaminants in the water at Camp Lejeune, as determined by the Secretary.

VA takes the Camp Lejeune matter very seriously but has concerns with the legislation as written. S. 1518 would provide a very broad enrollment and treatment authority for servicemembers and their families. As the legislation is written, any condition that cannot be specifically eliminated as related to the contaminated water at Camp Lejeune would require VA to provide treatment. We note this authority is broader than that conferred on radiation-exposed Veterans. Moreover, the legislation would also require VA to provide medical services and nursing home care to those family members who either consumed contaminated water or were in utero at the time of consumption if the condition or disability can be associated with exposure to contaminated water at Camp Lejeune.

From the 1950s through the mid-1980s, persons residing or working at the U.S. Marine Corps Base Camp Lejeune were potentially exposed to drinking water contaminated with volatile organic compounds. Two of the eight water treatment facilities supplying water to the base were contaminated with either tricholoroethylene (TCE) or tetrachloroethylene (perchloroethylene, or PCE). The Department of Health and Human Services' Agency for Toxic Substances and Disease Registry (ASTDR) estimated that the level of PCE in drinking water exceeded current standards from 1957 to 1987 (when the contaminated wells were shut down) and represented a potential public health hazard.

An ATSDR study begun in 2005 is evaluating whether children of mothers who were exposed while pregnant to contaminated drinking water at Camp Lejeune are at an increased risk of spina bifida, anecephaly, cleft lip or cleft palate, and childhood leukemia or non-Hodgkin's lymphoma. The results of this report have not yet been released. In the same year, a panel of independent scientists convened by ATSDR recommended the agency identify cohorts of individuals with potential exposure, including adults who lived or worked on the base and children who lived on the base (including those that may have been exposed while in utero), and conduct a feasibility assessment to address the issues involved in planning future studies at the base.

In October 2008, the Department of the Navy issued a letter to Veterans who were stationed at Camp Lejeune while in military service between 1957 and 1987. This letter informed Veterans that the Navy had established a health registry and encouraged them to participate. VA currently provides Veterans with information about this issue and referrals to the Navy registry. Veterans who are a part of this cohort may also apply for enrollment if they are otherwise eligible, and are encouraged to discuss any specific concerns they have about this issue with their health care provider. Veterans are also encouraged to file a claim for VA disability compensation for any injury or illness they believe is related to their military service. VA environmental health clinicians can provide these Veterans with information regarding the potential health effects of exposure to volatile organic compounds and VA's War-Related Illness and Injury Study Centers are also available as a resource to providers.

It is unclear exactly how many people were potentially affected, but some estimates place the number at one million Veterans and family members. Though the Department of the Navy has attempted to contact all servicemembers who were stationed at Camp Lejeune during the three decades of potential exposure, it is possible not everyone was reached or identified. Records over a half-century old may not be available, and the legislation leaves open-ended what "resided" or "stationed" means because there is no limitation such as a minimum time requirement on the base. Consequently, a broad definition of these terms may mean VA's estimates of 500,000 Veterans and 500,000 family members are too conservative.

Because of these concerns, VA recommends that if any enhanced Veteran care is authorized, it should be modeled upon the authority providing for benefits and services for radiation-exposed Veterans and limited to conditions that can be associated with consumption of contaminated water. VA also would recommend that any care for potentially eligible family members be provided by DOD as the exposure is directly related to service at Camp Lejeune.

VA estimates the legislation, as written, would cost $299.7 million in FY 2010, $319.5 million in FY 2011, $1.71 billion over 5 years and $4.16 billion over 10 years.

S. 1531 "DEPARTMENT OF VETERANS AFFAIRS REORGANIZATION ACT OF 2009"

S. 1531 would amend 38 U.S.C. 308 to increase the number of Assistant Secretaries in the Department from seven to eight. It would also increase the number of Deputy Assistant Secretaries from 19 to 27. The bill would also require that one Assistant Secretary be appointed Assistant Secretary for Acquisition, Logistics, and Construction and would cap the number of Deputy Assistant Secretaries the Secretary may appoint to manage programs relating to construction, facilities, asset

management, and IT. In addition, S. 1531 would modernize some of nomenclature relating to construction and acquisition functions in 38 U.S.C. 308.

VA generally supports this legislation. Elevating the construction and acquisition function to the Assistant Secretary (AS) level will help ensure consistent and sound business decisions are made in VA's acquisitions, logistics, and construction programs. This position will also further transform and modernize VA's business practices and processes. Similarly, expanding the number of Deputy Assistant Secretaries (DAS) is necessary given the size, scope, and complexity of VA's missions and geographic distribution. However, VA opposes language in S. 1531 which specifies the title and responsibilities of the AS and which caps the number of DAS assigned to certain functions as this limits the agency's flexibility to address changing needs and demands.

S. 1547 "ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009"

S. 1547 proposes to alter and expand a number of authorities available to VA with regard to preventing and reducing Veteran homelessness. VA has initiated an ambitious plan to end homelessness among Veterans and supports the Committee's interest in providing additional services and assistance to homeless Veterans. However, VA needs additional time to evaluate S. 1547. We will provide views and costs on these provisions as soon as they are available.

S. 1556 "VETERANS VOTING SUPPORT ACT"

S. 1556 would to require VA to support Veterans in registering to vote and voting. While VA is committed to helping Veterans exercise their right to vote, the agency needs additional time evaluate S. 1556. We will provide views and costs to the Committee as soon as they are available.

S. 1607 "WOUNDED VETERAN SECURITY ACT OF 2009"

S. 1607 would amend title 38 to establish certain employment rights for persons absent from work for treatment of a service-connected disability. VA defers to the Department of Labor on this legislation as it concerns rights and benefits of employment.

S. 1668 "NATIONAL GUARD EDUCATION EQUALITY ACT"

S. 1668 would amend section 3301 of title 38, United States Code, to add to the definition of "active duty" under the Post-9/11 GI Bill, full-time duty served under title 32, United States Code, by members of the Army National Guard or Air National Guard of any State, thereby making this service qualifying service for purposes of the Post-9/11 GI Bill. This would include, but not be limited to, active duty (1) under orders from the Governor of a State or Territory of the United States in response to a domestic emergency; (2) as part of the Active Guard Reserve; (3) as part of Air Sovereignty Alert; (4) as part of Operation Jumpstart; (5) in response to Hurricane Katrina; (6) as part of an airport security mission; or (7) as part of a counterdrug activity.

A bill similar to S. 1668 (H.R. 3554) was introduced in the House of Representatives on September 10, 2009. H.R. 3554 also proposes to amend the Post-9/11 GI Bill to include Army National Guard and Air National Guard active-duty service under title 32, United States Code, as qualifying service for the Post-9/11 GI Bill. However, H.R. 3554 would also allow individuals who served at least 30 continuous days in a Reserve Component and were released for a service-connected disability to be eligible for the Post-9/11 GI Bill.

VA does not oppose S. 1668, subject to Congress identifying offsets for the additional benefit costs; however, we would prefer to see a provision in this measure similar to the one in H.R. 3554, noted above, that would authorize eligibility under the Post-9/11 GI Bill for certain individuals released from active duty for service-connected disabilities.

On average, the Army National Guard has the largest number of beneficiaries in the Reserve Educational Assistance Program (REAP), as well as the Montgomery GI Bill—Selected Reserve program (MGIB-SR). The Air National Guard has the third largest number of beneficiaries in these programs. Enrollments in these programs would be reduced if title 32 active-duty service became qualifying service under the Post-9/11 GI Bill.

Servicemember and service-period data are electronically exchanged between VA and DOD for some members who served under title 32 and became eligible for either the MGIB—Active Duty, REAP, or MGIB-SR. However, VA and DOD would need to manually verify this data until it could be electronically exchanged. Addi-

tionally, administration of the Post-9/11 GI Bill would be impacted by the anticipated increase in the number of individuals who would qualify for the Post-9/11 GI Bill.

VA estimates that the enactment of S. 1668 would result in a benefits cost to VA of $120.6 million in FY 2011, $1.1 billion over 5 years, and $2.3 billion over 10 years.

S. 1752 "PRESUMPTION OF SERVICE-CONNECTION FOR PARKINSON'S DISEASE"

S. 1752 would add Parkinson's disease manifested to a degree of 10 percent or more to the list of diseases presumed service-connected in a Veteran who served in Vietnam.

VA supports the objective of this bill. Based on an independent study by the Institute of Medicine, the Secretary announced on October 13, 2009, that VA would add Parkinson's disease to the list of presumptive diseases associated with herbicide exposure. However, this provision is unnecessary based on the Secretary's recent determination.

VA cannot provide a cost estimate on this bill at this time because sufficient data are not yet available. With the Chairman's permission, we will provide a cost estimate in writing for inclusion in the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

Chairman AKAKA. Thank you. Thank you very much, Dr. Cross and Mr. Mayes.

Dr. Cross, VA has stated in the past that it does not support legislation on expanding voting registration activities because such mandates would be overly burdensome. What kind of directive does VA currently have in place that addresses voter registration activities?

Dr. CROSS. Senator, we think that voting for veterans is very important and are doing what we can within our organization—as a health care organization, speaking for my part—to encourage them and to support them in that effort to vote. We have taken this seriously. I want to hold up before you, and we can provide this to the Committee, a directive that was issued September 8, 2008, supporting that initiative. Now I will ask my colleague from General Counsel to comment on that in more detail.

Chairman AKAKA. Mr. Hall?

Mr. HALL. Yes, sir. This directive was issued prior to the election last year. It went through a couple of iterations, but this is the final version that was in place during the election season last year. It requires that each facility have a written policy on how we are going to take care of veterans, who because they are residents or patients at a VA facility are unable to access their own voter regulation facilities.

It requires that we give them access to voting, whether it is by absentee ballot or by giving them leave from the VA facility to go vote. It requires that information on the Voting Assistance Program be provided to every inpatient who comes into a VA hospital, that we post information on how and where veteran patients who are in our facilities can get voter registration and voting information within the facility. It makes provision for allowing local voter registrars, officials from the offices of the Secretaries of State, and nonpartisan voter registration organizations to come into VA facilities to register our veteran patients.

As I said, it was in place during the election last year and we think we met with great success. We registered a great number of

veterans—both our inpatients and outpatients—and assisted a number of them with their absentee balloting.

Chairman AKAKA. Thank you very much, Mr. Hall.

Dr. Cross, it is the view of the American Academy of Physician Assistants that PAs, unlike doctors or nurses, are not considered a critical occupation in VA. What is your view about that?

Dr. CROSS. Well, my view is I do consider them to be a critical occupation. They are great health care providers. I wouldn't want to startup one of our hospitals without them. Every day, they go to work providing superior care to our veterans and working as part of the team, part of a team of health care providers within the organization.

I don't have the exact number that we have on duty today, but as I recall, the last time I checked, it was over 1,600. That is a very important resource for us. I am proud that I have had opportunities to work with the PAs and attend their meetings. We have created the PA Advisor position, and their professional organizations come to visit me at least, I think, once a year where we discuss issues. I think it has been a good relationship.

Chairman AKAKA. Dr. Cross, I understand that PAs now make up 30 percent of all mid-level providers in VA. Why are there fewer PAs than other types of mid-level providers in VA?

Dr. CROSS. I think what you are referring to, Senator, if I understand your question, is that we have more Nurse Practitioners than PAs. I don't really have a specific answer for that. I think that the PAs do a great job—are very competitive—as do the Nurse Practitioners. Often, when we open up positions, as I recall from when I was in primary care, we advertise it for both and we are happy to do that.

Chairman AKAKA. Dr. Cross, Senator Pryor's reorganization bill would establish within VA one Assistant Secretary for Acquisition, Logistics, and Construction. VA supports this bill. Help me understand the rationale for including construction issues within the purview of this new Assistant Secretary.

Dr. CROSS. Senator, I will defer to Mr. Hall for that answer.

Mr. HALL. Yes, sir. All construction done by VA is, of course, done through contracting, whether it is planning or design, most of that is done by contract and certainly all the construction that we do. We don't have an actual construction activity within the Department. It is all done through contracting.

In determining where oversight of construction best fit—since this is an activity that is carried out entirely through contracting—it was determined that closer contact with the organization that had the best understanding of the needs of the contract activity was the place it best fit, where it could get the best oversight, and the best supervision.

Chairman AKAKA. Well, thank you very much.

I would like to call on our Ranking Member for his questions.

Senator BURR. Thank you, Mr. Chairman.

Dr. Cross, thank you and I thank all of you today for the service you provide this country.

If I understand it, your concerns with S. 1518 is that it gives broader enrollment and treatment authority than exists for radiation-exposed veterans. However, my legislation was modeled after

the existing treatment authority Congress conferred on participants of Project Shipboard Hazard and Defense, or SHAD—a series of chemical and biologic warfare tests conducted between 1962 and 1993. Why do you recommend that my legislation be modeled after the Radiation-Exposed Veterans versus Project SHAD?

Dr. CROSS. I think there were two things that came to mind as we were working on this. By the way, Senator, let me say that I brought the book with me. This is something I am personally reading. The work that we are doing with it on the task force which we have put together as a joint effort between all of the people that you see here—Brad Mayes, myself, the General Counsel—to move this forward. And we are putting our best scientists to work on this type of toxic exposure, to move this Lejeune issue forward.

I want to give you my personal commitment up front before I get into the details of the discussion, along with Brad and along with the General Counsel, we are going to move this forward, get the analysis done, make some recommendations, whatever they may be, to our leadership within the organization.

The way the bill is constructed, and what I think caused concerns with some of the staff, is, in fact, that the language was very broad. We found that the work that was done on the radiologic exposure was more precise than tying it to perhaps level of exposure and to determining exactly who should get the benefit.

I noticed that in the way the legislation is constructed right now, as I understand it, anyone who was there for any amount of time would basically be treated the same as someone who lived there and resided there in housing for perhaps a period of years. That might be a bit of something that we could talk about with your staff offline, to work on that part of it.

I will ask my colleagues to comment on this, as well.

Senator BURR. Mr. Mayes?

Mr. MAYES. Yes, Senator. On the benefits side, as a follow-up to the hearing 2 weeks ago, we are trying to get that registry. I think the point you were trying to make is that we need to know who potentially was impacted by contaminated drinking water. So we have asked for the names and the identifying information of those servicemembers who potentially were exposed.

We need to sensitize our field personnel that are adjudicating these claims to the fact that if somebody is coming into one of our offices with a claim for a disease related to consuming contaminated drinking water, they need to know that, in fact, this servicemember was there. That would be helpful for us.

As Dr. Cross said, we are participating in the special work group that is evaluating the science that is in that Institute of Medicine report to determine if, for example, a presumption of service connection would be in order. The IOM has identified some conditions where there is at least limited suggestive evidence of causation of certain diseases with exposure to PCE and TCE in the drinking water.

So, those are the things we are doing. I also had reiterated this point of sympathetically looking at these claims on a call we had, as a matter of fact, last week, and we talked about sodium dichromate at Qarmat Ali and all of the exposures that, Mr. Chairman, you and Senator Burr had raised in the hearing 2 weeks ago.

Senator BURR. One follow-up comment. Clearly, the studies that have been done up until this time didn't take into account benzene, or to the same level of concern, TCE and/or PCE. That may not be determined until additional studies are conducted or the conclusions of those studies are finished. This is a call we have to make as to whether the science says exposure to benzene, not specifically benzene exposure at Camp Lejeune, could be the cause of certain health conditions like male breast cancer.

I would only remind you from the standpoint of the scope of the bill, though it is broad, it is directly linked to a health condition that might be the result of exposure. Therefore, it is impossible to disqualify somebody because they lived there 6 months and at 39 developed breast cancer, or 6 years and at 55 developed breast cancer as a male. So I think there are some unknowns and I would hope that we could err on the side of coverage of individuals that have health conditions that science suggests may be the cause of exposure to these contaminants.

You have raised an issue about whether there is a Department of Defense responsibility for family members. Let me just ask you, I think, an obvious question. Should we be more focused on providing care needed or who pays for it?

Dr. CROSS. Senator, you and I both know the answer to that. We take care of the patient and take care of the veteran——

Senator BURR. Thank you.

Dr. CROSS [continuing]. But we will work that out.

Senator BURR. Mr. Mayes, you alluded to the fact that you have requested the registry.

Mr. MAYES. I had asked Dr. Postlewaite following that hearing 2 weeks ago for the names, and a formal request is on its way, over to Navy. There have been a lot of exchanges between individuals between both agencies.

Senator BURR. Would you provide for the Committee when that formal request is made and then notify the Committee when they have fulfilled or denied the request?

Mr. MAYES. Yes, sir, Senator. We will do that.

[The response for the record follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BURR TO BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington, D.C. 20420
OCT 2 1 2009

Colonel Donald Noah
Acting Deputy Assistant Secretary of Defense for
Force Health Protection and Readiness
5113 Leesburg Pike, Skyline Four Building, Suite 901
Falls Church, VA 22041

Dear Colonel Noah:

I am writing to request assistance in your capacity as a member of the DoD-VA Deployment Health Working Group (DHWG). I understand that the DHWG's objective is to identify and foster opportunities for sharing information and resources between VA and DoD, and that you meet monthly to discuss a wide-ranging array of military-exposure issues.

The specific exposure event I am writing about is the discovery of chemicals, including trichloroethylene and tetrachloroethylene, in the Camp Lejeune drinking water in the early 1980's. I understand that through various avenues, including mandates in the FY08 National Defense Authorization Act, components of DoD have attempted to notify former residents of Camp Lejeune of their potential exposure to the chemicals.

During an October 8, 2009, hearing before the Senate Committee on Veterans Affairs, Major General Eugene G. Payne, Jr., testified that as of September 28, 2009, more than 140,000 individuals have been registered with the Marine Corps. Assuming that many of these registrants are now former service members who may be in need of VA's assistance, I am requesting the VA be allowed access to the Camp Lejeune database, to include names, addresses, Social Security numbers/service numbers, and any other information possessed by DoD that could be of use to VA. Your cooperation is, as always, greatly appreciated.

Sincerely yours,

for Bradley G. Mayes
Director
Compensation and Pension Service

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

NOV 02 2009

HEALTH AFFAIRS

MEMORANDUM FOR DEPUTY COMMANDANT FOR THE MARINE CORPS
INSTALLATIONS AND LOGISTICS

SUBJECT: Camp Lejeune Database of Service Members Potentially Exposed to Contaminated Ground Water

We received the attached letter from the Director of the Veterans Benefits Administration (VBA) Compensation and Pension's office requesting that the VBA be provided with information on former Service members who may have been exposed to contaminated drinking water while at Camp Lejeune to include "names, addresses, social security numbers/service numbers, and any other information possessed by the DoD that could be of use to" the Department of Veterans Affairs (VA). We have a similar request from Senator Daniel Akaka, in the form of a question for the record emanating from the Senate Veterans Affairs Committee hearing on Veterans Exposures held October 8, 2009.

There may be a number of requirements pertaining to privacy safeguards and perhaps even permissions to be addressed before making this data available to the VA. Please take the necessary steps to ensure these data are made available to the VA as expeditious as possible. In keeping with our agreed upon process with the VA, we would like to serve as a conduit for the transmission of data to the VA or assist to provide access to the data. Please keep my Director, Deployment Health Surveillance, Col Mike Butel, apprised of your progress in providing access to this data as well as your anticipated timeline. Colonel Butel can be reached at (703) 578-8524 or Michael.Butel@tma.osd.mil. Thank you for your support.

Donald L. Noah, Col, USAF, BSC
Acting Deputy Assistant Secretary of Defense
Force Health Protection and Readiness

Attachment
As stated

cc:
Director, Joint Staff
Navy Surgeon General

Senator BURR. Thank you. Additionally, in that hearing we talked about the regional offices being fully informed. You alluded to that. Do you feel that sufficient notification has been made to the regional offices of this exposure and this population?

Mr. MAYES. Sir, we have reinforced this information again, but I don't think we have done enough yet. We still have a formal policy guidance that is in concurrence, which I owe the Committee once it is issued. What I would like to do, ideally, is at the time of issuance of that guidance, provide access, possibly through a link, to the names on the registry. That is what I would really like to do. I don't know if I am going to have the names of service-

members who were potentially exposed by the time that goes out. We will issue it one way or the other.

Senator BURR. We will do everything we can to help you get that.

Mr. MAYES. Thank you, Senator.

Senator BURR. My last question, Dr. Cross. We continually talk about the homelessness issue. I personally believe we have to focus on prevention to stop the cycle before it begins. We must look at the short- and long-term housing needs, job training needs, medical, dental, substance abuse, and much more. Share with us where you currently see gaps in our ability to end homelessness with our veterans.

Dr. CROSS. Your comment, I think, is precisely what we are focusing on. There are two broad groups I look at in the homeless community: the chronically homeless; and those who, for some short period of time during the course of a year, may experience homelessness. Prevention is far better than trying to deal with it after it occurs.

When we look at the veterans who we see that are homeless, mental health issues come to the fore. That is a critical component of substance abuse. Then there are issues about access to housing. There are issues occasionally about economic factors, loss of jobs, and those kinds of things. But mental health and substance abuse are really at the core of this, particularly in talking about severe mental illness, schizophrenia and those conditions, and ongoing substance abuse.

That is why I think with our mental health programs we have to make a difference before homelessness occurs. We are going to make a tremendous effort to identify everyone who is homeless right now and do something about it. One hundred thirty-one thousand veterans—we believe from the last nationwide survey—were homeless. The good news is that was down from what it was the year before, and that was down from the year before that. It has been going down steadily. That may reflect some effort on the part of our mental health folks, but there is much more to be done there.

The Secretary's announcement on homelessness has captured our imagination. It has captured the enthusiasm of my staff. We want to make this a success. We feel that there is no reason why we should ever see a veteran on the street with a sign that says, "homeless veteran."

Senator BURR. Thank you, Dr. Cross, and Mr. Chairman. If I might add to that, I would love to see this Committee and the VA have a roundtable on mental health issues and mental health services—not an official hearing, but one where we don't have the formalities that we've got here—where we can exchange ideas, and hear the concerns within the system. And I hope if we get an opportunity to do that, you would also be prepared to talk to us about the possible expansion of telemedicine as a mental health tool, and our ability to reach people that we currently can't get into a site that has the services in-house, and how we might be able to use that technology to treat mental health problems. Thank you.

Dr. CROSS. Sir, we would accept that invitation with enthusiasm.

Senator BURR. Thank you.

Chairman AKAKA. Thank you very much, Senator Burr.

Now, we will have questions from Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman. I share Senator Burr's concern about exposure issues and ensuring the VA knows who is affected, whether it is a base here in the United States, a base abroad, or it is on the battlefield. We have been down this road before—whether it is Agent Orange or Gulf War Syndrome—and making sure the VA has access to those names is critical. So I want to thank Senator Burr and work with him on that.

On the issue of homelessness, as you know, the Homeless Women Veterans and Homeless Veterans with Children Act of 2009 is before the Committee today. The Ranking Member, Senator Burr, asked you about the question of why people are homeless. Well, two of the growing populations are: women; and both women and men with children, which is who we are trying to address in this legislation. I appreciate the VA's support of that bill before this Committee today.

Can you talk specifically about some of the things you are doing currently to make sure that women veterans in particular, and women and men with children, understand that there are services and how we can accommodate those groups in a better way?

Dr. CROSS. I think in so many of the program efforts that we are making right now, we have identified as a key element the increasing numbers of women veterans that we expect to receive in our health care systems over the coming years. When we look at the active duty force and the percentage of women in the force, comparing it to the patients that we have right now who are female, we see a steady rise over time.

So here is what we are doing. We don't think that our facilities and our staff were always really focused and well prepared to address the specific issues that are important to women. We want to make sure that privacy is clearly taken care of. We want to make sure we have a welcoming, friendly environment that specifically meets the needs of our women veterans. We want to make sure that we do anything we can do down the road in finding ways to support them with health care providers who are uniquely trained to address their needs.

So one of the things that we have done to accomplish that, for instance, on that last point, is to create many residencies, training, special training, intensive training specifically focused on nothing except the unique care that we want to provide women veterans. We have digitalized all of our mammography systems so that they are state-of-the-art in that regard. We have so many different things that we are doing to offer a better, more welcoming environment. I could go on for some time. I would be happy to discuss that further.

Senator MURRAY. Thank you. It is welcome news to my ears to have the VA recognize that this is an issue and talk about what they are doing, making sure it reaches VA facilities at every level where it really is important. I want to work with all of you to make sure it is not just rhetoric from the top, but that it truly creates a better atmosphere for women. They are a growing population in the VA. They come in with unique challenges. If they walk in a door and it is all men, they are going to turn around and go back

out. That doesn't help anybody. And the privacy issue that you mentioned is an important part of that. Making sure that they have child care is critical, because women often trot in with kids and they are not going to leave them sitting in a waiting room.

So, we need to address these issues. My bill begins that effort. I know you are making efforts, as well, and I think if we continue at all levels, we will make progress.

Dr. CROSS. Senator, I forgot to mention one of our key efforts, and that is the Women's Coordinators at our medical centers.

Senator MURRAY. Correct. Does the VA have those at every facility now?

Dr. CROSS. One hundred forty-four.

Senator MURRAY. That is a huge leap forward from where we were even a year ago, so I appreciate that very much.

I have to get to another committee to be the 12th vote to vote some nominees out. I will go do that, Mr. Chairman, and return in order to be here for the second panel, but I want to thank the VA for its testimony today.

Chairman AKAKA. Thank you very much, Senator Murray.

And now we will take questions from Senator Johanns.

Senator JOHANNS. Thank you, Mr. Chairman.

Dr. Cross, if I could call your attention to the VA Hospital Quality Report Card Act, I appreciate in your testimony your indication that in spirit, at least, you support this legislation, if not the actual legislation itself. Let me just ask you, something like a grading system, where literally it was A through F, don't you think that would be beneficial to the average veteran who doesn't want to try to peel through thick reports and all of the things you do, which I think is very important? Don't you think that would be beneficial to a veteran?

Dr. CROSS. Conceptually, yes. What we wanted is to match up with what is being done in the civilian sector, and I think in the written testimony, we noted that they are not using so much a letter grade as we had in high school or college, but that they are using other types of indicators for patients.

I think one issue that we have in the bill that we think is very strong in its intent, and we support the intent very strongly; it is just that we want to match up nicely with our civilian colleagues so that we can be compared more directly. That direct comparison is where we want to go. We are not afraid of that. The Secretary has told me he wants us to do this. I have got staff working on making sure this happens. We are going to use programs like Hospital Compare. We are going to publish more data than has ever been published before.

I wanted to point out a couple of things, if I might. We work with many different agencies, but this is the CBO report. The Congressional Budget Office did a complete review of health care quality at the VA. This was published in August of this year. Not suitable for patients to utilize—very technical—but still a very important document.

Another area where we compare ourselves to the private sector every day—including Medicare and Medicaid and the commercial sector—is our outpatient scores on how we are doing on process measures and actually outcome measures. This is very important

for the staff and for the Committee to understand. I would love to provide copies of this. Again, its very technical; not what patients need.

I think as we design what we are going to do beyond Hospital Compare, beyond those initiatives, we have to meet with our stakeholder and see what they would prefer that we utilize. That would be our VSOs, particularly, and the patients themselves.

So two things. We want to compare to our civilian colleagues. And number 2, we want to make sure that our stakeholder support the way that we are going to present the information.

Senator JOHANNS. I am a joint sponsor on this so I would certainly want to consult with Senator Wyden, but from my standpoint, all I am looking for is something that is an easy reference for the patient. Absolutely, we want the VSOs to be involved. I don't see offhand any problem in trying to match this with what is going on in the private sector.

So, I guess what I would say to you is that I am hoping we can work together on the right process, the right approach, because just as you testify, it seems to me that you are trying to accomplish what we are trying to accomplish.

Dr. CROSS. And the Secretary wants this to happen quite soon.

Senator JOHANNS. OK.

Dr. CROSS. Sir, if you can work with us, we can work with your staff to show what we are doing, see if it meets your approval, and then move on from there.

Senator JOHANNS. OK. We would welcome that.

My last question. I ran into this situation when I was making my way around the State for the August recess, which relates to S. 1444. Again, I appreciate your concern about expanding the evidentiary standard and potentially making it too broad. It relates to injuries, or Post Traumatic Stress Disorder, actually, when you are not actually on the battlefield. This is what I ran into.

I spoke to a woman whose husband had been in Iraq, and his job was literally to clean up the equipment. So you think about that job and you think to yourself, gosh, that can't be so stressful compared to being in combat. But then you come to realize that this person was dealing with the aftermath of combat and you can only imagine the horror that that individual and others were seeing every day in cleaning up that equipment. This person came back and is suffering from Post Traumatic Stress Disorder, but struggled to get through the process to get the help they needed to deal with this issue.

Tell me how we work our way through those kinds of problems. I understand the desire for clean lines and, you know, you are not in combat so these conclusions result. So, how would you suggest we deal with that, because to me, that is very real, and that person had a very, very real condition as a result.

Dr. CROSS. I will kick that over to my colleague, Brad Mayes, who deals with this from the compensation point of view. That is the bill that they are dealing with.

As a physician, though, I understand one particular aspect of this. Each patient is different——

Senator JOHANNS. Yes.

Dr. CROSS [continuing]. And the stressors that affect them, they react to differently. We have to understand that and be sensitive to that. I want all of my examiners who do the C&P exams for Brad to convey that sensitivity and that awareness.

Mr. Mayes?

Mr. MAYES. Thank you, Dr. Cross. First of all, we, too, have come to recognize that we needed to do something regarding the process which we were following to establish service connection for Post Traumatic Stress Disorder. The basic elements of establishing service connection have not changed, and one is that we need to have a diagnosis of PTSD, which is strictly a medical determination, not a legal determination on the benefit side. We need to have what we term "credible supporting evidence" of a stressor—something in service that precipitated the disorder. Then we need the medical link between that diagnosis and that stressor, again, something provided by the professional medical person.

So, where we were hung up on the legal side, on the benefits side, was establishing this so-called credible supporting evidence of the stressor. We were following the words and the regulations very strictly and trying to place an individual in a specific event in service that would have caused these symptoms to manifest either immediately, or in some cases, many years after the veteran suffered from exposure to this event. We were finding, as you found, Senator, that we were spending an inordinate amount of time and not being sensitive to the fact that just being deployed—given the changing nature of warfare over there, and some would argue the nature of warfare even in previous conflicts—leads to certainly more intense potential for harm because of exposure to IEDs, mortar attacks, and terrorist activity.

We said, let us get out of the business of trying to prove that somebody was at a specific place. If they assert that they had a stressor, and it is consistent with the types, places, and circumstances of their service—which, by the way, is the threshold in the statute that allows the reduced evidentiary burden for combat veterans—so we are applying the same evidentiary standard for PTSD claims; then we are going to move it on to Dr. Cross and to his psychiatrists and psychologists. We are not going to question that. Then we let the psychiatrist or psychologist examine the veteran to determine if we have PTSD and the medical link between that stressor and the Post Traumatic Stress Disorder.

Dick, do you want to add to that? I might have missed something there.

Mr. HIPOLIT. I just wanted to add that for our proposed rule which Mr. Mayes is referring to, the comment period closes this Friday. After that we will be able to move forward toward a final rule.

Senator JOHANNS. I appreciate your efforts. We are way out of time here, and I don't want to impose on my colleagues. But, boy, you run into these real situations and it is just heartbreaking to see what is happening to the family if there isn't some kind of treatment provided. So I really appreciate any effort you could focus here, which it sounds like the rule is headed in the right direction, if not the right direction. So we will follow that closely. Thank you.

Chairman AKAKA. Thank you, Senator Johanns.
Now we will take questions from Senator Begich.

HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman. I will just have a few questions. Let me just make sure I understand on the voting legislation, which was S. 1556. You are doing something now, but you don't support the legislation; help me make sure I am clear on what the position was.

Dr. CROSS. I believe the position, Senator, is that we are not ready to officially State a position for the hearing today and will do so.

Senator BEGICH. OK. When will you do that?

Dr. CROSS. Time is always the question——

Mr. HALL. Yes, it is a problem. We will do it as quickly as possible. It is developing a position and getting a number of people——

Senator BEGICH. To review it.

Mr. HALL [continuing]. To review and agree that that is the way to go.

Senator BEGICH. OK. So, quickly, could——

Mr. HALL. It is sort of out of our immediate control, but hopefully, within the next couple of weeks.

Senator BEGICH. OK. Very good.

In regards to the chiropractic care legislation, I think it is S. 1204, if I can just make sure I am, again, on the same path. You don't think that bill is necessary, if I read the notes right. You feel you are already providing the care that is requested, or at least the capacity, at this point, is that——

Dr. CROSS. Generally. May I comment on that just a little more?

Senator BEGICH. Absolutely.

Dr. CROSS. You know, I commented earlier about the PAs and all of our professional groups, and we value them all and their dedication. The work that they do on behalf of our veterans is very important and our veterans really appreciate it. I think one of the issues here is how prescriptive and how narrowly directive Congressional legislation might be at times resulting in the real loss of flexibility that we have.

Each site that we have within the VA has to carry on business that meets the needs of their own population. Sometimes we do this by care within house—particularly with the chiropractic specialty—and sometimes we do it by engaging with the community and working with civilian non-VA providers in the community; we send patients out there.

Senator BEGICH. Right.

Dr. CROSS. I think the VA has been very positive in welcoming this group of professionals. In fact, I heard from one of our leaders in chiropractic just recently who actually did a video for the organization about how the VA is the best place for them to practice. So, I want to keep up that positive approach, and I also want to give my hospital directors flexibility, because if you bring the position in-house, that can be valuable at times. Other times, engagement with the community is also very valuable.

Senator BEGICH. I agree. I know in Alaska, that is what you do—you engage the community. So, as a user of chiropractic care, I

think it is important. But I know your time span for service provided to a patient can be up to 30 days, and there is one thing I know about chiropractic care: if you wait 30 days, you are in worse shape; you are in more pain. So, is there a way we could look at this legislation to support your efforts of both in-house and outhouse. I don't want to say outhouse, but——

[Laughter.]

Senator BEGICH. There is the Alaska component in me that just came out. [Laughter.]

About the contracted services. Is there a way to support that, because I think the services are important. My worry is the time gap, especially with chiropractic care, because it is not just one visit and you are done. I hope—because I enjoy my chiropractic, but there are times when I wish I didn't have to go—it is frequency that is important. If you are on a 30-day cycle, that is not going to do the job with this type of care. So, is there a way, through this legislation, to support your efforts to do both what you have just described and also speed up the process of a client receiving services?

Dr. CROSS. I understand your question precisely, I believe. We have really worked hard to apply the same standards to this professional group as to all others. The 30-day standard is the same standard that we apply to cardiology, oncology, and primary care. So, we are fitting them in as part of the team; and applying the same standards that we measure across the board. Now, that is for routine care.

Senator BEGICH. Right.

Dr. CROSS. Understood. Whether it be cardiology or anything else, if the veteran—the patient—has a more acute need, the 30-day standard is irrelevant.

Senator BEGICH. Right.

Dr. CROSS. We have to meet their needs. Ultimately, what we have to judge our success by is the satisfaction of our patients, and right now—broadly speaking, not specifically in relation to chiropractors—regarding patient care, our satisfaction levels are very good. We can look at this more specifically in regard to that cohort.

Senator BEGICH. Very good. My time is up. I am not sure yet where I am on the quality report card idea, but let me throw out something that is happening right now that *Consumer Reports* is about to do. They are engaged in a pretty extensive effort to analyze and measure hospitals, as well as professionals within the hospital. I worry about the statement that we want to measure up to the measurements that current hospitals or other physicians are using, because as we are dealing with health care, we are not sure those measurements are the best measurements, to be very frank with you, because they are not outcome-based. They are sometimes process-based, which is not the right way to measure.

So, as you evaluate this—I know you had kind of a back-and-forth discussion a little bit here on that—would you be willing to engage—again, *Consumer Reports* is doing a national measurement standard that, if you have ever used *Consumer Reports*, you know it is easy to understand. It is consumer friendly. So, they have taken this on as an initiative to measure quality care for hospitals and physicians within those hospitals. I think it is a very intriguing project that would make sense to our veterans because they

might get care from two providers—private as well as VA—so they can measure apples to apples.

I don't know if that is of interest to you. Our office could provide you with the contacts out of New York that are undertaking this effort.

Dr. CROSS. Senator, if you will give me the contact, we will invite them this afternoon and set up a meeting either by phone or in person.

Senator BEGICH. Excellent.

Dr. CROSS. If they want us to come to New York, we will go to New York.

VHA ISSUE BRIEF

Issue Title: Consumer Reports Health Ratings Center

Date of Report: December 7, 2009

Brief Statement of Issue and Status:
At the SVAC hearing on 10-21-09, Senator Begich (AK) commented when discussing legislation regarding VA quality data reporting legislation that Consumer Reports was working on its own effort to measure hospital quality, and asked Dr. Cross if VA would talk with them. Dr. Cross responded enthusiastically that he would. On December 1st, representatives from VHA's Office of Quality and Safety and Office of Communications Management met with John Santa, MD, MPH, and Steve Findlay from the Consumer Reports Health Ratings Center.

Background, Current Status, and Actions:
Consumer Reports (CR) started a health ratings division about two years ago. They have published two separate Health Ratings publications. The first was published in May 2008. It translated the Dartmouth Atlas information on intensity of services in the last two years of life for consumers of the CR data. The second publication of ranking occurred in August 2009 and focused on the use of patient satisfaction CMS data generated from the HCAHPS survey tool. CR has plans for reporting on safety and infections by hospital; however, they depend on publically available data for these reports so only those states that mandate public reporting will be included. CR is advocating for public reporting of all quality measures and is advocating this effort as a recommended component of health care reform.

As VHA publishes its quality data on Hospital Compare, CR will have access to that data for inclusion in their reports. CR also is interested in compelling health care stories and would like to partner with VHA on such stories such as efforts in decreasing CLAB-C infections, health information technology, and ratings of assistive devices for disabled veterans. CR also discussed whether VA could help with dissemination of information such as bulk sales of their publications in VA Canteens. CR believes that special topic issues such as hearing aids, non specific back pain, and prescription drug comparisons would be of interest to the VA and Veterans.

CR is looking for partners in doing research and/or sharing data, and would like to explore opportunities to work with VHA. Other future projects include ratings of and stories about health prevention practices. CR will follow up with VHA's Office of Communications Management about potential stories.

1

Senator BEGICH. Excellent. I think it is a very interesting idea they are pursuing. I think it is going to be benefiting the whole health care system, and VA is obviously a huge piece.

I know I said that was my last question, Mr. Chairman. This is probably a yes or no. About the interagency on homelessness out of the White House—are you part of that interagency organization——

Dr. CROSS. Yes.

Senator BEGICH. I thought your answer was going to be yes. Good. Thank you very much.

Chairman AKAKA. Thank you very much, Senator Begich.

Dr. Cross, you say in your testimony that there is not enough patient demand to justify putting a chiropractor in every VA hospital. Could this be perceived as lack of demand or a lack of availability of these services in VA hospitals?

Dr. CROSS. I would like to phrase that slightly differently. We provide chiropractic services either through the community or through the VA by in-house staff at all of our facilities. So we send thousands of patients out to engage in the civilian community to buy services; to work with our colleagues in the civilian community, wherever that might be.

We see this as a valuable, balanced, and flexible approach. It lets us tailor the needs to each location. The facility director can then make the decision, say the demand is such that he wants to hire staff within the hospital, or he can say we have very good services within the community. Patients are satisfied. Let us continue doing that. This balanced approach and this flexibility that our facility directors and VISN directors have is very important to maintain.

Chairman AKAKA. Dr. Cross, at the Committee's recent hearing on contract health care regarding ambulatory care solutions, you testified that they already had pay-for-performance requirements in their contracts. Would it be fair to say you have already put these requirements in place in some of your clinic contracts?

Dr. CROSS. I don't have the precise number. I believe about roughly one-third, perhaps a little less than one-third of our clinics are contract clinics. The contracts have a great deal of information in terms of requirements as to what they have to do. Where they have not met those standards, we have been quite aggressive in actually eliminating those contracts and going to a different provider at a different location. We are doing this already. We think that we will take the Committee's recommendation and expand that capacity, as well. But I wanted the Committee to be reassured that within our contracts, we do take action if they don't meet the requirements, even right now.

Chairman AKAKA. In S. 1427, which is the Hospital Quality Report Card Act of 2009, it shares many provisions with S. 692, a bill sponsored by then-Senator Obama during the 110th Congress. In May 2007, you testified that VA opposed the bill because it duplicated existing efforts. But today, and I say this with a smile, you testified that VA opposes the bill because some of the requirements may not be possible. Can you shed any light on this thinking?

Dr. CROSS. Senator, I am always surprised when we bring up my old testimony. [Laughter.]

The important message here in regard to the hospital report card is we are all for this. We are strongly in support of this—not the specific legislation, but the concept. We think our patients have a right to know how well their services are being provided. We think that that is fundamental and we have to do a better job of communicating that. We have to do it in language that they understand.

We posted 46,000 articles and research—that was four-six-zero-zero-zero—over the past 7 years, but they are not things that pa-

tients really read. We need to give them understandable, accessible information about the quality and accessibility of the health care that we provide. We want to do a better job of that than anybody else.

And let me be very clear—we are not afraid of the comparison. And as quickly as we can move out on this, we will; and the Secretary fully supports this.

So I think that what we are going to do, you will be proud of. I think that it will meet the intent of this legislation. Some of the language in the legislation was very precise, might require some IT configuration, in some cases engagement with Medicare and Medicaid Services, and would be calling for data that they can't provide us. And so we found technical issues in the legislation that would be very difficult for us to achieve.

Chairman AKAKA. Of course, this is building on what Senator Johanns was asking, having to do with the kind of information that is made available to the public about the quality of care provided in individual VA hospitals and clinics. You just stated that there are about 46,000 articles that are sent out. Are there any other kinds of information that are sent out?

Dr. CROSS. We sent to Congress last year a hospital report card. It was a fairly comprehensive review. It was the first time that we have done that. I was proud of that document because it didn't just point out the great things that we are doing, it also pointed out some of the problems that we face. So, it wasn't just the good things. We sent that to Congress about a year ago. The new one has just been finished. I think it is about to be released within days, and we will be forwarding that over to the Committee, too.

Chairman AKAKA. Specifically, what information do you give the public and the patients?

Dr. CROSS. On the Web sites that we have with the Joint Commission, we publish our data, as do other hospitals. The Joint Commission has data relative to our hospitals as well as others so that the patients can go look that up.

On our Web sites, we have information about our programs. Quite frankly, I think a lot of the information that we put out there is quite technical. I think that the average veteran would often have difficulty reading it and understanding what it really means.

And some of the information that we put out has no comparison in the civilian sector. Because of our Electronic Health Record, I can produce statistics that are simply not available in the civilian sector.

I think what we have to do is a much better job of communicating in the veteran patients' own understandable language much better than we have. Hospital Compare, I think, will be a step in the right direction.

Chairman AKAKA. My final question to you is having to do with the Mental Health Commission. You testified that creating a Mental Health Commission was unnecessary. Can you expand a little bit about how this bill would duplicate existing efforts in VA?

Dr. CROSS. Sir, we are always willing to welcome another committee, but there are many committees already that we engage with; and we engage with our Veterans Service Organizations, our patients, in many different forms.

Let me give you a list of some of the Committees that we have right now. The Special Committee on Serious Mental Illness reports to the Under Secretary for Health. The Special Committee on PTSD reports to the Under Secretary for Health. The Advisory Committee on Homeless Veterans, to the Secretary. The Advisory Committee on Women Veterans, Office of Mental Health Services, and to the Secretary of VA. The Advisory Committee on Minority Veterans, the Longitudinal GPRA Study on Mental Health, to the Under Secretary of Health. And then the many OIG and GAO reviews.

We have tremendous engagement with our stakeholders. We have many committees, FACAs and others, that oversee, look at, and provide advice. We get lots of input from veterans themselves. We are not lacking in this endeavor and we value the input that we have, which is substantial.

Chairman AKAKA. Thank you.

Senator Burr, any further questions?

Senator BURR. No.

Chairman AKAKA. Senator Murray, anything further?

Senator MURRAY. No.

Chairman AKAKA. Senator Begich?

Senator BEGICH. No.

Chairman AKAKA. Fine. Well, I want to thank this panel very much for your responses and I would like to welcome the second panel. Thank you, Dr. Cross.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. GERALD M. CROSS, M.D., FAAFP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. VA's written testimony stated that VA did not have "views and estimates on several bills including S. 1109, S. 1467, S. 1556, S. 1753, and a draft bill regarding exposure to chemical hazards referred to in the list of bills provided in the Committee's witness letter of October 8." It also stated VA would forward those as soon as they are available. Please provide VA's views and estimates on S. 1109, S. 1467, S. 1556, S. 1753, and S. 1779 within 30 days of this request.

Response. VA provided views on S. 1467 "Lance Corporal Josef Lopez Fairness for Servicemembers Harmed by Vaccines Act of 2009" and S. 1753 "Disabled Veteran Caregiver Housing Assistance Act of 2009" on March 23, 2010. (See below.) VA is in the process of finalizing views on several other bills, including, S. 1109 "Providing Real Outreach for Veterans Act of 2009", S. 1556 "Veteran Voting Support Act of 2009", and S. 1779 "Health Care for Veterans Exposed to Chemical Hazards Act of 2009."

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 23, 2010

The Honorable Daniel K. Akaka
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This letter is in response to your invitation to submit for the record the Department's views on several bills, S. 1467, S. 1547, and S. 1753. These bills were on the schedule of the October 21, 2009 legislative hearing, but we were unable to provide views at that time. We thank you for the opportunity to provide our comments and cost estimates for the record.

S. 1467 "Lance Corporal Josef Lopez Fairness for Servicemembers Harmed by Vaccines Act of 2009"

S. 1467 would extend coverage under the traumatic injury protection program of Servicemembers' Group Life Insurance (TSGLI) for adverse reactions to vaccinations administered by the Department of Defense (DoD). Current law permits VA to prescribe by regulation conditions that are excluded from TSGLI coverage. S. 1467 would except from that permission a qualifying loss experienced by a servicemember as a result of an adverse reaction to a vaccination administered by DoD for purposes of military accession, training, or deployment. The change would be effective as if included in the law that originally established the TSGLI program in 2005.

VA opposes this bill, primarily because it would not be in keeping with the purpose for TSGLI benefits. Congress and the Administration designed TSGLI to provide short-term monetary assistance to severely injured servicemembers who suffer a qualifying loss as a direct result of a traumatic injury. VA determined that vaccinations, like other medical or surgical procedures, are not "traumatic events" envisioned by Congress in establishing the benefit. That determination accords with the practice of private insurers who provide accidental death or dismemberment coverage. Typically, such policies do not cover losses due to adverse reactions to vaccinations.

This bill would also create equity issues. Because TSGLI coverage excludes surgical trauma and adverse outcomes of medical procedures, this change would create an inequity between servicemembers provided coverage for adverse reactions to

vaccinations and those who suffer adverse consequences of surgical or other medical procedures. This legislation would also result in increased premiums for servicemembers and costs to the Government during periods of conflict when TSGLI claims exceed civilian levels and are therefore subsidized by appropriated funds.

VA estimates that the cost of enactment of this bill would be $16.3 million during the first year, $23.5 million over 5 years and $32.5 million over ten years.

S. 1547 "Zero Tolerance for Veterans Homelessness Act of 2009"

S. 1547 proposes to alter and expand a number of VA authorities designed to prevent and reduce Veteran homelessness. One of VA's top priorities is eliminating Veteran homelessness. As such, the FY 2010 President's Budget significantly increased funding targeted to enhancing homeless programs, and VA has also increased its collaboration with federal and local partners to expand services.

Although VA supports the intent of this bill, we have three significant concerns – 1) assigning this program to VBA instead of the Department in general, 2) creating an entitlement for homeless services, and 3) the duplication of current programs. As a result, VA can support certain provisions in S. 1547 as discussed below.

Section 3 would require the Secretary of Veterans Affairs to establish a program in the Veterans Benefit Administration (VBA) to prevent homelessness by identifying Veterans who are homeless or at imminent risk of becoming homeless and by providing various types of assistance to those identified. Such assistance may include the provision of short-term or medium-term rental assistance, housing relocation and stabilization services, services to resolve personal credit issues, assistance with security or utility deposits, moving costs, referral to other Government programs, and other assistance the Secretary determines is appropriate. VA supports the intent of this bill; however we note that many of these services are currently provided by VA or our federal partners. In some cases, we believe some services are more appropriately provided through our partners that have specific expertise and operate programs specific to these services. Also, the administration of such a comprehensive program should be assigned to the Department in general rather than solely to VBA. We look forward to working with Committee staff to identify gaps in services provided to homeless Veterans. VA estimates the cost of enacting section 3 at $50 million in the first year, and $250 million over 5 years.

Section 4 would allow the use of grants for new construction of facilities under 38 U.S.C. 2011 and would permit grant applicants to be considered if the entity proposes to use funding from other private or non-profit sources, contingent upon the applicant's demonstration of oversight by a private non-profit organization. It would also require VA to conduct a study within 1 year of enactment concerning grant and per diem (GPD) payments under 38 U.S.C. 2012 and to develop improved methods for disbursing funds and reimbursing grant recipients. VA would, within 1 year of enactment, report on the findings of the study and provide any recommendations based

on the study's findings. This section would also increase VA's authorization for programs carried out under 38 U.S.C. 2013 to $200 million for FY 2010 and "such sums as may be necessary" for each of fiscal years 2011 through 2014. In addition, section 4 would remove the phrase "[s]ubject to the availability of appropriations" from 38 USC 2011(a)(1). The amendment would establish section 2011 as an entitlement authority. Entitlement spending is mandatory under the Budget Enforcement Act.

VA supports the increase in GPD authorization to include $200 million in FY 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014. The Administration and the Department have a goal of ultimately ending homelessness among our nation's Veterans. To achieve this goal, VA will strive to assist every eligible homeless Veteran willing to accept its services. We will help them acquire safe housing and obtain needed treatment, services, and benefits assistance, while working with our partners at the Department of Labor to also provide opportunities to return to employment. This includes education, job training, substance abuse and mental health care, as well as an assortment of other benefits. It will require close partnership with Federal and State agencies, local, non-profit and private groups; outreach and education to Veterans, people and organizations providing services to Veterans, and the general public; universal and targeted prevention; treatment focused on recovery and tailored to individual Veterans' needs; housing and supportive services; and income, employment and benefits assistance. We will leave no opportunity unexplored, and we will continue this pursuit until every Veteran has safe housing available and access to needed treatment services.

Though we are in favor of increasing the GPD authorization, the Department opposes establishing 38 USC 2011 as an entitlement authority. Accordingly, we recommend that the Committee retain the phrase "[s]ubject to the availability of appropriations" in 38 USC 2011(a)(1).

VA currently estimates the cost of the Homeless Grants and Per Diem program, which is an integral part of VA's plan to end homelessness, to be $171.6 million in FY 2010, $217.6 million in FY 2011, $1.2 billion over 5 years, and $2.8 billion over 10 years.

Section 5 would expand the Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH) voucher program by 10,000 vouchers each year through FY 2013 (beginning with 30,000 vouchers in 2010 and ending with 60,000 vouchers in 2013). It would also require the Secretary of Veterans Affairs to ensure homeless-Veteran case managers provide appropriate supportive services, including medical care to Veterans to help achieve an end to chronic homelessness.

VA supports the intent of this section; however, our role is to execute the vouchers funded through the Department of Housing and Urban Development. Over the last year, VA, in conjunction with HUD, have placed great focus on aggressively expanding outreach, and the agencies capacity to assign and execute increased numbers of housing vouchers to homeless Veterans. Within requested resources, we will reach our goal of reducing the number of homeless Veterans from 131,000 to

59,000 by 2012. VA estimates this section would cost $43.4 million in FY 2010, $132.1 million in FY 2011, $1.54 billion over 5 years and $7.74 billion over 10 years.

Section 6 would create a Special Assistant for Veterans Affairs within the Office of the Secretary for Housing and Urban Development. VA defers to HUD regarding section 6.

Section 7 would require development of a homeless Veteran management information system available to HUD and VA with data on Veterans within 1 year from the date of enactment. Ten million dollars is authorized for this project.

The Department notes that HUD has already created and implemented a Homeless Management Information System (HMIS) in Continuums of Care throughout the country. VA has committed to support the use of local Homeless Management Information Systems to track its own performance; however, as part of VA's plan to eliminate Veteran homelessness, we need a system with national identified data, which HMIS does not contain, in order to have a real time data management system to monitor its progress in meeting the goals for a zero tolerance for homelessness among Veterans. VA also has a need for a long term data warehouse to further evaluate the effectiveness and outcomes of its programs and services. The data warehouse/registry will also assist VA in monitoring the progress and service utilization of Veterans who have been homeless or are at risk for homelessness. This data will also be used to generate reports to Congress regarding the effectiveness of VA's homeless Veteran programs.

VA estimates the cost of supplementing HMIS with identifiable information to be $10 million for FY 2010. The proposed budget would be used to develop the many different intellectual documents such as requirements, project plan and the software requirements specification. These are needed to define and procure the different IT systems and services needed to initiate and build the needed components for the VA/ VHA Homeless program. Funding for the out years for this effort are estimated to be $5 million per year for ongoing design, upgrades and operations costs from an overall perspective.

Section 8 would require VA to develop a plan within 1 year of enactment on how to end Veteran homelessness, with special consideration for homeless Veterans in rural areas.

As described above, VA has already initiated an ambitious goal to expand outreach, collaboration, and programs in order to ultimately end homelessness among our Nation's Veterans. In addition, legislation enacted by Congress in May of this year, the *Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009* ("HEARTH ACT") (Division B of PI 111-22), requires that not later than 12 months after enactment, the United States Interagency Council on Homelessness shall "develop, make available for public comment, and submit to the President and to Congress a National Strategic Plan to End Homelessness, and shall update such plan annually" (42 USC 11313). Work on developing this plan has begun and VA, as one of the

19 member agencies of the Council, is at the table. As such, we do not believe this section is necessary.

S. 1753 "Disabled Veteran Caregiver Housing Assistance Act of 2009"

Pursuant to section 2102A of title 38, eligible disabled Veterans and active duty servicemembers who are temporarily living or intend to temporarily live in a home owned by a family member, are eligible for a Temporary Residence Adaptation (TRA) grant. Currently, the grant amount is limited to $14,000 for individuals eligible for assistance under 38 U.S.C. § 2101(a), and $2,000 for those individuals under 38 U.S.C. § 2101(b). S.1753 would amend section 2102A of title 38, United States Code, to increase the aggregate amount of assistance available for a TRA grant from $14,000 to $28,000 if the individual is eligible for the 2101(a) grant and from $2,000 to $5,000 if the individual is eligible for the 2101(b) grant. The bill would also authorize VA to apply the same cost-of-construction index applicable to the other grants authorized under chapter 21. The purpose of the cost-of-construction index is to provide for annual increases to the aggregate amounts of assistance available.

VA supports this legislation. Under the Housing and Economic Recovery Act of 2008, Congress authorized the Secretary to establish a cost-of-construction index and apply this index to increase the aggregate amounts of assistance available for 2101(a) and 2101(b) grants. VA published its index selection in the *Federal Register* in September 2009. The proposed legislative change would allow the Temporary Residence Adaptation grant to keep pace with these other grants on a relative basis.

VA does not expect that any benefit costs would be associated with this legislation as the TRA grants are currently counted toward the maximum amounts allowable for other grants authorized under chapter 21, title 38, U.S.C.

Thank you again, Mr. Chairman, for the opportunity to provide VA's views on these bills.

The Office of Management and Budget advises that there is no objection from the standpoint of the Department's program to the submission of this letter on S. 1467, S. 1547, and S. 1753 to the Congress.

Sincerely,

Eric K. Shinseki

Question 2(a). GAO reported (GAO–09–637R) on June 15, 2009 to Members of Congress that VA has processed nine TRA grants since its creation on June 15, 2006 through a period ending February 28, 2009. During the same period, VA processed 2,431 SAH and SHA grants. This is a substantial difference in the number of applications for each program. Have any more of these grants been processed since February?

One possible explanation for this difference is that TRA is deducted from the maximum benefit of SAH and those eligible want to maintain the maximum benefit of SAH for when they obtain permanent housing. Another explanation is that each TRA grant

counts as one of the three grant usages allowed under either SAH or SAH.

Response. Since the inception of the TRA grant program, VA's Loan Guaranty Service has fully disbursed a total of 17 TRA grants and has approved an additional five for processing. In an effort to increase grant usage, VA has expanded outreach to all eligible individuals on at least an annual basis. VA also conducted a survey of eligible individuals in FY09, to which respondents stated that they were not ready to make a decision and had deferred grant use to some future date or that the cost to install even a few of the necessary adaptations can quickly exceed the maximum TRA grant amount. As a result, eligible individuals may choose to forego necessary adaptations, pay for them with personal funds, or acquire them through the generosity of others.

Question 2(b). Does VA see any reasons not to make them two separate grants?

Response. VA does not anticipate any programmatic concerns should Congress choose to separate the TRA grants from the maximum allowable usages for the § 2101(a) or § 2101(b) grants. Additional PAYGO costs would be incurred if the TRA grants were separated from the current maximum dollar limits for the SAH and SHA grants.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. ROGER F. WICKER TO DR. GERALD M. CROSS, M.D., FAAFP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Senator Wyden's bill, S. 1429, the Servicemembers Mental Health Care Commission Act, would establish a commission to oversee programs dealing with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or other mental health disorders caused by military service. Absent in this proposed legislation is any reference to military chaplains. I feel that servicemembers are far more likely to discuss these types of topics with their chaplain than with their chain of command. Does the VA provide training to chaplains to help them recognize symptoms of mental health problems?

Response. Yes. The VA National Chaplain Center (NCC) has an extensive program to provide ongoing continuing education for VA Chaplains on the specific health care issues most often experienced by our Veteran population. Chaplains are trained about Post Traumatic Stress Disorder (PTSD); Traumatic Brain Injury (TBI); substance abuse treatment; and acute mental health issues, including: depression, bipolar disorders, suicide ideation and suicide prevention; as well as dual diagnosis often associated with homelessness at the National Chaplain Training Center. The NCC is working closely with the Office of Mental Health Services to provide ongoing training to Chaplains as the spiritual care providers on the Mental Health Teams. The Office of Mental Health provides a psychiatrist from the Durham Mental Illness Research Education and Clinical Center (MIRECC) as a consultant for curriculum development and instruction.

Question 2. Are there areas where VA and DOD can work together to make sure that our chaplains are properly trained in this regard?

Response. Yes. The National Chaplain Center is currently negotiating with the National Guard Bureau to provide Clinical Pastoral Education (CPE) for Army and Air Guard Chaplains. Since 1994, the NCC has had a similar Resource Sharing Agreement with the Navy Chaplain Corps to provide CPE for Navy Chaplains in these specialty areas, specifically, PTSD and substance abuse treatment. In November 2009, the NCC began collaboration with the Center for PTSD in Palo Alto to provide a series of three day training seminars for VA and National Guard Chaplains to be held at four Veterans Integrated Service Networks (VISN) national locations. The planning committee is anticipating the first seminar will occur in March/April 2010. Although still in the planning stages, the plan is to complete the seminars by the end of the 4th quarter FY2010 and carry the training into FY2011.

Question 3. If Senator Wyden's bill is enacted, would military chaplains be candidates to serve on a Mental Health Care Commission?

Response. Military Chaplains who are clinically trained to understand mental health issues and the role of spirituality and religion would be appropriate to serve on a Mental Health Care Commission. Experience on a health care treatment team should also be required inasmuch as not all military chaplains have health care experience. VA defers to DOD to provide their position on this question also.

Chairman AKAKA. I would like to welcome Mr. Robert Jackson, Assistant Director of the National Legislative Service for the Veterans of Foreign Wars. We have Mr. Ian DePlanque, who is Assistant Director for the Claims Service of the Veterans Affairs and Rehabilitation Commission at the American Legion. Also, I want to welcome Mr. John Driscoll, President and CEO for the National Coalition for Homeless Veterans, and Dr. Rick McMichael, President of the American Chiropractic Association. Finally, Mr. William Fenn, Vice President of the American Academy of Physician Assistants is also here with us today.

Mr. Jackson, will you please begin with your statement.

STATEMENT OF ROBERT JACKSON, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. JACKSON. Mr. Chairman, Ranking Member Burr, Members of the Committee, on behalf of the 2.2 million men and women of the Veterans of Foreign Wars, I thank you for the opportunity to provide testimony today on pending veterans legislation. Because the Committee is considering so many bills this morning, I am going to focus my testimony on three or four bills, as time allows.

The first bill I would like to talk about is S. 1302, the Veterans Health Care Improvement Act. The VFW appreciates and supports the intent of this legislation, which aims to improve the contract services provided by VA's Community-Based Outpatient Clinics, or CBOCs. As you know, many CBOCs are administered by private contractors under the supervision of regional VA medical centers. VA's method for creating these contracts varies from medical center to medical center with little uniformity on how they are structured. This legislation would create a pilot program for pay-for-performance contracts as opposed to the per capita system.

In the *Independent Budget*, we have argued for stronger oversight in management of the contracts VA uses, especially with respect to CBOCs. Among the recommendations we have made is that there needs to be an aggregation of CBOC contracting authority at the medical center or network level so as to ensure consistency of care, cost, performance measures, and simplification of oversight and administration.

The next bill I would like to comment on is S. 1547, the Zero Tolerance for Veterans Homelessness Act. The VFW strongly supports this legislation, which would provide many necessary changes to ensure America's servicemembers do not find themselves homeless in the country they have fought so bravely to defend. This legislation takes proactive measures. Particularly, it would institute flexible funding in which VA could provide short-term rental assistance, housing relocation and stabilization, security deposits, utility payments, and costs associated with moving. Additionally, this legisla-

tion would provide financing for capital projects while better aligning health care services payments with the actual health care cost.

Furthermore, this bill would create a Special Assistant for Veterans Affairs within HUD to ensure veterans have access to HUD's assistance programs while providing better data collection to accurately track and count America's homeless veterans. It would also require the VA to develop a comprehensive plan for ending veterans' homelessness within 1 year of the bill's enaction.

The third piece of legislation I would like to comment on is S. 1668, the National Guard Education Equality Act. The VFW also strongly supports this bill, which would qualify certain members of the Army National Guard who were activated under Title 32 orders but were excluded from Chapter 33 benefits. More than 30,000 members of the National Guard currently do not enjoy the benefits of the Post-9/11 G.I. Bill, but were activated in defense of our Nation for critical purposes and at critical times. In regards to Post-9/11 G.I. Bill improvements, this is the VFW's number 1 priority. Certain veterans who should be eligible for the benefit are not, and the VFW strongly encourages Congress to address this issue as quickly as possible.

And finally, the VFW supports S. 1204, the Chiropractic Care Available to All Veterans Act, which would provide veterans with direct access to chiropractic health care. Currently, chiropractic care is offered to veterans with injuries, but on a limited basis. In many instances, veterans are paying out of their own pocket for chiropractic care outside of the VA for service-related injuries. This legislation would require 75 VA medical centers to provide chiropractic services by the end of 2010 and at all VA medical centers by the end of 2012. We believe this legislation to be of great need, considering the known injuries many veterans have received in battle. Chiropractic care can help with pain management and encourage more active physical therapy and VFW believes that this type of treatment will offer veterans another option in their health care recovery.

I have got a couple of seconds left. I would like to just throw in a few comments about S. 1467. VFW supports this bill and encourages the Senate to pass this legislation to provide justice to servicemembers severely disabled by DOD vaccines through the extension of Servicemembers' Group Life Insurance Traumatic Injury Protection Program (TSGLI) coverage.

Mr. Chairman, thank you again for the opportunity to provide my testimony at this important hearing. This concludes my statement. Thank you.

[The prepared statement of Mr. Jackson follows:]

PREPARED STATEMENT OF ROBERT JACKSON, ASSISTANT DIRECTOR NATIONAL LEGISLATIVE SERVICE VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Akaka, Ranking Member Burr and Members of the Committee: Thank you for the opportunity to provide testimony on pending veterans' benefits legislation. The 1.8 million men and women of the Veterans of Foreign Wars of the U.S. appreciate the voice you give them at this important hearing.

S. 977, THE PRISONER OF WAR BENEFITS ACT

The VFW supports this legislation, which would dramatically improve the benefits this Nation provides to those who are former Prisoners of War (POWs).

First, it would repeal the 30-day minimum period of detainment or internment for a POW to be eligible for presumptive conditions, as well as adding Type–2 Diabetes and expanding eligibility for a presumption for osteoporosis. These worthwhile additions recognize the special circumstances POWs had to endure. The 30-day standard is an arbitrary one, and even a few hours of confinement is enough to increase dramatically the stresses and strains upon a servicemember's body.

The second major change the bill would make is that it lays out a process by which the Secretary can consider new diseases to be presumed service-connected for POWs. The VFW supports these changes, believing that the evidence required will, if applied properly, lead to fair treatment for those who have given so much to this country.

S. 1109, THE PROVIDING REAL OUTREACH FOR VETERANS ACT

The VFW certainly supports the idea behind the Providing Real Outreach for Veterans Act. This legislation would essentially automate much of VA's initial outreach efforts, better informing separating servicemembers about the benefits and services available to them through the Department of Veterans Affairs.

To achieve this, it would require VA and DOD to share electronic data that includes enough information so that VA can determine whether a veteran is eligible for basic benefits, as well as information to determine the likelihood that veterans would be ultimately eligible for other benefits with more complex eligibility requirements.

Based upon that information, VA would then be required to send notices to veterans to inform them of the benefits for which they are likely to be eligible. The VFW thinks that a tailored approach—highlighting those things specifically applicable—would be more likely to be successful than a general overview of all benefits.

While this exact bill might not be achievable in the short-term, it perfectly lays out the kind of approach VA should be taking over the long-term. The Department must leverage technology and the information available to it in any manner necessary, and a targeted approach to outreach would greatly assist veterans toward a more seamless transition.

S. 1118

The VFW supports this legislation, which would provide increased Dependency and Indemnity Compensation (DIC) to the surviving spouses of those who died from injuries or disabilities incurred while serving in the military.

It would also reduce, by two years, the age at which a widow or widower of a veteran could remarry without having to forfeit DIC.

Section 2 would allow the surviving spouse of a veteran who dies of a non service-connected disability to be eligible for DIC if the veteran has been totally disabled from a service-connected disability for at least five years. Current law requires ten years for DIC eligibility.

The VFW believes that a family of a totally disabled veteran suffers financial hardship and is often solely reliant on the income provided by VA. A totally disabling service-connected condition frequently contributes to and may even hasten death. Under current law, families who have depended on VA benefits as their primary income lose everything unless the veteran lives longer than 10 years after being found to be totally disabled from disabilities related to service. This bill would provide some financial stability to surviving spouses and their children.

S. 1155

This legislation would require VA to appoint a full-time Director of Physician Assistant Services to report to the Under Secretary of Health with respect to the training, role of, and optimal participation of Physician Assistants (PA). We are pleased to support it.

Congress created a PA advisor role when it passed the Veterans Benefits and Healthcare Improvement Act of 2000 (P.L. 106–419). The law required the appointment of a PA Advisor to work with and advise the Under Secretary of Health "on all matters relating to the utilization and employment of physician assistants in the Administration." Since that time, however, the Veterans Health Administration (VHA) has not appointed a full-time advisor; instead, it has utilized the skills of someone already employed who serves in a part-time capacity in addition to his or her regularly scheduled duties. We doubt that this is what Congress envisioned when it created the role. The current PA advisor has had little voice in the VA planning process, nor has VA appointed the PA advisor to any of the major health care strategic planning committees.

With the role that PAs play in the VA health care process, it only makes sense to invite their participation and perspective. VA is the largest employer of PAs in the country, with approximately 1,600. They provide health care to around a quarter of all primary care patients, treating a wide variety of illnesses and disabilities under the supervision of a VA physician. Since they play such a critical role in the effective delivery of health care to this Nation's veterans, they should have a voice in the larger process. We urge passage of this legislation and the creation of a full-time PA Director position within the VA Central Office.

S. 1204, THE CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT

The VFW supports this legislation, which would provide veterans with direct access to chiropractic healthcare. Currently, chiropractic care is offered to veterans with injuries but on a limited basis. In many instances, veterans are paying for chiropractic care outside of the VA for service-related injuries out of their own pocket.

This important legislation would require 75 VA medical centers to provide such services no later than December 31, 2010, and at all VA medical centers by no later than December 31, 2012. We believe this legislation to be of great need considering the known injuries many veterans have received in battle. Chiropractic care can help with pain management and encourage more active physical therapy. It puts special emphasis on spinal cord stress while offering wellness and lifestyle modifications to help promote physical and mental strength. VFW believes that this type of treatment will offer veterans another option in their health care recovery.

S. 1237, THE HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT

The VFW is pleased to support this legislation, which focuses on helping homeless women veterans and homeless veterans with children.

Specifically, this legislation would authorize the Department of Veterans Affairs to make Special Needs Grants to facilities to provide services and care for male veterans that are homeless with their children and to the children of all homeless veterans. Under current law, those groups are not covered by the Grant and Per Diem program's Special Needs Grants.

The bill would also extend the Department of Labor's Homeless Veterans' Reintegration Program (HVRP) to provide workforce training, job counseling, childcare services and placement services including literacy and skills training to homeless women veterans and homeless veterans with children to give these men and women every possible opportunity to lead satisfying and productive lives.

S. 1302, THE VETERANS HEALTH CARE IMPROVEMENT ACT

The VFW appreciates the intent of the Veterans Health Care Improvement Act. This legislation aims to improve the contract services provided by VA's Community-Based Outpatient Clinics (CBOCs).

Many CBOCs are administered by private contractors under the supervision of regional VA medical centers. VA's method for creating these contracts varies by medical center to medical center, with little uniformity on how they are structured. In this case, this legislation would create a pilot program for pay-for-performance contracts, as opposed to a capitated system.

If the contract is designed poorly, it can create disincentives to high-quality, proper care. The bill's sponsor, Senator McConnell, points out that a capitated system places the emphasis on the number of patients seen, not the outcomes. We certainly agree that that places the emphasis in the incorrect spot. Optimal patient outcomes should be at the forefront of all health care delivery systems and processes.

In the *Independent Budget*, we have argued for stronger oversight and management of the contracts VA uses, especially with respect to CBOCs. Page 81 of the FY 2010 Independent Budget contains our discussion on CBOC contracting.

Among the recommendations we made is that there needs to be an aggregation of CBOC contracting authority at the medical center or network level so as to ensure consistency of care, cost, performance measures and simplification of oversight and administration.

This legislation could serve as a step toward that, but we would ask the Committee to consider a wider range of possibilities, especially with its continued interest in contract oversight.

S. 1394, THE VETERANS ENTITLEMENT TO SERVICE ACT

The VFW supports this legislation, which would require VA to acknowledge, through either mail or email, when it receives certain types of correspondence related to veterans' claims for medical service, disability compensation or pensions.

With all the uncertainty that surrounds the claims process, especially the black box a veteran on the outside of the system sees, this is a small measure that would do much to alleviate concern and worry that a veterans' records and requests are not being taken care of. With the recent shredding incidents at various Regional Offices throughout the country, it would also provide veterans with extra assurance that their claim has been received and is being treated properly and fairly.

S. 1427, DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT

The VFW is pleased to support the VA Hospital Quality Report Card Act, legislation that would require VA to develop and implement a system to measure data about its health care facilities.

VFW believes the data would be of great service. It would allow veterans to compare the quality of service VA provides, letting them make informed judgments about their health care. It would allow VA to identify areas of improvement, and it would provide critical data for Congress to better use its essential oversight authority.

S. 1429, THE SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT

The VFW supports this bill, which recognizes the many challenges faced by veterans suffering from PTSD, TBI and many other mental health issues, especially from those returning from Iraq and Afghanistan.

This bill would create a Commission, with members appointed by VA and DOD that would oversee the treatment of veterans suffering from these conditions. It would require the Commission to study the long-term effects of these disabilities, as well as how well VA and DOD are doing at treating individuals and any barriers to proper mental health care that may exist, especially with respect to the stigma associated with care that many Active Duty servicemembers face.

The Commission would make regular recommendations and report its findings to Congress.

With all that is unknown about the true effects of these conditions, as well as with how critical it is for these two Departments to properly manage and administer programs that provide effective treatment to servicemembers and veterans, it is clear that the oversight powers of an organization such as this Commission are needed.

Should this bill become law, the VFW would hope that Congress carefully considers and acts upon the Commission's well thought-out recommendations so that all who need care receive high-quality service whenever and wherever they may need it.

S. 1444, THE COMBAT PTSD ACT

The VFW strongly supports this legislation, which would make much-needed changes to current law to allow veterans who served in combat areas to have easier access to the benefits VA provides to those suffering from PTSD. It would changed the definition of "combat with the enemy" so that veterans who served in a theater of combat operations during a period of war or against a hostile enemy in a period of hostilities no longer have to provide explicit evidence of the exact enemy and exact location an incident occurred.

The wars in Iraq and Afghanistan are wars with no true front lines. Incidents and danger lay everywhere, and this legislation acknowledges that events can happen anywhere at any time, and the stresses and strains of sustained action in undefined combat zones dramatically affect those who serve.

We appreciate and support VA's proposed regulation on this issue, but see no harm in codifying it into law.

S. 1467, THE LANCE CORPORAL JOSEF LOPEZ FAIRNESS FOR SERVICEMEMBERS HARMED BY VACCINES ACT

The VFW supports this legislation, which would amend the Traumatic Servicemembers' Group Life Insurance (TSGLI) to prevent the exclusion of a qualifying loss experienced by a servicemember as a result of an adverse reaction to a vaccination administered by the Department of Defense (DOD), whether voluntarily or involuntarily, for the purposes of military training or deployment.

This legislation was introduced in response to a situation involving Marine Lance Cpl. Josef Lopez, who went into a coma with a rare adverse reaction to a smallpox vaccination he received just before deploying to Iraq, leaving him permanently and seriously disabled. However, since he was felled by the vaccine and not "combat," he is ineligible for special disability funds to help seriously wounded troops (for such expenses as modifying a home to accommodate a disability).

We believe that our government is obligated to care for those servicemembers who are seriously and permanently disabled while in service to their country, regardless as to how, when or where the disabling injury occurred. It is for that reason we strongly support this legislation.

S. 1483

This legislation designates the Department of Veterans Affairs (VA) outpatient clinic in Alexandria, Minnesota as the Max J. Beilke Department of Veterans Affairs Outpatient Clinic. The VFW has no objection to this proposal.

S. 1518, CARING FOR CAMP LEJEUNE VETERANS ACT

The VFW is pleased to support the Caring for Camp Lejeune Veterans Act of 2009, which would require the Department of Veterans Affairs (VA) to provide health care to servicemembers, veterans, and their family members who have experienced adverse health effects as a result of exposure to well water contaminated by human carcinogens at Camp Lejeune.

Thousands of Navy and Marine veterans and their families who lived on Camp Lejeune have fallen ill with a variety of cancers and diseases believed to be attributable to their service at the base before the Environmental Protection Agency (EPA) designated it a Superfund site in 1988. Additionally, the National Research Council recently reported numerous adverse health effects associated with human exposure to the chemicals known to have been in water at the Marine installation.

This legislation would allow a veteran or military family member who was stationed at Camp Lejeune during the time the water was contaminated to receive needed health care at a VA facility. We believe the government has a moral obligation to provide care for those affected by contaminated water at Camp Lejeune.

S. 1531, THE DEPARTMENT OF VETERANS AFFAIRS REORGANIZATION ACT

This legislation would create a new Assistant Secretary for Acquisition, Logistics and Construction, consolidating and eliminating the functions of the Director of Construction and Facilities Management. The VFW has no objection to this proposal.

S. 1547, THE ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009

The VFW strongly supports this legislation, which would provide many necessary changes to ensure America's heroes do not find themselves homeless in the country they fought so bravely to defend. President Obama addressed the VFW at our National Convention last month. He stated "I've directed Secretary Shinseki to focus on a top priority—reducing homelessness among veterans. After serving their country, no veteran should be sleeping on the streets. No veteran. We should have zero tolerance for that."

We have faith that this administration, and this Congress, will fully and immediately address this issue, by eradicating homelessness for America's heroes forever.

This measure would take a positive step toward the President's goal. This legislation takes proactive measures in preventing homelessness. Particularly, it would institute flexible funding in which VA could provide short-term rental assistance, housing relocation and stabilization, security deposits, utility payments, and costs associated with moving for homeless veterans. This would allow the VA to take necessary actions to help homeless veterans and those at risk from being homeless get off the streets.

Additionally, this legislation would provide financing for capital projects, while better aligning health care services payments with the actual health care cost.

The bill would also authorize a much-needed increase of up to 60,000 HUD-VASH vouchers in which participating veterans receive case management. These services include assistance in locating housing and accessing benefits and health services.

Furthermore, S. 1547 would create a Special Assistant for Veterans Affairs within HUD to ensure veterans have access to HUD's assistance programs while providing better data collection to accurately track and count America's homeless veterans.

Finally, this legislation would require the VA to develop a comprehensive plan for ending veterans' homelessness within one year of the bill's enactment. The VFW ap-

plauds this measure and strongly urges Congress to pass this important measure that will help us get every American veteran off the streets.

S. 1556, THE VETERAN VOTING SUPPORT ACT

The VFW offers our support for S. 1556, the Veteran Voting Support Act.

This important legislation would require the Secretary of Veterans Affairs to permit facilities of the Department of Veterans Affairs to be designated as voter registration agencies. Specifically, the legislation would require the VA to provide voter registration forms whenever veterans enroll in the VA health care system, or change their status or address in that system, and provide veterans with access to and receive assistance with absentee ballots at VA facilities.

Additionally, the legislation would allow nonpartisan groups and election officials to provide nonpartisan voter information and registration services to veterans. It would also require Attorney General enforcement through civil suits and injunctions and require an annual report to Congress from the VA on progress related to this legislation.

The VFW has long been deeply committed to ensuring that all veterans have the opportunity to vote in Federal elections. Veterans have dedicated their lives to protecting our country and they deserve every commitment from the government to offer them the opportunity to participate in the political process.

S. 1607, THE WOUNDED VETERAN JOB SECURITY ACT

The VFW supports the intent behind the Wounded Veteran Job Security Act, but we have some concerns about the impact it would have should it be passed into law.

This legislation would allow disabled veterans to receive any necessary service-related health care without facing any repercussions from their places of employment. Essentially, it ensures that veterans who need time off from work for service-connected treatments are able to receive it without fear of losing their job.

Clearly, that is something we should strive for. But as written, it could create problems.

The legislation makes no distinction for the level of disability nor for the size or demands of an employer. So, for example, in the case of a small business with just a handful of employees, the employer would have to allow a disabled veteran all the time off he or she needed to receive treatment, no matter the impact upon the business.

While that is of great benefit to the veteran, it could potentially create a barrier to a veterans' employment in the future. If an employer knows and understands that hiring a disabled veteran—especially one with severe disabilities—is going to create a hardship for that business, it is a strong disincentive for that employer to choose a veteran over a non-veteran in the first place.

The VFW believes that protections for service-disabled veterans are a worthy goal, but our concerns about the incentives and disincentives created by this bill prevent us from supporting it.

S. 1668, THE NATIONAL GUARD EDUCATION EQUALITY ACT

The VFW strongly supports this legislation, which would qualify certain members of the Army National Guard who were activated under Title 32 orders but were excluded from Chapter 33 benefits.

More than 30,000 members of the National Guard currently do not enjoy the benefits of the Post-9/11 GI Bill but were activated in defense of our Nation for critical purposes and at critical times. In regards to Post-9/11 G.I. Bill fixes, this is the VFW's number one priority. Certain veterans who should be eligible for the benefit are not and the VFW strongly encourages Congress to address this issue as quickly as possible.

S. 1752

The VFW applauded the Secretary Shinseki's recent decision to add Parkinson's disease to the list of diseases presumed to be service-connected due to their relationship with herbicide agents amongst certain veterans serving in Vietnam. We continue to urge the Secretary and this Committee to look at all available scientific research, as well as to continue researching these conditions, especially as the impact of their long-term effects are becoming increasingly clear. To that end, we certainly support the inclusion of this disease within Title 38.

VFW supports this vital legislation that would more than double the amount of specially adapted housing assistance available to veterans residing temporarily in housing owned by a family member.

Many disabled veterans are being cared for by family members that have had to make structural changes to their homes in order to provide the best possible care and support. In today's economy even small changes to structures in a home can be expensive. By providing this increase you will be making a difference in the quality of life for many disabled veterans and their families.

This concludes my statement. I would be happy to answer any questions you may have.

POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO ROBERT JACKSON, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Question 1. Veterans register to vote and vote at a significantly higher rate than their civilian counterparts. Have your members experienced problems with registering to vote or actually voting? If so, what have those problems been?

Question 2. What is the VFW doing to help your members, as well as other veterans, register to vote and to vote?

Question 3. What do you anticipate the cumulative costs would be for VA to: 1) provide a mail voter registration application form to each veteran who seeks to enroll in the VA health care system, and to each enrolled veteran any time there is a change in the enrollment status of address change of the veteran; 2) provide each veteran with information and assistance with voter registration; 3) accept completed voter registration application forms and transmit them to the appropriate State election official, and ensure that all of the information and assistance with voter registration is nonpartisan; 4) provide assistance in voting by absentee ballot to veterans residing the medical or community living centers; and 5) prepare an annual report to compliance report to Congress?

Question 4. What exactly about the current VA directive dated September 8, 2008 regarding voter registration and voting do you find insufficient?

Question 5. Do you support the provision of S. 1556 which states that subject to reasonable time, place and manner restrictions, the Secretary shall not prohibit any election administration official from providing voting information to veterans at any (emphasis added) VA facility, even if that includes national cemeteries?

[The Committee had not received responses by press time.]

Chairman AKAKA. Thank you very much, Mr. Jackson.

Mr. Ian DePlanque.

STATEMENT OF IAN DePLANQUE, ASSISTANT DIRECTOR FOR CLAIMS SERVICE, THE AMERICAN LEGION

Mr. DEPLANQUE. Good morning, Mr. Chairman, Members of the Committee. On behalf of the American Legion, I would like to thank you for the opportunity to testify on a broad spectrum of legislation being considered before this Committee this morning. Because of the large number of bills before the Committee, I would note that you have our written testimony on the full slate of legislation and instead I will focus on a select few.

The Veterans Health Care Improvement Act provides for an introduction of pay-for-performance compensation mechanisms into the contracts of VA with Community-Based Outpatient Clinics for the provision of health care services and so forth. The Community-Based Outpatient Clinics have greatly enhanced the ability of VA providers to provide veterans with more ready access to medical care. This is particularly important with the large percentage of veterans in rural communities who lack access to the more central urban existing VA facilities. However, due to findings of an inaccu-

racy of fee adjustment for care, as is mentioned in Section 2 of the piece of legislation, we believe the incorporation of pay-for-performance compensation mechanism into agreements between VA and the contractors is essential to ensure veterans receive adequate and timely care.

Regarding two of the bills that deal with homelessness, the Homeless Women Veterans and Homeless Veterans with Children Act and also the Zero Tolerance for Homelessness Act, they highlight an area of great concern for the American Legion. The unique circumstances that women veterans are facing present challenges to assist them. We must continue to recognize the changing face of the American veteran. Women are deploying in support of our forces in greater numbers than ever before and have unique issues associated with their transition that are different from those anticipated previously in the system.

One of the bills would establish a grant program for the reintegration of homeless women veterans and homeless veterans with children, expanding the grant program, as well, for homeless veterans with special needs to include the male homeless veterans with minor dependents. The American Legion supports the efforts of public and private sector agencies and organizations with resources necessary to aid homeless veterans and their families.

Approximately 200,000 female Operation Iraqi Freedom veterans are isolated during and after deployment, making it difficult to find gender-specific peer-based support. As was mentioned earlier by Senator Murray, approximately one in ten homeless veterans under the age of 45 is now a woman. Access to gender-appropriate care for these veterans is essential.

We are also looking at the growing numbers of homeless among veterans and it is very important for these people who have proven their value to society by standing up for their country, that they not be allowed to slip through the cracks. And I will come back and mention one more point on that in a moment.

But first, I would like to talk about the Combat PTSD Act. This centers on a much-needed legislative change to how VA implements Section 1154(b) of Title 38 of the U.S. Code. The section was originally created in special recognition of the unique challenges of recordkeeping under the conditions of combat. Section 1154(b) is there precisely because the ability to clearly document each individual event or occurrence under combat conditions can be an extreme challenge.

VA has already made a step forward with their proposed regulation which will help veterans suffering from PTSD. However, there is a tendency with this to focus too narrowly on PTSD and on the present conflict. This legislation is more important because it focuses on the bigger picture—what 1154(b) was intended to do.

I would like to give an example of other veterans who would be affected by this bill but not by the current proposed regulation. When I was working at the Board of Veterans Appeals, I was working on behalf of a veteran who was a communications soldier in the U.S. Army in Vietnam. He was working with the Military Assistance Command in Vietnam and as a part of that spent almost all of his time seconded out, or assigned out to Vietnamese units—units from the Republic of Vietnam. Obviously, it is very difficult

to get unit records for the South Vietnamese Army. So, because he was a communications soldier, he didn't have access to things like a combat infantry badge that would have enabled VA to give him the full provisions of 1154(b) and say that the events that he described occurred in combat.

This legislation would expand that to all soldiers in unique conditions. It is easy to say unique conditions when we recognize that it actually applies to so many different soldiers. War is an unusual place. This would expand it to all of them and it is a much needed benefit.

The VA stated a number of times that they are concerned about being too broad with a regulation, but we should ask ourselves if we are being broad enough, if we are casting a wide enough net. So, I come back to the homelessness situation. It is a clear example in front of us where veterans are slipping through those nets, where we have not been broad enough. Thus, for measures such as the Combat PTSD Act or for the various legislation to address homelessness—or really any legislation—we shouldn't ask if it is too broad. We should be asking if it is broad enough.

Thank you. I will be happy to answer any questions that may come up.

[The prepared statement of Mr. DePlanque follows:]

PREPARED STATEMENT OF IAN DEPLANQUE, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee: Thank you for this opportunity for The American Legion to present its views on the broad list of veterans' legislation being considered by this Committee.

S. 977, PRISONER OF WAR BENEFITS ACT OF 2009

This bill addresses the addition of presumptive conditions specifically as they relate to those veterans formerly held as Prisoners of War. The bill would add certain conditions to the list of presumptive disabilities and would provide for the updating of such list as sound medical evidence determines that a positive association exists between being a Prisoner of War and the occurrence of a disease in humans. Should such conditions be determined the bill directs the Secretary of Veterans Affairs to add them to the presumptive list of disabilities.

This is in accordance with presumptions of disabilities with medical findings as is found in other situations, such as harmful dioxin in the chemical herbicide Agent Orange, and represents a sound commitment to the veterans of this country by utilizing constant reevaluation to determine the most current medical understanding and applying it to the disability claims process.

The American Legion is supportive of enhancing the manner in which the former Prisoners of War are treated, and to ensuring that they receive the benefits to which they are due, based on the accumulated sum of medical science.

S. 1109, PRO-VETS ACT OF 2009

This bill seeks to provide improved transfer of information capabilities between the Department of Defense (DOD) and the Department of Veterans Affairs (VA), as well as to increase awareness among veterans of the benefits to which they may be entitled. By identifying key data points within a veteran's military records, the data could be used to assist in the determination of which benefits each veteran may likely be eligible to receive.

Veterans would then receive notification explaining the benefits to which they are entitled, along with an explanation of those benefits. This would ultimately provide for a more streamlined process in the application for benefits by veterans transitioning from service.

The American Legion is strongly supportive of enhancements to the transition process and of increased communication and data sharing between DOD and VA. Such enhancements are vital to ensuring that veterans of this Nation receive all benefits to which they are entitled. Furthermore, information sharing and swift

transmittal of information between these two departments is a vital element in fairly adjudicating the claims of veterans. Without access to complete and detailed military records, proving a claim can be difficult for many veterans, so enhancements to the sharing of this information can be vital.

S. 1118

The purpose of this bill is to amend title 38, United States Code (U.S.C.), to provide for an increase in the amount of monthly Dependency and Indemnity Compensation payable to surviving spouses by VA. The bill would provide a more equitable distribution of this benefit among surviving spouses, and would lower the age at which remarrying surviving spouses could marry and still retain their benefit.

This bill represents an improvement to the surviving spouses of veterans, and The American Legion is supportive of this enhancement of their benefit.

S. 1155, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO ESTABLISH THE POSITION OF DIRECTOR OF PHYSICIAN ASSISTANT SERVICES WITHIN THE OFFICE OF THE UNDERSECRETARY OF VETERANS AFFAIRS FOR HEALTH

This bill seeks to amend title 38, U.S.C., to establish the position of Director of Physician Assistant Services within the Office of the Under Secretary of Veterans Affairs for Health.

The American Legion supports legislation to establish a Director of Physician Assistant (PA) Services within VA. It is The American Legion's contention that the elevation of the current position of PA Advisor to Director is a necessity to increase veterans' access to quality medical care by ensuring efficient utilization of the VA's programs and initiatives, in addition to providing proper oversight from the policy level.

The American Legion urges Congress to act on the matter immediately to ensure that the approximately 2,000 PAs within VA have sufficient and full-time representation at the policy level.

S. 1204, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2009

This bill seeks to make chiropractic care available to veterans at all VA medical centers. The American Legion supports legislation that definitively stands to provide all veterans with adequate medical service throughout the entire VA health care system.

S. 1237, HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009

This bill seeks to amend title 38, U.S.C., to expand the grant program for homeless veterans with special needs to include male homeless veterans with minor dependents and to establish a grant program for reintegration of homeless women veterans and homeless veterans with children.

The American Legion supports the efforts of public and private sector agencies and organizations with the resources necessary to aid homeless veterans and their families. Homeless veterans' service providers' clients have historically been almost exclusively male. This is changing as more women veterans, especially those with young children, have sought help. Additionally, approximately 200,000 female Operation Iraqi Freedom veterans are isolated during and after deployment making it difficult to find gender-specific peer-based support. Reports show that one of every ten homeless veterans under the age of 45 is now a woman. Access to gender appropriate care for these veterans is essential.

Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) sites continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. It reports that 118 sites (85 percent of all sites) reported a total of 1,282 homeless veterans with families seen. This was a 24 percent increase over the previous year's 1,038 homeless veterans with families (FY 2008 VA CHALENG report). This legislation is a tremendous step forward with addressing the special needs that come with being a homeless veteran with families. The American Legion supports this legislation, because it will provide medical, rehabilitative and employment assistance to homeless veterans with families.

S. 1302, VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009

The purpose of this bill is to provide for the introduction of pay-for-performance compensation mechanisms into VA contracts with Community Based Outpatient Clinics (CBOCs) for the provision of health care services, and for other services.

The American Legion supports the CBOC concept s because they improve access to VA healthcare. However, due to findings of an inaccuracy of fee adjustment for care, as mentioned in Section 2 of this piece of legislation, we believe the incorporation of the pay-for-performance compensation mechanism into agreements between VA and contractors is essential to ensure veterans receive adequate and timely care.

S. 1394, VETERANS ENTITLEMENT TO SERVICE ACT OF 2009

The purpose of this bill is to provide for notification acknowledgement from the Secretary of Veterans Affairs of the receipt of medical, disability and pension claims. It requires notification of the receipt of such claims, as well as clarification of the date such claims are received.

VA has recently taken a "black eye" in the handling of documents submitted by veterans through the "shredder scandal" of late 2008. Much must be done to regain the trust of American veterans. They must be convinced that their claims are being handled with the professionalism, attention and care due to them. This would provide an important protection to veterans. A written record could assist veterans in establishing key aspects of their claims if documentation issues arise in the future.

The American Legion is supportive of this legislation.

S. 1427, DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT OF 2009

The American Legion supports legislation that would seek to ensure the quality of care for the veterans of this Nation. In addition, The American Legion also concurs with this measure to assist with sustaining quality at VA medical centers.

For example, The American Legion's Resolution 206, "Annual State of VA Medical Facilities," serves a synonymous purpose. The American Legion, national staff and Task Force Members visit VA Medical Facilities, compile reports of findings, and advocate on behalf of veterans before Congress for adequate and timely funding for the VA.

This piece of legislation, with the proper oversight, would provide a more definitive system of checks and balances within VA and ensure quality care is constantly maintained. However, it should be measured alongside inspections by other organizations, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), to provide corroboration. The American Legion is supportive of this direction provided that the due diligence is followed.

S. 1429, SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT

This bill is to establish a Commission on Veterans and Members of the Armed Forces with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or other mental health disorders. Also to enhance the capacity of mental health care providers and assist such veterans. Finally, to ensure such veterans are not discriminated against, and for other purposes.

The American Legion supports this legislation that strengthens the consortium of continuity of care between DOD and VA. We feel such a commission would be required to monitor the care of these individuals who are suffering from PTSD, (TBI), and other mental disorders, as they move from DOD to VA.

As Congress considers this piece of legislation, we urge that further thought be placed into the Section 2(f), Authorization of Appropriations, of this bill to ensure adequate and appropriate funding is provided.

S. 1444, COMBAT PTSD ACT

The purpose of this bill is to clarify the definition of "combat with the enemy" as used by VA under section 1154(b), title 38, U.S.C. This bill would define "combat with the enemy" as including service or active duty in a theater of combat operations (as determined by the Secretary [of the Department of Veterans Affairs] in consultation with the Secretary of Defense) during a period of war; or in combat against a hostile force during a period of hostilities. The American Legion has long been supportive of such change due to the changing realities of modern warfare and war fighting.

VA recently proposed a regulation change which would liberalize the process of proving the occurrence of stressor events in combat zones for veterans suffering from PTSD. The measure taken by the VA does not address entirely the root cause of the problems many veterans have faced due to the difficulty of record keeping in a combat zone. Section 1154(b), title 38, U.S.C. was created in recognition of the fact that in combat it is very difficult to document every single occurrence with precise accuracy.

The provisions of that section were put into place to recognize this, and to allow servicemembers who had experienced combat to provide lay testimony alone to document the occurrence of events. It requires that the events described were consistent with the hardships and circumstances of combat, and that there was no clear evidence to the contrary that such events took place. The flaw in the original regulation was that an inordinate amount of benefit is given to those servicemembers who could easily document combat, such as Infantry soldiers. Those servicemembers with non-traditional combat specialties were often left with an even more difficult task of proving that the combat took place, let alone the events described in combat.

As recognition of the non-linear, asymmetric battlefield of modern warfare has increased, it has become clear that combat is no longer something clearly ascribable to combat specialists such as Infantry alone. Clerks and chefs were assigned guard duty in remote outposts in Vietnam. Military Police currently perform convoy duty on Improvised Explosive Device (IED) riddled convoy routes in Iraq. Air Force ground personnel were subject to mortar fire in Bosnia.

This bill can provide one simple benefit to servicemembers: recognition that their experiences and sacrifices in a hostile environment are understood. This is not a blanket dispersal of benefits. It would provide assistance in proving the one elusive piece of evidence needed to receive benefits to which they are entitled. A veteran must still provide evidence of a current condition and they must still provide evidence of a medical linkage between their current condition and the events they maintain took place in combat. This proposed legislation is a much needed change to assist in establishing the occurrence of events that caused their medical conditions. The American Legion supports this legislative change.

S. 1467, LANCE CORPORAL JOSEPH LOPEZ FAIRNESS FOR SERVICE MEMBERS HARMED BY VACCINES ACT OF 2009

The purpose of this bill is to amend title 38, U.S.C., to provide coverage under Traumatic Servicemembers' Group Life Insurance for adverse reactions to vaccinations administered by the DOD. The legislation recognizes the situation of Lance Corporal Josef Lopez, a Marine from Springfield, Missouri, who, in September 2006, as a result of a smallpox vaccination administered by DOD just prior to a deployment to Iraq. One week after his arrival in Iraq, Lance Corporal Lopez suffered complete paralysis, a coma, and the loss of two activities of daily living, all of which were subsequently diagnosed as resulting from a rare adverse reaction to the smallpox vaccine.

The struggles of his family to deal with the situation within the current system are well documented. This legislation is an important step forward to attempt to remedy that system.

The American Legion believes a fundamental inequity exists in the TSGLI program when insured individuals who suffer a traumatic physical injury and qualifying loss are treated differently because one injury is medically induced and the other is not. Some situations should be considered qualifying injuries under the TSGKI Schedule of Losses, such as adverse reactions to military vaccines, and negative results of surgical mistakes, incorrect diagnoses, and incorrect drug prescriptions. However, other situations, such as disease or illnesses or possible adverse effects of regular and accepted medical procedures when properly conducted, would be more readily directed toward alternative compensation programs such as VA Compensation.

TSGLI was formulated by using the Dismemberment portion of the private sector Accidental Death and Dismemberment (AD&D) insurance industry as a guide. The goal was to maintain lower costs by limiting coverage definitions to a low frequency of occurrences for a large number of the insured. At the time the enabling legislation was developed, we were advised by the VA that Congress wished to keep the premiums for this coverage in the vicinity of $1 per month. Expanding the definition of injuries for TSGLI may very well require increases. Potentially substantial premiums paid by servicemembers, and increased government costs may result. It is incumbent upon Congress to take into consideration this possibility and insure the TSGLI program is not put in a position of financial jeopardy. The American Legion strongly supports the continuation of the TSGLI program, as well the right to VA Compensation following discharge from active duty.

In considering only vaccinations, the incidence of cases so severe as to fall within the scope of TSGLI's qualifying losses seems limited, and would probably not impose a burden on the program. The Vaccine Injury Compensation Program (VICP) (military personnel do not qualify) as adjudicated by the U.S. Court of Federal Claims, offers compensation maximums in excess of TSGLI benefits. The American Legion strongly believes benefit programs for servicemembers and veterans be administered

in a fair and equitable manner, and that TSGLI benefits should be available to insured servicemembers.

The American Legion supports S. 1467, Lance Corporal Josef Lopez Fairness for Servicemembers Harmed by Vaccines Act of 2009.

S. 1483, A BILL TO DESIGNATE THE DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC IN ALEXANDRIA, MINNESOTA, AS THE "MAX J. BEILKE DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC."

The American Legion has no position on this piece of legislation.

S. 1518, CARING FOR CAMP LEJEUNE VETERANS ACT OF 2009

The purpose of this bill is to amend title 38, U.S.C., and to furnish hospital care, medical services, and nursing home care to veterans who were stationed at Camp Lejeune, North Carolina, while the water was contaminated.

This bill would require VA to provide health care to veterans and their family members who have experienced adverse health effects as a result of exposure to well water contaminated by human carcinogens at Camp Lejeune.

The American fully supports this bill and urges VA to conduct further scientific studies of the residents who were affected by those contaminants.

S. 1531, DEPARTMENT OF VETERANS AFFAIRS REORGANIZATION ACT OF 2009

The purpose of this bill is to amend title 38, United States Code, to establish within VA the position of Assistant Secretary for Acquisition, Logistics, and Construction, and for other purposes.

The American Legion has no position on this bill.

S. 1547, ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009

This bill seeks to amend title 38, U.S.C., and the United States Housing Act of 1937, to enhance and expand the assistance provided by VA and the Department of Housing and Urban Development (HUD) to homeless veterans and veterans at-risk of homelessness. Homelessness is the end result of problems that an individual cannot resolve without assistance.

Generally, these problems can be grouped into three categories—health issues, economic hardships, and lack of affordable housing. These impact all homeless individuals, but veterans face additional challenges when trying to overcome these obstacles. Prolonged separation from traditional supports such as family and close friends, highly stressful training and occupational demands can affect their personality, self esteem and ability to communicate with people in the civilian sector after separation from military duty. Over 131,000 veterans are affected by homelessness and are in desperate need of assistance.

With S. 1547, specific programs are outlined to help combat homelessness for veterans such as: helping to resolve credit issues; assistance with moving costs; housing relocation; short-term housing assistance; and, financial assistance with security or utility payments. In addition, S. 1547 authorizes $200 million for FY 2010 and any sums that are necessary for FY 2011 to FY 2014. The American Legion supports taking this necessary action to combat and aid in eliminating homelessness among the veterans' population. S. 1547 also outlines the program manager's responsibilities, roles in creating an environment conducive for successful case management services, and counseling for veterans and their families. If enacted, this bill will provide veterans who are at high risk for, or are already affected by, homelessness with the housing and supportive services they need in order to return to mainstream society. In this volatile economy, with the thousands of men and women who are returning from Iraq and Afghanistan, it is paramount that Congress pass legislation that provides resources for homeless veterans so they can return to financial independence and a high quality of life.

The American Legion strongly supports S. 1547 and its goals to end homelessness within the veterans' community.

S. 1556, VETERAN VOTING SUPPORT ACT OF 2009

This bill would facilitate improved voter registration for veterans enrolling in the VA Health Care System, as well as those already enrolled. The overall effect would be an improvement of voter registration within the veterans' community. The bill specifically cites the unique qualifications of veterans to understand issues of war, foreign policy, and government support of veterans and cites the importance of furthering their opportunities to voice their understanding through voting.

The American Legion has a national "Get Out the Vote" program that consists of three elements: voter registration; voter education; and, voter participation. Clearly, this legislation would advance the voter registration element advocated by this program. However, The American Legion stresses the nonpartisan and nonpolitical participation in all three elements. Voter registration is provided for all eligible potential voters. Voter education is strictly encouragement of registered voters to be "informed voters" on issues important to them. Voter participation encourages getting registered voters to the polls or assist with participation in absentee voting consistent with individual state laws and regulations.

S. 1607, WOUNDED VETERAN JOB SECURITY ACT OF 2009

The purpose of this bill is to protect the rights and benefits of those veterans absent from employment for certain periods, enabling them to receive medical treatment for service-connected disabilities. Veterans disabled in service to the country already bear an inordinate burden as these disabilities impact their employment. Further impact from the lost time at work that the treatment of these disabilities requires can only worsen the problem.

While a service-connected veteran is compensated through the disability system for their individual conditions, the disability schedule can easily fail to address the other obstacles faced by disabled veterans in their career path. Many disabilities require regular medical appointments and can easily overwhelm the normal sick leave granted by employers as is consistent with long term disability. For veterans who have already sacrificed so much, it would seem worse to ask them to sacrifice even more of their career options when some obstacles could be removed and they could be given the assistance that they deserve.

The American Legion is supportive of this legislation.

S. 1668, NATIONAL GUARD EDUCATION EQUALITY ACT

This bill amends title 38, U.S.C., to provide for the inclusion of certain active duty service in the Reserve components as qualifying service for purposes of Post-9/11 Educational Assistance Program. This legislation will extend benefits to title 32, U.S.C., Active Guard Reserve (AGR) servicemembers under the Post-9/11 GI Bill. Many AGR personnel were called to active duty via title 32, U.S.C., in support of the response to the attacks on America on September 11, 2001, in addition to deploying to the United States—Mexico border during 2007 and 2008 for Operation Jump Start. Thus, AGR servicemembers have answered the Nation's call to arms and should receive equal education benefits for their service. When enacted, this bill would provide a full four-year college education to members of the National Guard, who are discharged with a service-connected disability.

The American Legion fully supports enacting the National Guard Education Equality Act.

S. 1752

The purpose of this bill is to amend title 38, U.S.C., to direct the Secretary of Veterans Affairs to provide wartime disability compensation for certain veterans with Parkinson's disease. This bill would add a presumption of service connection for those veterans who have served in the Republic of Vietnam and who have Parkinson's disease manifest to a degree of 10 percent disabling.

The American Legion notes that VA has added Parkinson's disease to the list of presumptive disabilities for veterans with service in the Republic of Vietnam. This action has the same effect as that proposed in this legislation and would thus seem to obviate the need for this bill. However, the American Legion notes that VA must continue to pay heed to and adjust the rolls of presumptive disability according to current medical findings such as the published reports of the Institute of Medicine in their studies of Agent Orange.

S. 1753, DISABLED VETERAN CAREGIVER HOUSING ASSISTANCE ACT OF 2009

This bill would amend title 38, U.S.C., to increase assistance for disabled veterans who are temporarily residing in housing owned by a family member. With the rising costs of adaptive housing construction, it has become necessary to allocate funding for these veterans and their families that will pay for the special equipment they require, due to their service-connected disabilities. These veterans are in need of temporary support from family members in order to receive adequate care and readjust back into mainstream society. Maintaining a level of stability and housing provided by loved ones is a necessity for these veterans who are returning with severe disabilities. By increasing the amount of funds that these injured veterans receive

for residential home cost-of-construction; it will give them the ability to get the basic/crucial equipment they need to get on the path of living a high quality of life.

The American Legion supports this legislation.

DRAFT DISCUSSION ON HEALTH CARE FOR MEMBERS OF THE ARMED FORCES EXPOSED TO CHEMICAL HAZARDS ACT OF 2009

This draft bill would amend title 38, U.S.C., to direct the Secretary of Defense to establish and administer a registry of members and former members of the Armed Forces who were exposed to occupational and environmental hazards in the line of duty on or after September 11, 2001.

This draft bill would also require the Secretary of Defense to notify members and former members of the Armed Forces who may have been exposed to such hazards and provide a complete physical and medical examination. In addition, the draft bill would authorize the Secretary to enter into an agreement with the Institute of Medicine (IOM) to conduct a scientific review(s) of the evidence related to health consequences as a result of exposure.

This draft would also authorize such veterans to be eligible for hospital care, medical services, and nursing home care through VA for any disability, notwithstanding insufficient medical evidence, to conclude, the disability and its possible association with such exposure.

The American Legion Fully supports this draft bill.

As always, The American Legion appreciates the opportunity to testify and represent the position of its 2.5 million wartime veterans. We hope that we also express what is in the best interests of the totality of veterans in this country.

Mr. Chairman, this concludes my formal testimony.

RESPONSE TO POST-HEARING QUESTION SUBMITTED BY HON. DANIEL K. AKAKA TO IAN DEPLANQUE, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Question 1. Veterans register to vote and vote at a significantly higher rate than their civilian counterparts. Have your members experienced problems with registering to vote or actually voting? If so, what have those problems been?

Response: The American Legion has a national "Get Out the Vote" campaign that consists of three components: voter registration, voter education, and voter participation. This program is executed through the 14,000 local American Legion Posts around the world.

Nationally, The American Legion has not experienced complaints about voter registration; however, absentee voting by American citizens overseas and military servicemembers still seems to generate uncertainties as to whether individual ballots were actually received in a timely manner and/or counted.

Question 2. What is the American Legion doing to help your members, as well as other veterans, register to vote and to vote?

Response: In 1920, during The American Legion National Convention in Cleveland, the organization went on record urging all American Legion members to become qualified voters. Since then, the organization has passed countless similar resolutions advocating Legionnaires to not only exercise their constitutional responsibility to vote, but to also encourage others to do the same.

The Legion's "Get Out the Vote" program encourages all Americans to register and vote in all elections. In addition, Legionnaires, posts, districts, and departments are encouraged to fully involve themselves in the electoral process by serving as poll volunteers, poll workers and by encouraging and assisting others to register and vote.

Information about how to run a successful "Get Out the Vote" campaign is available through The American Legion's Americanism Division. The American Legion can provide a copy of the most recent publication geared to the 2008 election.

Question 3. What do you anticipate the cumulative costs would be for VA to: 1) provide a mail voter registration application form to each veteran who seeks to enroll in the VA health care system, and to each enrolled veteran any time there is a change in the enrollment status of address change of the veteran; 2) provide each veteran with information and assistance with voter registration; 3) accept completed voter registration application forms and transmit them to the appropriate State election official; and ensure that all of the information and assistance with voter registration is nonpartisan; 4) provide assistance in voting by absentee ballot to veterans residing the medical or community living centers; and 5) prepare an annual report to compliance report to Congress?

Response: Voter registration is handled by state guidelines; therefore, there is not a "cookie-cutter" response to this question.

1) The American Legion would recommend simply notifying each veteran who seeks to enroll in the VA health care system or a change of address that voter registration assistance is available through the Department of Veterans Affairs upon request. This should minimize costs and eliminate sending voter registration forms to veterans already registered to vote.

2) The American Legion would recommend simply notifying veterans via various communications venues that voter registration assistance is available.

3) The American Legion would recommend that return of voter registration applications be sent directly to the state's voter registration offices by the veteran.

4) The American Legion and other veterans' and military service organizations are actively involved in VA's Volunteer Services. Such nonpartisan organizations could be a valuable resource in assisting VA in fulfilling this important activity. http://www4.va.gov/vaforms/medical/pdf/vha–10–0462–fill–9–08.pdf

5) The American Legion would recommend each VA facility be given the opportunity to develop its own reporting procedure to comply with this requirement with each Regional Office. Regional Office would in turn report results to VA Central Office to comply with this directive. Again, a "cookie-cutter" approach would seem inappropriate. http://www.coatesville.va.gov/news/PressReleases/Oct15_PressRelease_Voter_Registration.pdf

Question 4. What exactly about the current VA directive dated September 8, 2008 regarding voter registration and voting do you find insufficient?

Response: VHA Directive 2008–053, appears sufficient; however, it directs each individual facility director to have a written published policy; inconsistencies may exist from facility to facility. Outreach appears limited to just the facility's physical plant.

Question 5. Do you support the provision of S. 1556 which states that subject to reasonable time, place and manner restrictions, the Secretary shall not prohibit any election administration official from providing voting information to veterans at any (emphasis added) VA facility, even if that includes national cemeteries?

Response: The American Legion supports S. 1556 legislative intent was to meet the needs of veterans seeking assistance in voter registration or assistance in voting.

Chairman AKAKA. Thank you very much, Mr. DePlanque.

Mr. John Driscoll.

STATEMENT OF JOHN DRISCOLL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COALITION FOR HOMELESS VETERANS

Mr. DRISCOLL. Thank you, Mr. Chairman, Ranking Member Burr, and distinguished Members of the Committee. The National Coalition for Homeless Veterans is honored to appear before this Committee to comment on what we believe are two of the most important bills in the history of the homeless veteran assistance movement. That is quite a statement for me. We have attempted to be the Nation's primary liaison between community- and faith-based organizations that help homeless veterans, Congress, and the Federal agencies that are invested in the campaign to end veteran homelessness for 20 years.

VA officials have testified before Congress that this partnership is largely responsible for the phenomenal reduction in the number of homeless veterans on the streets of America, from about 250,000 in fiscal year 2004 to 131,000 today. Ending veteran homelessness is a priority of the Obama administration and our Federal partners are mobilizing their departments to make sure that this happens. We believe these bills figure prominently in our collective chances to succeed.

I will start with the Homeless Women Veterans and Homeless Veterans with Children Act. For the first time in American history,

women comprise 11 percent of this Nation's combat forces currently serving in Iraq and Afghanistan. Included among them are 30,000 women with dependent children. Women account for 15 percent, or will account for 15 percent of our Nation's veterans within the next 10 years.

Currently, 5 percent of the veterans who request homeless veterans assistance through VA facilities and the organizations NCHV represents are women. The majority of them are between the ages of 20 and 29. The majority represent minority communities. And roughly 24 percent are disabled. More than 10 percent of these women have dependent children.

Senators Murray, Johnson, and Reed, in introducing this bill, recognize that the same difficulties faced by single female parents are experienced by single male parents. We have learned that during the last 2 years, more than 11 percent of the men who receive assistance through the HUD-VASH program are single parents with dependent children. According to VA, the highest unmet needs of these single veteran parents are: child care assistance; legal aid for credit repair; child support issues; and access to affordable housing.

S. 1237 would authorize up to $10 million in grants to community- and faith-based organizations through the Department of Labor and VA to provide critical specialized supports for these deserving men and women as they work their way out of homelessness. There are 200 community-based grant per diem programs across the country that have services for women; and there are 90 community-based veteran employment and training service grants who provide training assistance and placement for homeless veterans under the Homeless Veterans Reintegration Program, which is one of the most successful programs in the Department of Labor portfolio.

The point here is that the value that won't necessarily show on the bottom line if this bill is passed is that the infrastructure is already there. These dollars would go directly to services to immediately help homeless women veterans and veteran single parents with dependent children. For that, we urge the Committee to consider pushing this bill forward.

The Zero Tolerance for Veteran Homelessness Act is probably, we believe, the most comprehensive bill ever submitted. For several years, NCHV has realized there can be no end to veteran homelessness until we develop a national strategy that addresses the needs of former guardians before they become homeless. We believe this Act, introduced by Senators Reed, Bond, Murray, Johnson, Kerry, and Durbin, and cosponsored by 12 Senators, has the potential to set this Nation on course to finally achieve victory in the campaign to end veteran homelessness in the United States.

Victory in the campaign requires success on two fronts: intervention, which we believe has come a long way in the last 20 years; and prevention strategies, which only now is seeing light. We believe this Act addresses both needs. It provides an expansion of HUD-VASH housing for chronically homeless veterans, to the level of 60,000 over the next 5 years. According to analysis of data by the National Alliance to End Homelessness, about 63,000 veterans can be classified as chronically homeless. This measure alone

would, therefore, effectively end chronic veteran homelessness as we understand it today.

The Act would also authorize $50 million annually to provide supportive services for low-income veterans to reduce the risks of becoming homeless and to help those who are homeless find housing. The provisions include, as you have heard, short- to medium-term rental assistance, repair of poor credit rating histories, housing search and relocation assistance, and help with security and utility deposits. For many of the Nation's 630,000 veterans living in extreme poverty, this could mean the difference between achieving stability or continuing the downward spiral into homelessness. It is key to a national prevention strategy.

The Act would modernize the highly successful VA grant per diem program to allow for innovative project funding, including the use of low-income housing tax credits and matching funds from other Federal sources to hasten project development and expansion.

For years, service providers have appealed for a system that reflects the actual costs of providing services to homeless veterans rather than a flat per diem rate based on the reimbursements paid to State veterans homes. We know that many VA officials agree with this request, and NCHV endorses giving the new Secretary of the Department of Veterans Affairs time to study the issue.

The Act calls for an increase in the annual authorization for grant per diem to $200 million beginning in 2010, which could immediately provide additional funds for outreach through community-based service centers and mobile service vans in rural areas—both of which are allowed under current law—while continuing to increase bed capacity at VA's partners. These outreach initiatives will play a key role as the VA forwards its prevention strategies.

In closing, the homeless veteran assistance movement we represent is now 20 years old, but much of the success we have realized together has been realized in only the last 10 years. The partnership between VA, DOL, HUD, and the 1,600 community-based organizations NCHV represents, has presented this Nation with an infrastructure necessary to end veteran homelessness.

The Zero Tolerance for Veterans Homelessness Act of 2009 represents an historic opportunity for those who sacrificed some measure of their lives in service to our country. They shall not be abandoned in their greatest hour of need.

Personally, I would like to convey my appreciation and gratitude to the Members of this Committee and also to your staffs for the work that you have done to bring us to this hour and this place. On behalf of all who serve our Nation's veterans in crisis, we humbly applaud you for what we believe is a defining moment in this Nation's history. I truly believe the entire nation is ready to support you in this cause. Thank you.

[The prepared statement of Mr. Driscoll follows:]

PREPARED STATEMENT OF JOHN A. DRISCOLL, PRESIDENT AND CEO, NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Senator Akaka, Ranking Member Senator Burr, and Distinguished Members of the Committee: The National Coalition for Homeless Veterans (NCHV) is honored to appear before this Committee today to comment on what we believe are two of the most important bills in the history of the homeless veteran assistance movement we represent.

For 20 years, NCHV has worked diligently to serve as the Nation's primary liaison between the community- and faith-based organizations that help homeless veterans, the Congress, and the Federal agencies that are invested in the campaign to end veteran homelessness in the United States. Department of Veterans Affairs (VA) officials have testified before the Congress that this partnership, despite considerable financial pressures due to war and economic uncertainty, is largely responsible for the phenomenal reduction in the number of homeless veterans on the streets of America each night—from about 250,000 in FY 2004 to 131,000 today, according to the annual VA Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) Reports.

The VA and U.S. Department of Labor, through some of the most innovative and successful grant programs in the Federal arsenal, have jointly nourished a nationwide, community-based homeless veteran assistance network that provides transitional housing and services support for more than 100,000 veterans each year. The U.S. Department of Housing and Urban Development has become the third critical partner in this campaign through the HUD-VA Supportive Housing Program (HUD-VASH) for veterans with serious mental illness and other disabilities, and by incentivizing the inclusion of homeless and extreme low-income veterans in local Continuum of Care funding applications.

The success of these Federal agencies and the community- and faith-based service partners NCHV represents over the last five years offers proof that the campaign to end veteran homelessness can be won. The President has established this as a priority of his Administration; and VA Secretary Eric Shinseki is mobilizing his Department to strengthen its intervention programs and expand its support of local prevention strategies.

S. 1237—HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009

One of the most daunting challenges in the campaign to end veteran homelessness is presented by the changes in the demographics of this special needs population. For the first time in American history, women comprise more than 11% of the forces deployed to serve in the wars in Iraq and Afghanistan, according to Department of Defense (DOD) figures early this year, including more than 30,000 single women with dependent children (DOD, March 2009). The VA anticipates women will account for 15% of the Nation's veterans within the next 10 years.

Because of the Nation's reliance on Reserve and National Guard personnel, men and women must leave their families at the highest rate since World War II—approximately half of them for multiple deployments. This places considerable strain on family relationships, which in turn makes the difficult process of readjustment to civilian life after wartime service even more stressful.

Currently more than 5% of veterans requesting assistance from VA and community-based homeless veteran service providers are women. According to VA officials, more than half of these veterans are between the ages of 20–29, a majority represent minority communities, and roughly 24% are disabled or were medically retired from the service. More than 10% of these women have dependent children.

Senators Murray, Johnson and Reed, in introducing this bill, recognize the same readjustment difficulties for single women veteran parents are experienced by single male parents. During the last two years, more than 11% of male veterans receiving housing vouchers in the HUD-VASH program are single parents with dependent children.

According to VA data in its annual CHALENG Reports, the highest unmet needs of homeless single veterans with dependent children are:

- Child care assistance
- Legal aid for credit repair and child support issues
- Access to affordable permanent housing

S. 1237 would authorize up to $10 million in grants to community- and faith-based organizations to provide critical, specialized supports for these deserving men and women as they work their way out of homelessness. There are about 200 homeless veteran assistance providers under the VA Homeless Providers Grant and Per Diem Program (GPD) that offer housing assistance for women veterans. More than 90 community-based programs offer job preparation and placement assistance to homeless veterans under the Homeless Veterans Reintegration Program—one of the most efficient, effective programs in the Department of Labor portfolio.

These programs provide irrefutable evidence that stable, safe transitional housing—with access to health and employment services—empowers the great majority of homeless veterans to achieve self-sufficiency within their eligibility limits. The addition of child care assistance promises to enhance those successful outcomes

through supports that will enable veteran parents to pursue their employment goals without having to worry about the health and safety of their children.

NCHV believes this funding level would allow for immediate implementation of an employment assistance program for single parents with dependent children within an existing and highly successful service provider community, and allow for evaluation of the effectiveness of this innovative strategy. We strongly urge the Committee to champion this cause in the 111th Congress for the sake of our Nation's veterans in crisis, and for their families.

S. 1547—ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009

For several years the homeless veteran assistance movement NCHV represents has realized there can be no end to veteran homelessness until we, as a Nation, develop a strategy to address the needs of our former guardians before they become homeless—victims of health and economic misfortunes they cannot overcome without assistance.

The causes of all homelessness can be grouped into three primary categories: health issues, economic issues, and lack of access to safe, affordable housing for low and extreme-low income families in most American communities. This has been a chronic problem since the birth of the Great Society during the Johnson administration.

The additional stressors veterans experience are prolonged separation from family and social support networks while engaging in extremely stressful training and occupational assignments; war-related illnesses and disabilities—both mental and physical; and the difficulty of many to transfer military occupational skills into the civilian workforce.

NCHV believes the Zero Tolerance for Veteran Homelessness Act of 2009, introduced by Senators Reed, Bond, Murray, Johnson, Kerry and Durbin—with the support of 12 cosponsors—has the potential to set this Nation on course to finally achieve victory in the campaign to end veteran homelessness in the United States.

Victory in this campaign requires success on two fronts—effective, economical intervention strategies that help men and women rise above adversity to regain control of their lives; and prevention strategies that empower communities to support our wounded warriors and their families before they lose their ability to cope with stressors beyond their control.

We believe the Zero Tolerance for Veteran Homelessness Act addresses needs on both fronts.

- The Act provides for the expansion of HUD-VASH to a total of 60,000 housing vouchers for veterans with serious mental and emotional illnesses, other disabilities, and extreme low-income veteran families that will need additional services to remain housed. According to an analysis of data by the National Alliance to End Homelessness, about 63,000 veterans can be classified as chronically homeless. This Act would, therefore, effectively end chronic veteran homelessness within the next five years.
- The Act provides authorization for up to $50 million annually to provide supportive services for low-income veterans to reduce their risks of becoming homeless, and to help those who are find housing. Provisions include short- to medium-term rental assistance, poor credit history repair, housing search and relocation assistance, and help with security and utilities deposits. For many among the Nation's 630,000 veterans living in extreme poverty (at or below 50% of the Federal poverty level), this aid could mean the difference between achieving stability and continuing on the downward spiral into homelessness.
- The Act would modernize the extremely important and successful VA Grant and Per Diem Program (GPD) to allow for the utilization of innovative project funding strategies—including the use of low-income housing tax credits and matching funds from other government sources to facilitate and hasten project development.
- The Act calls for the Secretary of Veterans Affairs to study the method of reimbursing GPD community providers for their program expenses and report to Congress, within one year, his recommendations for revising the payment system. For years service providers have appealed for a system that reflects the actual cost of providing services to veterans with multiple barriers to recovery rather than a "per diem" rate based on reimbursements paid to state veterans' homes.
- The Act calls for an increase in the annual GPD authorization to $200 million, beginning in FY 2010, which could provide additional funds for outreach through community-based veteran service centers and mobile service vans for rural areas, while continuing to increase the bed capacity of VA's community-based partners. These outreach initiatives will likely play a pivotal role as the VA's veteran homelessness prevention strategy moves forward.

• The Act would establish within HUD a Special Assistant for Veterans Affairs to ensure veterans have access to housing and homeless assistance programs funded by the Department.

SUMMATION

The homeless veteran assistance movement NCHV represents is now 20 years old, but much of the success we have seen in reducing the number of homeless veterans has been realized in just the last decade. The partnership between the Departments of Veterans Affairs, Labor and Housing and Urban Development, and our 1,600 community- and faith-based associates has presented this Nation with the infrastructure necessary to end veteran homelessness through innovative intervention programs and low-level supports that can serve as the foundation for a nationwide prevention strategy.

Never before in the history of this Nation have we been better prepared to support the men and women who serve in harm's way to preserve our freedom and prosperity. The Zero Tolerance for Veteran Homelessness Act of 2009 represents a historic opportunity to ensure that those who sacrifice some measure of their lives to serve our country will not be abandoned in their greatest hour of need.

We owe the Committee a great debt of gratitude for bringing us to this hour and place, where we can focus on prevention far wiser than we were when the campaign to end veteran homelessness began. On behalf of all who serve our Nation's veterans in crisis, we humbly applaud you for bringing us to this moment in history, and express profound appreciation and gratitude for your leadership.

Chairman AKAKA. Thank you very much, Mr. Driscoll.

Now, we will receive the statement of Dr. Rick McMichael.

STATEMENT OF RICK McMICHAEL, D.C., PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION

Dr. MCMICHAEL. Chairman Akaka, Ranking Member Burr, Members of the Committee, I am Rick McMichael, a Doctor of Chiropractic from Canton, Ohio, and current President of the American Chiropractic Association. On behalf of the ACA, I thank you for providing an opportunity to testify today in support of S. 1204, the Chiropractic Care Available to All Veterans Act.

The ACA provides professional and educational opportunities for Doctors of Chiropractic, supports research, and offers leadership for the advancement of the profession. ACA promotes the highest standards of ethics and patient care, contributing to the health and well-being of millions of chiropractic patients.

The ACA wholeheartedly supports S. 1204, as introduced by Senator Patty Murray, and believes it will assist veterans in receiving quality care, especially for the treatment of very prevalent musculoskeletal injuries and conditions. Painful and disabling joint and back disorders continue to be reported as the top health problems of veterans returning from Iraq and Afghanistan, according to Department of Veterans Affairs statistics. The most recent numbers from VA now show that over half of our returning veterans seek VA care due to musculoskeletal ailments.

Chiropractic benefit had theoretically been available within the VA system for many years, but Congress took action when it became apparent the VA had failed to take any reasonable steps to provide veterans with chiropractic care. As a result of legislation in the 107th and 108th Congress, as well as recommendations issued by a Congressionally-mandated advisory committee of which I was a member, the VA now provides chiropractic care at 36 major treatment facilities in the U.S. Doctors of Chiropractic practicing at these VA facilities have become an integrated part of the VA health

care team and regard it as a valuable source of safe and effective care for veterans.

Speaking with Dr. Cross a little bit earlier, we agreed that chiropractic services have been a positive addition to the VA health care team and that the VA is supporting that process and that integration of chiropractic.

By all accounts, the care provided by DCs in the VA produces positive outcomes and high levels of patient satisfaction and is cost efficient. In addition, Doctors of Chiropractic bring new ideas and viewpoints to patient-centered care, clinical research, and education. These new perspectives help strengthen the VA and the care of veterans.

Despite this progress, the overwhelming majority of America's eligible veterans continue to be denied access to chiropractic care because the VA has not taken steps to provide these services at approximately 120 additional major VA facilities. Detroit, Denver, and Chicago are just a few examples of major metropolitan areas still lacking a Doctor of Chiropractic at the local VA medical facility. In my home State of Ohio, the only VA site that offers chiropractic care is the Columbus facility. There is another that is looking to be stood up in Dayton, but major health care facilities of the VA in Chillicothe, Cincinnati, and Cleveland still do not employ DCs, and veterans in those areas are limited to chiropractic care via outside referrals, which are spotty, at best. I frequently take calls from our doctors across the country asking how they can get their veteran patients referred for chiropractic care, and it is not a simple process in many cases.

As referenced earlier, in a VA report released just this month, with 52 or nearly 52 percent of veterans returning from Iraq and Afghanistan seeking care at the VA for musculoskeletal ailments, we need to remember that Doctors of Chiropractic offer expert conservative care for many of these ailments, commonly caused by injuries in combat, heavy gear, motor vehicle accidents, and blast injuries. Clearly, the need for expanded access to Doctors of Chiropractic and our high-touch care has never been more crucial. Without a Congressional directive, further expansion to VA facilities will happen only on a case-by-case basis and more than likely will be excruciatingly slow.

Veterans want, need, and deserve access to chiropractic care and our goal should be to ensure that chiropractic is available and accessible at every major VA health care facility. The chiropractic profession welcomes the opportunity to serve our Nation's veterans. It is an honor to serve those who have given so much for us.

Passage of the Chiropractic Care Available to All Veterans Act will ensure that our veterans receive the highest level of care possible. The American Chiropractic Association urges Congress to pass this legislation immediately.

I thank the Chairman for the opportunity to testify today and look forward to any questions from the Committee. Thank you.

[The prepared statement of Dr. McMichael follows:]

PREPARED STATEMENT OF RICK MCMICHAEL, DOCTOR OF CHIROPRACTIC AND PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION

IN SUPPORT OF S. 1204, THE CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT

Chairman Akaka, Ranking Member Burr, and Members of the Committee: I am Dr. Rick McMichael, a Doctor of Chiropractic from Canton, Ohio, and current President of the American Chiropractic Association. On behalf of the ACA, I thank you for providing an opportunity to testify today in support of S. 1204, the Chiropractic Care Available to All Veterans Act.

The ACA provides professional and educational opportunities for doctors of chiropractic, supports research, and offers leadership for the advancement of the profession. ACA promotes the highest standards of ethics and patient care, contributing to the health and well-being of millions of chiropractic patients.

The ACA wholeheartedly supports S. 1204, as introduced by Senator Patty Murray, and believes it will assist veterans in receiving quality care, especially for the treatment of very prevalent musculoskeletal injuries and conditions. Painful and disabling joint and back disorders continue to be reported as the top health problems of veterans returning from Iraq and Afghanistan, according to Department of Veterans Affairs' statistics. The most recent numbers from the VA now show that over half of our returning veterans seek VA care due to musculoskeletal ailments.[1]

A chiropractic benefit has theoretically been available within the VA system for many years, but Congress took action when it became apparent that VA had failed to take any reasonable steps to provide veterans with chiropractic care. As a result of legislation in the 107th and 108th Congress,[2] as well as recommendations issued by a congressionally mandated advisory committee—of which I was a member—the VA now provides chiropractic care, at 36 major VA treatment facilities within the United States.

Doctors of chiropractic, practicing at these VA facilities, have become an integrated part of the VA health care team and are regarded as a valuable source of safe and effective care for veterans.

By all accounts, the care provided by DCs in the VA produces positive outcomes and high levels of patient satisfaction, and is cost-efficient. Additionally, doctors of chiropractic bring new ideas and viewpoints to patient-centered care, clinical research and education. These new perspectives help strengthen the VA and care of veterans.

Despite this progress, the overwhelming majority of America's eligible veterans continue to be denied access to chiropractic care because the VA has not taken steps to provide these services at approximately 120 additional major VA facilities. Detroit, Denver, and Chicago are just a few examples of major metropolitan areas still lacking a Doctor of Chiropractic at the local VA medical facility. In my home state of Ohio, the only VA site that offers chiropractic care is the facility in Columbus. Another VA facility, Dayton, will soon begin to offer chiropractic services. However, major VA medical centers in Chillicothe, Cincinnati, and Cleveland do not employ DCs, and veterans in those areas are limited to chiropractic care via outside referrals, which are spotty at best.

As referenced earlier, in a VA report released just this month, nearly 52 percent of veterans returning from Iraq and Afghanistan, who have sought VA health care, were treated for musculoskeletal ailments—the top complaint of those tracked for the report. Doctors of chiropractic offer expert conservative care for many of these ailments, commonly caused by injuries from combat, heavy gear, motor vehicle accidents, and blast injuries. Clearly, the need for expanded access to doctors of chiropractic and their high-touch care has never been more crucial. Without a congressional directive, further expansion to VA facilities will happen only on a case-by-case basis and more than likely will be excruciatingly slow.

Veterans want, need and deserve access to chiropractic care, and our goal should be to ensure that chiropractic is available and accessible at every major VA health care facility. The chiropractic profession welcomes the opportunity to serve our Nation's veterans. It is an honor to serve those who have given so much for us.

Passage of the Chiropractic Care Available to All Veterans Act will ensure that our veterans receive the highest level of care possible. The American Chiropractic Association urges Congress to pass this legislation immediately. I thank the Chairman for the opportunity to testify today, and look forward to any questions from the Committee.

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[1] Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism Veterans, Oct. 2009

[2] Public Law 107–135 and Public Law 108–170

Chairman AKAKA. Thank you very much, Dr. McMichael.
Dr. Fenn, your statement.

STATEMENT OF WILLIAM FENN, PH.D., P.A., VICE PRESIDENT, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Mr. FENN. Good morning. Chairman Akaka, Ranking Member Burr, and other Members of the Committee on Veterans' Affairs. Mahalo and thank you for inviting the American Academy of Physician Assistants to present testimony on S. 1155, a bill to establish a full-time Director of Physician Assistant Services within the Office of the Under Secretary of Veterans Affairs for Health.

My name is Bill Fenn and I am a PA. I am also Vice President of the American Academy of PAs and currently a PA professor at Western Michigan University. I received my education as a PA in the U.S. Air Force where I ultimately retired as a Lieutenant Colonel. I am also personally familiar with the VA from two fronts. Since I have an active duty-related disability, I have, from time to time, received care from the VA. In addition to being a patient, I have also been employed as a clinician through the VA, working in one of the first VA rural health demonstration programs.

The AAPA represents more than 75,000 clinically practicing PAs in the United States. My testimony today also represents the views of the Veterans Affairs Physician Assistant Association, which represents PAs who are employed by the Department of Veterans Affairs.

AAPA and VAPAA are very appreciative of Senators Susan Collins and Daniel Inouye for their leadership in introducing this important legislation and we thank Members of the Committee who have added their names as cosponsors or indicated their support for the legislation. We also thank the many Veterans Service Organizations who have urged passage of this important legislation.

We believe that enactment of S. 1155 is essential to improving patient care for our Nation's veterans, ensuring that the nearly 1,900 PAs employed by the VA are most appropriately utilized.

PAs are fully integrated into the health care systems of the Armed Services and virtually all other public and private health care systems. PAs are on the front line in Iraq and providing immediate medical care for wounded members of the Armed Forces. They provide care in all levels of medical facilities throughout the military, and are covered providers in TRICARE.

In the civilian world, PAs work in virtually every area of medicine and surgery and are covered providers within the overwhelming majority of public and private health insurance plans. PAs play a key role in providing medical care in medically underserved communities. In some rural communities, in fact, the PA is the only health care professional available.

Currently, each branch of the Armed Services designates a PA Consultant to their Surgeon General, and many major medical institutions credit their integration of PAs into an effective workforce to a Director of PA Services. To name just a few, the Cleveland Clinic, Geisinger Clinic, the University of Texas M.D. Anderson Cancer Center, and New Orleans Oschner Clinic Foundation all have Directors of PA Services. We believe that what works for the

Armed Services and the private sector will also work well for the VA.

Approximately 40 percent of PAs currently employed by the VA are eligible for retirement in the next 5 years and the VA is simply not competitive with the private sector for new graduates. The U.S. Bureau of Labor Statistics, *U.S. News and World Report*, and *Money Magazine* all speak to the growth, demand, and value of the PA profession. In fact, recently, *Money Magazine* ranked the PA profession as its number 2 best job. Recruitment and retention of non-physician patient care providers, especially physician assistants, will be critical to meeting VA's primary care and other patient care needs.

We consider the Director of PA Services to be essential for VA recruitment and retention. We believe that the VA should formally designate PAs alongside physicians and nurses as critical occupations. This designation would allow priority in scholarships and loan repayment programs that are not currently available to PAs. Additionally, we believe that PAs should also be included in VA special locality pay bands so PA salaries may be regularly tracked and reported accurately by the VA.

The current position of PA Advisor to the Under Secretary for Health has been filled as a part-time field position with no designated administrative support. Prior to the law requiring the PA Advisor in 2000, the VA had never had a representative within VHA with sufficient knowledge of the PA profession. This lack of knowledge resulted in an inconsistent approach toward PA practice and underutilization of PA skills and abilities.

Although the PAs who have served as the VA's part-time field-based PA Advisor have indeed made progress on the utilization of PAs within that agency, there continues to be inconsistency in the way that local medical facilities use PAs and barriers to quality care delivery by PAs. The Academy believes that the elevation of the PA Advisor to a full-time Director of PA Services, located and accessible in the VA central office, consistent with the professions of similar size and scope, is necessary to increase veterans' access to quality medical care by ensuring efficient utilization of PAs in VHA patient care programs and initiatives.

PAs are a valuable resource in the transition from active duty to veterans health care. As health care professionals with a long-standing history of providing care in medically underserved communities, PAs also provide an invaluable link in enabling veterans who live in underserved communities to receive timely access to quality medical care.

Thank you very much for the opportunity to testify in support of this important legislation, S. 1155. Both AAPA and VAPAA are eager to work with the Committee on Veterans' Affairs to improve the availability and quality of medical care to our Nation's veteran population.

I would be happy to provide additional information on our profession and/or respond to any questions you might have.

[The prepared statement of Mr. Fenn follows:]

PREPARED STATEMENT OF WILLIAM FENN, PH.D., PHYSICIAN ASSISTANT, AND VICE PRESIDENT, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS AND REPRESENTING VETERANS AFFAIRS PHYSICIAN ASSISTANT ASSOCIATION

Good morning, Chairman Akaka, Ranking Member Burr, and other Members of the Committee on Veterans' Affairs, thank you for inviting the American Academy of Physician Assistants to present testimony on S. 1155, a bill to amend title 38, United States Code, to establish the position of Director of Physician Assistant Services within the office of the Under Secretary of Veterans Affairs for Health.

My name is Bill Fenn. I'm a physician assistant, and I'm Vice President of the AAPA. I received my training as a physician assistant while I was in the Air Force. I'm familiar with the VA from two fronts. Since I have an active-duty related disability, I have received care, from time to time, from the VA. In addition to being a patient, I've also been employed as a clinician through the VA. I worked in one of the first VA rural health demonstration programs.

The AAPA represents the more than 75,000 clinically practicing physician assistants in the United States. My testimony today also represents the views of the Veterans Affairs Physician Assistant Association. The VAPAA represents physician assistants who are employed by the Department of Veterans Affairs.

AAPA and VAPAA are very appreciative of Senators Susan Collins and Daniel Inouye for their leadership in introducing this important legislation. We thank Members of the Committee who have added their names as cosponsors and/or have indicated their support for the legislation. And, we also thank the veteran service organizations who have urged passage of S. 1155. (The annual Veteran Service

Organizations Independent Budget, endorsed by 35 professional and veteran service organizations, has recommended enactment of this legislation.)

AAPA and VAPAA believe that enactment of S. 1155 is essential to improving patient care for our Nation's veterans, ensuring that the nearly 1,900 PAs employed by the VA are fully utilized and removing unnecessary restrictions on the ability of PAs to provide medical care in VA facilities. Additionally, the associations believe that enactment of S. 1155 is necessary to advance recruitment and retention of PAs within the Department of Veterans Affairs.

Physician assistants are licensed health professionals, or in the case of those employed by the Federal Government, credentialed health professionals, who—

- practice medicine as a team with physicians
- exercise autonomy in medical decisionmaking
- provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting laboratory tests, diagnosing and treating illnesses, suturing lacerations, assisting in surgery, writing prescriptions, and providing patient education and counseling
- may also work in educational, research, and administrative settings.

Physician assistants' educational preparation is based on the medical model. PAs practice medicine as delegated by and with the supervision of a physician. Physicians may delegate to PAs those medical duties that are within the physician's scope of practice and the PA's training and experience, and are allowed by law. A physician assistant provides health care services that were traditionally only performed by a physician. All states, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. AAPA estimates that in 2008, over 257 million patient visits were made to PAs and approximately 332 million medications were prescribed or recommended by PAs.

The PA profession has a unique relationship with veterans. The first physician assistants to graduate from PA educational programs were veterans, former medical corpsmen who had served in Vietnam and wanted to use their medical knowledge and experience in civilian life. Dr. Eugene Stead of the Duke University Medical Center in North Carolina put together the first class of PAs in 1965, selecting Navy corpsmen who had considerable medical training during their military experience as his students. Dr. Stead based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II. Today, there are 142 accredited PA educational programs across the United States. Nearly 1,900 PAs are employed by the Department of Veterans Affairs, making the VA the largest single employer of physician assistants. These PAs work in a wide variety of medical centers and outpatient clinics, providing medical care to thousands of veterans each year. Many are veterans themselves.

Physician assistants (PAs) are fully integrated into the health care systems of the Armed Services and virtually all other public and private health care systems. PAs are on the front line in Iraq and Afghanistan, providing immediate medical care for wounded men and women of the Armed Forces. They provide care in all levels of medical facilities throughout the military. PAs are covered providers in TRICARE.

In the civilian world, PAs work in virtually every area of medicine and surgery and are covered providers within the overwhelming majority of public and private health insurance plans. PAs play a key role in providing medical care in medically underserved communities. In some rural communities, a PA is the only health care professional available.

Why are PAs so fully integrated into most public and private health care systems? We believe it's because they foster the use and inclusion of their PA workforce. Each branch of the Armed Services designates a PA Consultant to the Surgeon General. And, many major medical institutions credit their integration of PAs in the workforce to a Director of PA Services. To name just a few, the Cleveland Clinic, the Geisinger Clinic, the University of Texas MD Anderson Cancer Center, and New Orleans' Ochsner Clinic Foundation all have Directors of PA Services. We believe that what works for the Armed Services and the private sector will also work for the VA.

How does the lack of a Director of PA Services at the VA relate to recruitment and retention of the VA workforce? As far as the AAPA can tell, there are no recruitment and retention efforts aimed toward employment of physician assistants in the VA. The VA designates physicians and nurses as critical occupations, and so priority in scholarships and loan repayment programs goes to nurses, nurse practitioners, physicians, and other professions designated as critical occupations. The PA profession has not been determined to be a critical occupation at the VA, so monies are not targeted for their recruitment and retention. PAs are not included in any of the VA special locality pay bands, so PA salaries are not regularly tracked and reported by the VA. We've been told that this has resulted in lower pay for PAs employed by the VA than for health care professionals who perform similar medical care. Why are PAs not considered a critical occupation at the VA? Is it possible they were overlooked, because there was no one to raise the issue?

The outlook for PA employment at the VA does not differ from that for nurse practitioners and physicians. Approximately forty percent of PAs currently employed by the VA are eligible for retirement in the next five years, and the VA is simply not competitive with the private sector for new PA graduates. The U.S. Bureau of Labor Statistics, *US News and World Report*, and *Money* magazine all speak to the growth, demand, and value of the PA profession. In fact, *Money* magazine recently ranked the PA profession as its #2 best job. The challenge for the VA is that the growth and demand for PAs is in the private sector, not the VA.

Despite the fact that the VA PA workforce has risen by 19% in the last 5 years, the PA percentage of the VHA mid-level practitioner workforce has dropped to 30%. We believe that this directly relates to recruitment and retention.

The VA has acknowledged that an increasing physician shortage, especially in primary care, is expected at a time when the number of VA patients is expected to increase significantly. Recruitment and retention of non-physician patient care providers, especially, physician assistants, will be critical to meeting VA's patient care needs. Stationing the PA Advisor in the field creates a barrier to effectively addressing VA recruitment and retention issues, as well as to ensuring patient care initiatives and policies do not create additional, unintended barriers to optimal utilization of PAs.

According to the AAPA's 2008 Census Report, PA employment in the Federal Government, including the VA, continues to decline. AAPA's Annual Census Reports of the PA Profession from 1991 to 2008 document an overall decline in the number of PAs who report Federal Government employment. In 1991, nearly 22% of the total profession was employed by the Federal Government. This percentage dropped to approximately 9% in 2008. New graduate census respondents were even less likely to be employed by the government (17% in 1991 down to 5% in 2008).

Unless some attention is directed toward recruitment and retention for PAs, the AAPA believes that the VA is in danger of losing its PA workforce. This is particularly critical because it is happening at a time when the U.S. and the VA are facing a primary care workforce shortage. The elevation of the PA Advisor to a full-time Director of PA Services in the VA Central Office is the first step in focusing the VA's efforts on recruitment and retention of PAs.

The current position of Physician Assistant (PA) Advisor to the Under Secretary for Health was authorized through section 206 of Public Law 106–419 and has been filled as a part-time, field position. The position functions without any designated administrative support. Prior to Public Law 106–419, the VA had never had a representative within the Veterans Health Administration with sufficient knowledge of the PA profession to advise the Administration on the optimal utilization of PAs. This lack of knowledge resulted in an inconsistent approach toward PA practice, unnecessary restrictions on the ability of VA physicians to effectively utilize PAs, and an under-utilization of PA skills and abilities. The PA profession's scope of practice was not uniformly understood in all VA medical facilities and clinics, and unneces-

sary confusion existed regarding such issues as privileging, supervision, and physician countersignature.

The PA Advisor currently reports to the Chief Consultant for Primary Care. The numbers of VA PAs of PAs practice in all disciplines of medicine in VHA, it is reasonable that the Director of PA Services report to the Under Secretary for Health. This reporting mechanism would be consistent with all other Federal agencies and the Department of the Defense.

Although the PAs who have served as the VA's part-time, field-based PA Advisor have made progress on the utilization of PAs within the agency, there continues to be inconsistency in the way that local medical facilities use PAs. In one case, a local facility decided that a PA could not write outpatient prescriptions, despite licensure in the state allowing prescriptive authority. In other facilities, PAs are told that the VA facility cannot use PAs and will not hire PAs. These unfortunately common events are not based on any cohesive policy decision, but rather, a lack of appropriate PA utilization input at the Central Office level. These restrictions needlessly hinder PA employment within the VA, as well as deprive veterans of the skills and medical care PAs have to offer.

The Academy also believes that the elevation of the PA Advisor to a full-time Director of Physician Assistant Services, located in the VA central office, is necessary to increase veterans' access to quality medical care by ensuring efficient utilization of the VA's PA workforce in the Veterans Health Administration's patient care programs and initiatives. PAs are key members of the Armed Services' medical teams but are an underutilized resource in the transition from active duty to veterans' health care. As health care professionals with a longstanding history of providing care in medically underserved communities, PAs may also provide an invaluable link in enabling veterans who live in underserved communities to receive timely access to quality medical care.

Thank you very much for the opportunity to testify in support of S. 1155. Both AAPA and VAPAA are eager to work with the Committee on Veterans Affairs to improve the availability and quality of medical care to our Nation's veteran population.

Chairman AKAKA. Thank you very much, Dr. Fenn.

Dr. Cross has testified that VA intends to make the current Director of PA Services full-time and to locate the position in the central office. Would this address your concerns?

Mr. FENN. Mr. Chairman, that certainly would represent a step forward and is a positive statement. However, such an action remains a discretionary action and we believe that the importance of this position in ensuring efficient and effective care is indeed too important to be discretionary and needs to be established by directive of Congress.

Chairman AKAKA. Mr. DePlanque and Mr. Jackson, VA has a directive providing for—let me come back to voter registration, education, and participation. Do you find this directive insufficient? Mr. Jackson?

Mr. JACKSON. Could you repeat that question, Mr. Chairman? I want to make sure I understand it correctly.

Chairman AKAKA. Yes. VA has a directive providing for voter registration, education, and participation. My question is, do you find this directive insufficient?

Mr. JACKSON. I don't think I can answer that. I can get back to you with it in writing. But I can say first, we support the legislation; second, we believe the VA needs to do more to make voting and registration much easier for patients and people using the facilities.

Chairman AKAKA. Thank you. As you know, it was presented by the doctor here.

Mr. DePlanque?

Mr. DEPLANQUE. I would generally state, we support the legislation. We think it is an important step forward and we believe that

veterans, specifically, as it is cited in the bill, have unique qualifications. Understanding a number of the aspects of the political system and the direct impact of those things, we think those are important.

As to the specifics or a more detailed answer on what is and isn't addressed by the present state of affairs if this did not pass, again, I would have to defer to giving you a more detailed answer, but we would be happy to provide one in writing.

Chairman AKAKA. Please respond at a future date.

[This information was received and is being held in Committee files.]

Chairman AKAKA. Dr. McMichael, do you know of specific cases where veterans have sought chiropractic care and had been denied that care under the current system? If so, could you tell us about these cases?

Dr. MCMICHAEL. Thank you, Mr. Chairman. I have been made aware of numerous cases across the country. As to exact names and so forth, we could certainly attempt to get those for you. But there are many varied cases where veterans have been under chiropractic care or other forms of care within and outside the VA for years and have been unsuccessful at getting results with their pain levels and function, so they have requested referrals and have been unable to get those. So, the Doctors of Chiropractic will call me and ask if I can help them get that done. Usually, I try to refer them to their VA advocate at the site, but sometimes that is not getting the job done, either.

Chairman AKAKA. Well, will you please respond to this in the future.

[This information was received and is being held in Committee files.]

Chairman AKAKA. Mr. Driscoll, of the many women veterans requesting assistance from VA and community-based homeless veteran service providers, how many of them have dependent children?

Mr. DRISCOLL. Approximately 10 percent of the women who have requested homeless assistance have dependent children, and 11 percent of single parent males in the HUD-VASH programs.

Chairman AKAKA. Having to do with salaries, Dr. Fenn, how do VA's salaries and benefits for PAs compare with the private sector?

Mr. FENN. Mr. Chairman, I have some selected information I can give you today. I would be happy to have our Academy prepare a more detailed analysis across the board.

Perhaps the most important salaries in this time of growing demand are the entry-level salaries. The information we have currently is that the average salary for entry-level PAs in the VA is approximately $62,000. It goes as low as $47,000. That compares to entry-level salaries for other non-physician providers of the VA of $75,000 and an overall entry-level salary for PAs in the non-VA civilian world of approximately $74,500. But again, we will prepare a more detailed response and provide it promptly.

Chairman AKAKA. Thank you very much for that response.

Mr. Driscoll, do you have any estimates on how many service providers have to turn away homeless women veterans or homeless

veterans with dependent children because they cannot meet their needs?

Mr. DRISCOLL. I don't have actual numbers, but I could suggest to the Committee that that is precisely the intent of this bill, because heretofore, males or females with dependent children have had virtually no access to supportive services and transitional housing where they can stay connected with their dependent children.

Chairman AKAKA. Thank you. Will you please provide that.

[The response for the record follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO JOHN A. DRISCOLL, PRESIDENT AND CEO, NATIONAL COALITION FOR HOMELESS VETERANS

Question. Do you have any estimates on how many service providers have to turn away homeless women veterans or homeless veterans with dependent children because they cannot meet their needs?

Response. Approximately 200 of the 500 community-based organizations funded through the VA Homeless Providers Grant and Per Diem Program offer transitional housing and services to homeless women veterans, which means 60% of those programs must refer women veterans to other community programs. Of the 100,000 homeless veterans who receive help from VA-funded homeless programs each year, approximately 5,400 are women. Of those, 10%—or approximately 540—have dependent children.

Under current law, the VA is not allowed to provide direct services to the dependent children of single parent veterans. Therefore, virtually all VA Grant and Per Diem Program service providers must make other housing arrangements or find other funding for homeless women parents and single parent veterans with dependent children to keep families together. Only 7 Grant and Per Diem Programs currently have the capacity to serve women veterans with dependent children. The primary purpose of S. 1237 is to authorize both the VA and Department of Labor to provide assistance to single veterans and their dependent children, with funding dedicated for employment supports that—for the first time in U.S. history—include child care assistance.

Chairman AKAKA. Mr. Jackson, the *Independent Budget* VSOs, including VFW, supported consolidating VA contracts. Do you think this legislation would help to accomplish this goal? Why or why not?

Mr. JACKSON. I think it is probably a good step forward. I will refer to page 81 of the *Independent Budget* 2010, where we talk about centralizing the contract process. I think this bill probably gets us close, but we would probably want this Committee and VA to look a little bit broader range of solutions to the problem.

Chairman AKAKA. Mr. Driscoll, you stated in your testimony that 11 percent of male veterans receiving housing vouchers in the HUD-VASH program are single parents with dependent children.

Mr. DRISCOLL. Yes, sir.

Chairman AKAKA. Do you have any idea of how many we are talking about?

Mr. DRISCOLL. I could get that exact number for you. I believe the number is somewhere here, but rather than take a guess, I will get that exact number to you. We are in the second phase of the next 10,000 HUD-VASH vouchers which are being implemented now. I believe the number from the first 10,000 in fiscal year 2008 were in excess of 8,000 that have been allocated. So, if that gives you some sense——

Chairman AKAKA. Fine.

[The response for the record follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO JOHN A. DRISCOLL, PRESIDENT AND CEO, NATIONAL COALITION FOR HOMELESS VETERANS

Question. Mr. Driscoll, you stated that 11 percent of male veterans receiving housing vouchers in the HUD-VASH programs are single parents with dependent children. Do you have any idea how many we are talking about?

Response. Mr. Chairman, after conferring with VA homeless program officials, I need to correct my statement. The most recent information from VA shows that of first round of 10,000 HUD-VASH vouchers, approximately 8,000 have been allocated, with all 10,000 expected to be under lease by the end of 2009. Approximately 10% of those are being assigned to women veterans, and about 10% of ALL homeless veterans receiving HUD-VASH vouchers will be single parents with dependent children. This means approximately 900 of the first 10,000 HUD-VASH vouchers will be assigned to single male veterans with dependent children. The number will fluctuate some as veterans eligible for vouchers are actually placed in housing, but the VA expects the number of homeless single parents with dependent children receiving HUD-VASH vouchers to remain at that 10% level through the second round of 10,000 voucher allocations.

Chairman AKAKA. Mr. Jackson and Mr. DePlanque, according to the Congressional Budget Office, nearly 80 percent of enrolled veterans have access to other health care coverage. What impact do you think quality report cards will have on whether a veteran decides to get health care in VA? Mr. DePlanque?

Mr. DEPLANQUE. Well, on the one hand, I would actually say that in a large number of areas, VA health care and the service that they are providing is still—with areas that need to be addressed—is still excellent health care that in many cases can be better than the private health care that is out there. So, in some ways it is encouraging to get veterans to take advantage of the health care that is trying to be provided for them. In areas where they were not being as well served, it is also important to identify that.

I think, also, in terms of identifying individual areas, centers, so forth, and pointing out where the weak points are, grades—getting a failing grade is an opportunity for an improvement. That is a way to identify where you are weak and work at making you stronger. It is possible for a kid to get straight A's in school, and they should strive for that. If you have something that is very simply codified that is easy to understand by veterans, then they will be able to take advantage of that. It will also enable VA to determine where they need to address the most work and bring them all up to the A level which they should be providing.

Mr. JACKSON. I agree with Ian. Any time that you can have a standard to shoot for—as far as providing health care, quality health care for veterans—I think that is really important. It allows veterans to make choices on their own, as well. So, I agree with everything that Ian just said.

Chairman AKAKA. Thank you.

Mr. Jackson and Mr. DePlanque, have you heard from any of your members about veterans who have been exposed to chemical toxins and then denied health care by VA? We have held a hearing here on exposures.

Mr. JACKSON. Yes, Mr. Chairman. Nothing has come across my desk about that. That is not to say that it hasn't taken place.

Chairman AKAKA. Any comment?

Mr. DEPLANQUE. Mr. Chairman, I don't have anything in terms of any hard and fast numbers. We have anecdotal accounts of

servicemembers who were exposed to things and have difficulty, as often happens with any sort of thing where getting a direct connection made between being exposed—say, at Johnson Island or some other venue—to something, and then getting the medical science to align with a specific condition.

There are numerous anecdotal occurrences of people who struggle from a wide variety of environmental hazards. Specifically on this, I couldn't break it down into any numbers, though, other than to say that this—and environmental hazards in particular are an area that our veterans have often had a hard time getting the connection that they need through—which is one of the reasons we generally push so hard for presumptions when the medical evidence supports it.

Chairman AKAKA. Mr. Driscoll, from your organization's perspective, what still needs to be addressed in the area of homeless veterans that is not in either of these bills today?

Mr. DRISCOLL. That is a good question. I would hesitate to say that the most critical needs aren't addressed. What I would like to clarify with respect to the Zero Tolerance bill is this is actually what homeless service providers envision as the solution to helping the chronically homeless get access to supportive housing plus the services that will allow them to keep that housing.

If you look at a scale of 60,000 of those veterans in a service provider network which has the capacity to help approximately 100,000 veterans a year, then you could see where 60,000 of them over the next 5 years getting into permanent housing would free up considerable capacity in the infrastructure that helps those veterans who need transitional assistance. We believe that is the solution. And then if you have community-based prevention strategies—which the Zero Tolerance begins to address and fund—that should, hopefully, provide a low-level support of assistance which will prevent most veterans from ever going down that downward spiral toward homelessness.

[The response for the record follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO JOHN A. DRISCOLL, PRESIDENT AND CEO, NATIONAL COALITION FOR HOMELESS VETERANS

Question 3. Mr. Driscoll. From your organization's perspective, what still needs to be addressed in the area of homeless veterans that is not in either of these bills today?

Response. Mr. Chairman, Ranking Member Senator Burr, as I said during my testimony when you first asked that question, "I would hesitate to say that the most critical needs aren't addressed." The proposed build-out of the HUD-VASH program to a level of 60,000 vouchers by FY 2014 would effectively mean the end of chronic homelessness among veterans in this Nation. We believe that act alone would seal for the U.S. Senate in the 111th Congress, and your leadership, a special place of honor in American history.

We would also submit that the HUD-VASH program is, oftentimes, the only assistance available to extreme low-income veteran families who would be homeless without access to this program. It is absolutely critical that the full HUD-VASH build-out prescribed in S. 1547 occurs.

The only thing in the Zero Tolerance for Veteran Homelessness Act [S. 1547] that we would change is the process outlined for revising the payment policy by which community-based service providers are paid for the support they provide to homeless veterans through the Grant and Per Diem Program (GPD).

Under current law, service providers are paid a flat "per diem" rate for each veteran enrolled in their programs, based on the prevailing rate paid to state veteran homes (or domiciliary facilities). VA officials have testified before both the Senate

and the House of Representatives [H.R. 2735] they agree, in principal, that the reimbursement policy needs to be changed to cover the annual cost of services community-based organizations provide to help homeless veterans rebuild their lives rather than a flat rate based on custodial care models.

H.R. 2735 authorizes this change in law immediately. S. 1547 would conditionally support the objective, but gives the VA Secretary a year to study the issue and report his recommendations to the Congress, which could delay action on this critical need for another two to three years.

We respectfully submit this issue has been studied and discussed for more than three years; the community-based service providers NCHV represents and many of our Veteran Service Organization partners support and have testified in favor of this initiative; and VA officials have also testified in support of the intent of S. 1547. We urge this distinguished committee to adopt the language in H.R. 2735 on this issue, and authorize a change in the law. Then, once the Secretary and VA have developed a revised repayment policy, in accordance with the law, they will be able to implement it without delay.

The only other great hope we have is that the Senate will rise up in unity to support the Homes for Heroes Act of 2009. This measure [S. 1160] was first introduced by then-Senator Barack Obama in the 110th Congress, and has been overwhelmingly approved in the House of Representatives [H.R. 403 was approved 417–2].

This bill would provide critical funding for the development of supportive housing and affordable housing units for homeless and extreme low-income veterans in communities where there is a critical shortage of housing options for these deserving men and women. The lack of this type of housing is a chronic problem in many American communities, and has been for many years. We believe the build-out of the HUD-VASH program, as well as the prevention initiatives envisioned in the Zero Tolerance for Veteran Homelessness Act depend, to a large degree, on final approval of the Homes For Heroes Act of 2009.

We recognize the Act will not provide all of the development capital that will ultimately be needed to reach the goals of S. 1547, but it would provide an immediate infusion of public funds that would likely attract private investment dollars, create jobs, and most importantly, address a critical service and prevention need in many communities—safe, affordable housing for disabled and extreme low-income veterans.

In closing, I will once again express my gratitude for the opportunity to speak before the U.S. Senate Committee on Veterans Affairs on behalf of our former guardians who might otherwise have no voice. I was moved by Senator Burr's opening statement in the October 21 hearing; and honored that you, Mr. Chairman, would seek our counsel.

Many of us are veterans, and many have devoted our lives to this work. We would be proud to stand with you as this campaign moves forward.

Chairman AKAKA. Well, I want to thank you all very much; and for some of the questions some of you are willing to provide additional information on, we look forward to receiving. I just want to reemphasize that we are holding these hearings to discuss a wide range of needs that we feel our veterans have and we want to work on them together, and continue to bring sufficient services to help them.

So, I want to thank all of our witnesses for appearing today. As Chairman, I am committed to ensuring that this Committee does all that it can to ensure that veterans and their families receive the benefits and services they have earned. I pledge my continued support for this goal as we move forward together. And I look forward to working with all Members of this Committee as we develop legislation based on today's hearing for a markup later this year. We will also be pressing forward with the critical legislation being held by one member of the Senate, but we hope to get that out.

Again, I want to say thank you for your support in what we are doing.

This hearing is now adjourned.

[Whereupon, at 11:46 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Thank you Mr. Chairman for holding this very important hearing. I want to welcome the witnesses here from the various veterans service organizations, the VA, and the various associations.

I want to thank Chairman Akaka and his staff for continuing to work with my office as you move the larger omnibus veterans bills through the Senate. One of those bills, S. 728, contains two provisions I introduced to double the assistance provided to disabled veterans to purchase and adapt automobiles to accommodate their disabilities and a provision increasing the plot allowances from $300 to $745 with an index to the Consumer Price Index so that the level stays current over the years. I look forward to working with the Chairman to send this bill, and the others that we have completed, to the President for his signature as soon as possible, after completing conference with the House.

Today I want to touch on two pieces of legislation that I have introduced. A third piece of legislation that I introduced a few weeks ago, S. 1752, to add Parkinson's disease to the list of diseases presumed to have been incurred in or aggravated by service in Vietnam due to Agent Orange exposure is no longer necessary and that's good news. As many of my colleagues may know, last week Secretary Shinseki announced that after years of pressure from Veterans groups the VA has decided to accept the connection between Agent Orange exposure and Parkinson's disease, B cell leukemias, and ischemic heart disease. As VA noted in their announcement of the policy change, Agent Orange was "[u]sed in Vietnam to defoliate trees and remove concealment for the enemy" and "left a legacy of suffering and disability that continues to the present. Between January 1965 and April 1970, an estimated 2.6 million military personnel who served in Vietnam were potentially exposed to sprayed Agent Orange."

This policy change means that those veterans who have a presumed illness and served in Vietnam do not need to prove an association between their illness and their military service. I want to congratulate Secretary Shinseki for making this decision which will greatly simplify the application process for veterans and bring them the care they need and deserve. I also want to commend all of the veterans groups that pushed for this change, particularly the Vietnam Veterans of America, for their years of work on this issue.

Let me briefly discuss two other pieces of legislation that I have introduced. They are S. 1753, the Disabled Veteran Caregiver Housing Assistance Act of 2009 and S. 1798, the Automatic Reserve Component Enrollment Act of 2009.

S. 1753 would increase the amount of money a disabled veteran can receive to make physical improvements to accommodate their disabilities at their parent's home if they are living with them. This change to the law is supported by and recommended in the *Independent Budget* and I appreciate the support for this legislation by the American Legion and the VFW in their prepared testimony today. Last Congress I introduced legislation which, with the help of Chairman Akaka, we passed and was signed into law to help increase the amount of money a disabled veteran can receive to make repairs to his or her own home. But as we all know, when many of our younger veterans get injured and come home they live with their parents because they provide an incredibly supportive environment for a veteran to recover. The legislation I have introduced this Congress raises the assistance level from the current amount of $14,000 to $28,000 for veterans with severe service-connected disabilities. For veterans with service-connected blindness only or with loss or loss of use of both upper extremities, this legislation increases the payment from $2,000 to $5,000. Importantly, this legislation includes a cost-of-construction index so that this benefit will remain relevant in the years to come.

The need for this piece of legislation came to my attention when a brave Vermonter, Private First Class Andrew Parker, was injured in a road side bomb attack in Afghanistan and was paralyzed from the chest down. Andrew returned home to Hyde Park, Vermont, to live with his parents but their home needed to be renovated to accommodate his disabilities. In this case, the wonderful Vermont community where Andrew lives, and really the entire state, pitched in to pay for the changes to the home as well as raising $100,000 to help Andrew generally. I commend these efforts but clearly, our government needs to take more responsibility to help pay for these repairs. Not every community will be or can be as generous as this community in Vermont. Current law provides $14,000 and that is just not enough. My legislation would increase the benefit to a reasonable level so that future veterans like Andrew Parker can come home and get the resources they need to make changes to their parent's home.

The second bill I want to discuss is S. 1798, the Automatic Reserve Component Enrollment Act of 2009. I am proud that this legislation has the support of the National Guard Association of the United States and the Paralyzed Veterans of America.

This legislation would require members of the National Guard and Reserve to be automatically enrolled into VA health and dental care programs at discharge or separation from active duty.

As we all know, many members of the Guard and Reserve currently do not enroll in the VA health and dental care programs at demobilization because they are eager to get done with the paper work and see their families. By not signing up at this time, veterans sometimes miss certain windows of enrollment in VA programs such as the 180 day window after separation to sign up for dental care. Later, they go to sign up but may no longer be eligible or can't find the needed military records. This legislation would make the enrollment automatic at discharge but would not force the servicemember to use the VA and all the existing VA eligibility criteria would be remain unchanged.

The VA is currently doing a version of enrollment assistance for Guard and Reserve in many places across the country, including Vermont, but it is not a consistent process from state to state. This bill would require Veterans Benefit Administration and Veterans Health Administration staff to assist with the automatic enrollment, require the Secretary of Defense to provide resources and space at the demobilization sites to make this happen, and have a reporting mechanism to Congress so that we make sure that, if needed, VA receives additional resources to compensate for any increased patient load given the automatic enrollment.

As many of my colleagues may know, Secretary Shinseki is working on a larger concept that might include some form of this idea that he refers to as "uniform registration." I support and commend those efforts. I believe this bill is a good beginning point for the VA to start to streamline enrollment during the move from the DOD to VA which is one part of the larger seamless transition efforts.

I hope these two pieces of legislation will have the support of all of my colleagues and I look forward to working with you, Mr. Chairman, to move them forward.

Thank you Mr. Chairman.

PREPARED STATEMENT OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman, Ranking Member Burr and other Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) to submit testimony at this legislative hearing of the Committee on Veterans' Affairs. DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

We are providing testimony today on twelve bills that are concerned with health care, benefits and other services important to sick and disabled veterans who use the programs of the Department of Veterans Affairs (VA). This statement submitted for the record relates our positions on selected bills before you today, and we offer them for your consideration.

S. 977—PRISONER OF WAR BENEFITS ACT OF 2009

This bill would amend Federal veterans' benefits provisions for prisoners of war (POWs) by repealing the required 30-day minimum period of internment prior to the presumption of service connection for certain diseases for purposes of payment of a veteran's disability compensation. The bill also adds type 2 diabetes to the list of diseases and sets new rules for the Secretary in making these presumptions. It also requires the VA to consult with the POW advisory committee, where the Secretary

must make a decision within 60 days after a recommendation from said committee related to presumptions being established for non-listed diseases. The measure specifies that if the Secretary removes a disease made presumptive by this bill, that any veteran or survivor who was previously granted either compensation or dependency indemnity compensation (DIC) associated with the presumption will maintain their compensation or DIC payments.

DAV has long held, as referenced in Resolution 009, that former POWs suffered cruel and inhumane treatment, together with nutritional deprivation at the hands of their captors, which resulted in long-term adverse physical and/or psychological health effects. It is on the basis of their unique circumstance and sacrifices that DAV supports legislation that would add those medical conditions that are characteristically associated with or can be reasonably attributed to the POW experience as presumptive disorders for former POWs.

While we support enactment of this bill, we would also respectfully request the Committee consider amending this legislation to also provide for the expanded eligibility for DIC to surviving spouses of certain former POWs, who died prior to September 30, 1999, and who were rated totally disabled at the time of death for a service-connected disability for a period of not less than one year.

S. 1118—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROVIDE FOR AN INCREASE IN THE AMOUNT OF MONTHLY DEPENDENCY AND INDEMNITY COMPENSATION PAYABLE TO SURVIVING SPOUSES BY THE SECRETARY OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES.

This bill would increase the monthly rates of veterans DIC which is payable to surviving spouses through the VA. It provides a phase-in of DIC payments in the case of veterans who die of a nonservice-connected disability, after being eligible for at least five years for VA compensation for a service-connected disability rated as total. This bill also reduces the age from 57 to 55 after which the remarriage of a surviving spouse shall not terminate DIC payments.

At present, title 38, United States Code, Section 1318 (b)(1) provides DIC benefits for survivors of certain veterans rated totally disabled for ten or more years. DAV views this timeframe as creating undue financial hardship on surviving spouses who have devoted themselves to the care required by totally disabled veterans instead of a career outside the home. It is inherently unfair that surviving spouses should have this additional burden placed on them for 10 years or more before he or she can qualify for DIC when the veteran dies. In accordance with DAV Resolution No. 016, we support this legislation to reduce the ten-year rule for DIC qualification to a more reasonable period of time.

S. 1155—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO ESTABLISH THE POSITION OF DIRECTOR OF PHYSICIAN ASSISTANT SERVICES WITHIN THE OFFICE OF THE UNDER SECRETARY OF VETERANS AFFAIRS FOR HEALTH.

This bill would establish within the Veterans Health Administration (VHA) the full time position of Director of Physician Assistant Services at VA Central Office. This person must be a qualified physician assistant (PA) and shall be responsible to report directly to the VHA's Under Secretary of Health on all matters relating to the education and training, employment, appropriate utilization, and optimal participation of physician assistants within VHA programs and initiatives.

The VA is the largest Federal employer of PAs, with approximately 1,800 full-time PA positions. In the VA health care system, PAs are essential primary care providers working in ambulatory care clinics, emergency medicine and 22 other VA medical and surgical subspecialties. When the position of PA advisor was created in 2000, as authorized by the Veterans Benefits and Health Care Improvement Act of 2000, the position consisted of collateral administrative duties added to a field-based PA advisor's direct patient care responsibilities. In April 2008, the PA Advisor function was finally converted to a full-time position, but the incumbent continues to be field-based at a VA health care facility, rather than located at the VA Central Office.

DAV and the other veterans service organizations that coordinate the *Independent Budget* (*IB*) have urged that this position be made full-time within VHA headquarters. This transition would allow for: an increase in scope of PA-specific clinical and human resources policy issues; the opportunity to participate in major VA strategic health care planning committees and functions; and inclusion in aspects of planning on seamless transition, polytrauma centers, Traumatic Brain Injury staffing and the work of the newly established Office of Rural Health.

Additionally, PAs could assist in emergency disaster planning since 34 percent of all VA-employed PAs are veterans or currently serve in the military reserves. In ad-

dition to supporting this bill, we urge that this occupation be included in any recruitment and retention legislation the Committee reports. By 2012, it is projected that 28 percent of the VA PA workforce will be eligible for retirement. In our opinion, passage of this bill to require the PA Advisor to be located in VA Central Office on a full-time basis, would be a good start in addressing some of these human resources challenges.

Although we do not have a specific resolution in support of this measure, the bill is consistent with recommendations outlined in the fiscal year (FY) 2010 *IB* and would help to ensure access to high quality health care services for veterans using the VA health care system. Therefore, DAV supports this bill and urges its enactment.

S. 1204—CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2009

This bill seeks to amend the VA Health Care Programs Enhancement Act of 2001 to require a program under which the Secretary provides chiropractic care and services to veterans through VA medical centers and clinics to be carried out at no fewer than 75 medical centers by December 31, 2009, and all VA medical centers by December 31, 2011.

VA was authorized to offer chiropractic care and services under the provisions of section 204 of Public Law 107–135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001. We believe chiropractic care offers a valuable health care option to veterans and many support the system-wide availability of chiropractic services within the VA health care system.

While we have no adopted resolution from our membership calling for broader availability of chiropractic care in the VA health care system, we would not object to the enactment of this bill.

S. 1237—HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009

This bill would expand the grant program for homeless veterans with special needs to include male homeless veterans with minor dependents and to establish a grant program for reintegration of homeless women veterans and homeless veterans with children. This measure would also require grants to be used to provide job training, counseling, job placement services, literacy and skills training, and child care services to expedite reintegration of these veterans into the work force. The Secretary would be required to monitor the expenditure of funds under the grant program and carry out the program through the Assistant Secretary of Labor for Veterans' Employment and Training, and include data or the results or outcomes of the services provided to each homeless veteran. This measure authorizes $10 million to be appropriated for each of the FYs 2010–2014.

We are pleased to support this bill (S. 1237) and that there is specific emphasis on the needs of homeless women veterans and homeless veterans with children. We have greater numbers of women veterans coming to VA with post-deployment mental health issues due to combat exposure, which puts them at higher risk for becoming homeless. Likewise, many homeless veterans with minor children have been unable to avail themselves of VA's excellent programs because they have had no support for their children. It is clear this measure will provide more comprehensive services, to include child care services to this vulnerable population.

S. 1310—A BILL TO AUTHORIZE MAJOR MEDICAL FACILITY PROJECTS FOR THE DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2010, AND FOR OTHER PURPOSES.

This bill would authorize three major medical facility projects (in Livermore, Walla Walla and Louisville) and 15 capital leases (in Alabama, California, Florida, Georgia, Kansas, North Carolina, Pennsylvania, South Carolina and Texas). It would authorize appropriations of almost $1.2 billion for FY 2010 to carry out these projects. The bill would renew in FY 2010 previous Congressional authorization for construction of VA major medical projects in Denver and Bay Pines, with authorized appropriations to carry out these purposes.

DAV resolution no. 237 supports the enhancement of medical services through modernization of VA health care infrastructure. This resolution urges VA to request adequate funding and Congress to provide such funding to address the Department's internally identified needs based on the conclusions of the Capital Asset Realignment for Enhanced Services (CARES) initiative. Equally important, our members believe Congress should carefully monitor any intended changes in VA infrastructure that could jeopardize VA's ability to meet veterans' needs for specialized VA medical care and rehabilitative services, or be the cause of diminution of VA's established graduate medical and other health professions education and biomedical re-

search programs, consequential to deployment of any new facilities model of health care delivery.

Similarly, the *IB* for FY 2010 included a recommendation regarding infrastructure and urged Congress to ensure adequate funding for VA's capital budget so that VA may properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future. Accordingly, we are concerned with some of the health care leasing projects identified in this bill as "Health Care Centers." This new infrastructure concept is one about which we have written in the *IB* and expressed caution. In some cases, these Health Care Centers may be appropriate and beneficial. However, we believe there is the potential for unintended consequences through altering VA's future infrastructure and the possibility of disrupting its academic and research missions. Some of these leased health care centers are going to be activated where VA today operates major government-owned medical facilities, including the Loma Linda and Montgomery projects.

Therefore, prior to Congressional authorization of these particular requested projects for leased Health Care Centers, we ask the Committee to use due diligence to reassure the veterans community that these new facilities will not become the cause of the diminution of VA's other critical missions in training health manpower and conducting important biomedical research.

VA's intention to begin moving away from permanent government ownership of its health care facilities into a new phase in which VA could be a temporary leaseholder in privately owned buildings raises many questions about VA's future infrastructure and the implications on its missions other than health care delivery. We do not believe that VA has adequately evaluated how those other key missions would be affected by this new direction in infrastructure. A former VA Secretary reported to the Committee that, in respect to the Health Care Center leasing concept, no existing VA health facilities would be closed and no VA employees would lose their jobs. Before the Committee reports this legislation, we ask that you validate those assurances with the proponents of this bill, and to reassure the veterans community that VA's academic and scientific missions will be sustainable within these new arrangements.

S. 1427—DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT OF 2009

This bill would establish and implement a Hospital Quality Report Card Initiative to report on health care quality in VA medical centers. The purpose of the bill is to ensure that information on the quality and performance of VA hospitals is readily available and accessible to veteran patients and in identifying opportunities for quality improvement and cost containment. This measure would require the Secretary to make reports of the quality of each VA medical center available to the public and submit them to the House and Senate Veterans' Committees at least semiannually.

The established "hospital report card" would cover a variety of activities of hospital care occurring in the medical centers of the Department, including effectiveness; safety; timeliness; efficiency; patient satisfaction; satisfaction of VA health professionals; equity of care provided to various patient populations including—female, disabled, geriatric, rural, homeless, mentally ill, and racial and ethnic populations. Additionally, VA would be required to provide information on staffing levels of health professionals; rates of certain types of infections; hospital sanctions and violations; and the availability of emergency rooms, intensive care units, and specialty services. We believe validation of the delivery of high quality care to service-disabled veterans is important and concur that veterans under VA care have the same rights as private sector patients to access and review the quality and safety data related to the care they receive while hospitalized. Therefore, we support this bill.

We do note, however, that the purposes of this bill do not cover the majority of overall patient care workload in VA health care, namely primary (outpatient) care and extended care services provided in VA's nursing home care units and its various contracted programs.

S. 1429—SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT

This bill would establish a 12-member Commission on veterans and members of the Armed Forces with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or other mental health disorders, to enhance the capacity of mental health care providers to assist such veterans and members, to ensure such veterans are not discriminated against, and for other purposes.

The Commission would monitor and oversee the treatment of active duty members and veterans for mental health problems caused by military service, and would be required to conduct a thorough study of long-term adverse consequences of mental illnesses caused by military service. It would set rules for appointment for Commission members with specifications, and would empower the Commission to review programs, obtain reports, travel and secure necessary information to function, and would require the Commission to submit reports to the VA the Department of Defense (DOD) and Congress. Also, the bill would authorize appropriations of $1 million in FY 2010 to support the work of the Commission. The Commission would be rescinded when the two Secretaries concerned agreed to do so. We note that the bill would not authorize appointment of any staff to carry out the Commission's purposes.

While we appreciate the intended purposes of this new Commission, we ask the Committee to consider altering the scope of the bill to better account for the current situation in VA mental health services, and to consider our recommendations for an enhanced means of achieving better oversight and accountability in that program. We defer commentary on whether the Commission envisioned in this bill should also be responsible for monitoring mental health within DOD.

We recognize the unprecedented efforts made by VA over the past several years to improve the consistency, timeliness, and effectiveness of mental health care programs for disabled veterans. We are especially pleased that VA has committed through its national Mental Health Strategic Plan (MHSP) to reform VA mental health programs, moving from the traditional treatment of symptoms to embrace recovery potential in every veteran under VA care.

We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of comprehensive mental health services to meet the needs of veterans. One key part of improving mental health services and increasing access to those specialized services is through sufficient staffing levels. In that regard, DAV supports the intent of this measure, but we remain concerned that the intended goal of the bill will be unfulfilled unless Congress also requires VA to adopt and enforce mechanisms to assure its policies at the top are reflected as results in the field. As written, we are concerned that the bill may not surface the kind of information Congress needs to conduct proper oversight of VA's results and status in achieving mental health reforms.

The development of the MHSP and the new Uniformed Mental Health Services (UMHS) policy (detailed in VHA Handbook 1160.01, dated September 11, 2008) provide an impressive and ambitious roadmap for VHA's transformation of its mental health services. However, we have expressed continued concern about oversight of the implementation phase of these initiatives. The VA MHSP was developed before the impact of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) was evident, and we believe a pressing need is emerging for Congress to ramp up the monitoring of VA's strategies, policies, and operating plans being implemented to deliver on the promise of the current strategic plan. We believe VHA must also conduct accurate annual needs and gap assessments to take into account the changing needs of the veteran population, including the newest generation of combat veterans.

In response to the 2003 New Freedom Commission's call for action, VA developed a national strategic plan for mental health services which was finalized in November 2004. In showing sensitivity to VA's commitment to reform, Congress allocated new funds to enhance mental health services and required VA to spend these funds in pursuit of that reform. Despite these efforts, in May 2007 the VA Inspector General again criticized the consistency and adequacy of mental health services throughout the system.

To address these concerns VA has been provided with targeted mental health funds in more recent years' appropriations to augment mental health staffing across the system. This funding was intended to address widely-recognized gaps in the access and availability of mental health and substance-use disorder services that existed prior to the development of the MHSP, to address the unique and increased needs of veterans who served in OIF/OEF and to create a comprehensive mental health and substance-use disorders system of care within VHA that is focused on recovery—a hallmark goal of the New Freedom Commission. In addition, VHA developed its UMHS policy so that veterans nationwide can be assured of having access to the full range of high quality mental health and substance-use disorder services in all VA facilities and at the time that they are most needed. Timely, early intervention services can improve veterans' quality of life, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. These funds have been dispersed as part of special initiatives, with a clear mandate that they would be used to augment current mental health staffing, not merely replace older positions as they become vacant.

While the specialized mental health augmentation funding has significantly improved mental health services across VHA, a recent gap analysis conducted by VHA, resulting in the UMHS plan, underscores how much still needs to be done to assure equity of access for all veterans. Furthermore we understand that this analysis (one that VA has not released to the Congress or the veterans service organization community) does not fully take into account many important factors such as the cost and effort required to provide newer evidence-based treatments for priority conditions such as PTSD.

We believe the solution to this pressing problem would need two major components: an attentive oversight process, and an empowered organizational structure to inform that oversight responsibility.

The oversight process we envision in mental health would be a constructive one that is helpful to VA facilities, rather than punitive. It should be data-driven and transparent, and should include local evaluations and site visits to factor in local circumstances and needs. Such a process could assure that ongoing progress is made in achieving the goal of the VA MHSP and UMHS package to provide easily accessible and comprehensive mental health services equitably across the Nation.

Mr. Chairman, the second component necessary to make the first one meaningful would be putting in place an empowered VA organizational structure to assure that this oversight process is robust, timely and utilizes the best clinical and research knowledge available. Such a structure would require VHA to collect and report detailed data, at the national, network and medical center levels, on the net increase over time in the actual capacity to provide comprehensive, evidence-based mental health services. Using data available in current VA data systems, such as VA's payroll and accounting systems, supplemented by local, audited reports where necessary, could provide information down to the medical center level on at least the following for the period FY 2004 to the present fiscal year:

- The number of full-time and part-time equivalents of psychiatrists and psychologists;
- The number of mental health nursing staff;
- The number of social workers assigned to mental health programs;
- The number of other direct care mental health staff (e.g. counselors, outreach workers);
- The number of administrative and support staff assigned to mental health programs;
- As a basis for comparison, the total number of direct care and administrative full-time employee equivalents (FTEE) for all programs, mental health and others; and
- The number of unfilled vacancies for mental health positions that have been approved, and the average length of time vacancies remain unfilled.

In addition, we believe VA should be required to establish a web-based clinical inventory instrument to gather information from the field about existing mental health programs (i.e., PTSD, substance-use disorder, etc.) in each VA facility including hours of operation, case loads and panel sizes, staffing levels and current capacity to provide evidence-based treatments as specified in published *VA/DOD Evidence-Based Practice Guidelines*.

VA should also develop an accurate demand model for mental health and substance-use disorder services, including veteran users with chronic mental health conditions and projections for the needs of OIF/OEF veterans. This model development should be created parallel to the VA mental health strategic planning process. This model should include estimated staffing standards and optimal panel sizes for VA to provide timely access to services while maintaining sufficient appointment time allotment.

Assuming the creation of these resource tools, Congress should also require VA to establish an independent body such as suggested in this legislation, or, more preferable, a "VA Committee on Veterans with Psychological and Mental Health Needs," with appropriate resources, to analyze these data and information, supplement its data with periodic site visits to medical centers, and empower the Committee to make independent recommendations to the Secretary of Veterans Affairs and the Congress on actions necessary to bridge gaps in mental health services, or to further improve those services.

Membership of the Committee should be made up from VA mental health practitioners, veteran users of the services and their advocates, including veterans service organizations and other organizations concerned about veterans and VA mental health programs. The site visit teams should include mental health experts drawn from both within and outside of VA. These experts should consult with local VA officials and seek consensual, practical recommendations for improving mental health

care at each site. This independent body should synthesize the data from each of the sites visited and make recommendations on policy, resources and process changes necessary to meet the goals of the MHSP.

In addition to these changes, VA should be directed to conduct specialized studies, under the auspices of its Health Services Research and Development Program and/or by the specialized mental health centers such as the Mental Illness Education, Research and Clinical Centers (MIRECCs) in several sites, the Seriously Mentally Ill Treatment, Research Education and Clinical Center (SMITREC) in Ann Arbor; and the Northeast Program Evaluation Center in West Haven, among others, on equity of access across the system; barriers to comprehensive substance use disorders rehabilitation and treatment; early intervention services for harmful/hazardous substance use; couples and family counseling; and programs to overcome stigma that inhibits veterans, particularly newer veterans, from seeking timely care for psychological and mental health concerns. As an additional validation, we believe that the Government Accountability Office (GAO) should be directed to conduct a follow-on study of VA's mental health programs to assess the progress of the MHSP, the UMHS, and to provide its independent estimate of the FTEE necessary for VA to carry out the above-noted initiatives.

Congress should also require GAO to conduct a separate study on the need for modifications to the current VERA system to incentivize its fully meeting the mental health needs of all enrolled veterans.

While DAV supports the basic intent behind S. 1429, we ask the Committee to consider a broader scope of oversight of VA's mental health program than envisioned by the bill. We believe the ideas expressed above—ideas that we have gleaned from a number of mental health and research professionals in and out of VA, and from the literature, are necessary to fully ensure VA is moving its mental health policy and program infrastructure in a proper direction. Also, we urge the Committee, which would be the major recipient of this new approach to reporting true VA mental health capacity, to continue its strong oversight to assure VA's mental health programs and the reforms it is attempting meet all their promise, not only for those coming back from war now, but for those already here.

S. 1444—COMBAT PTSD ACT

This bill seeks to clarify the meaning of "combat with the enemy" for purposes of service connection of disabilities by adding that the term includes service on active duty in a "theater of combat operations during a period of war, or in combat against a hostile force during a period of hostilities."

The definition of what constitutes combat with the enemy is critical to all veterans injured in a combat theatre of operations, whether the issue is service connection of PTSD or other conditions resulting from combat. The current high standards required by the VA internal operating procedures for verifying veterans who "engaged in combat with the enemy" are impossible for many veterans to satisfy, whether from current or past wars. There are many reasons for this and possible scenarios include: unrecorded traumatic events taking place on the battlefield as operations expand and contract; unrecorded temporary detachments of servicemembers from one unit to another while in a combat theater of operations; field treatment for injuries that become problematic later but not in the circumstances and conditions of combat when servicemembers are compelled to return to duty by commitment to fellow servicemembers and country-and-poor recordkeeping.

A practical example of the problems associated with the current burden of proof required to determine who "engaged in combat with the enemy" can be found with the U.S. Marine Corps' Lioness Program in Iraq. Despite a DOD policy banning women from direct ground combat, Marine commanders have been using women as an essential part of their ground operations in Iraq since 2003. These soldiers who accompany male troops on patrols to conduct house-to-house searches are known as Team Lioness, and have proved to be invaluable. Their presence not only helps calm women and children, but Team Lioness troops are also able to conduct searches of women and children without violating cultural strictures. Against official policy, and at that time without the training given to their male counterparts, and with a firm commitment to serve as needed, these dedicated young women have often been drawn onto the front lines in some of the most violent counterinsurgency battles in Iraq.

The Combat Action Badge (CAB) was approved, according to the US Army's Web site (www.army.mil/symbols/combatbadges) on May 2, 2005, by the U.S. Army Chief of Staff to provide special recognition to soldiers who personally engage, or are engaged by the enemy. The CAB may be awarded by a commander regardless of the branch of Service or MOS. Assignment to a Combat Arms unit or a unit organized

to conduct close or offensive combat operations, or performing offensive combat operations is not required to qualify for the CAB. However, it is not intended to award all soldiers who serve in a combat zone or imminent danger area. It may be awarded to any soldier performing assigned duties in an area where hostile fire pay or imminent danger pay is authorized. The soldier must be personally present and actively engaging or being engaged by the enemy, and performing satisfactorily in accordance with the prescribed rules of engagement. Some Lioness veterans were awarded the CAB, but others were not.

The VA's current internal instruction (M21 Manual) requires proof by official military records that can be viewed as exceeding the law since the law does not require this level of documentation. To provide better assistance to veterans of military conflicts, VA should rely on the proper application of current legislation.

As the Committee considers this bill, we ask that you designate the "theatre of operations" as the combat zone. Using Iraq as an example, that country would be so designated as a combat zone and personnel assigned there, or who transit through Iraq as part of their duties, are considered to have engaged in combat for VA benefits purposes. Logistical staging and resupply points such as those found in Kuwait and Qatar have not been the scene of combat operations and thus personnel assigned to these areas would not be considered to have engaged in combat for benefits purposes. With such a designation, veterans must still provide satisfactory lay evidence consistent with their service.

The last area of our testimony deals with the title of the bill itself. The current title "Combat PTSD Act" does focus on this important condition, yet the legislative language addresses the relationship between combat with the enemy and service-connected disabilities of all types. We ask for the Committee's consideration to rename this legislation to reflect its full intent of clarifying the very definition of combat with the enemy. We are pleased to support this measure, in accordance with DAV Resolution No. 013, which calls for the presumption of exposure to stressors for veterans who served in a war zone and who suffer from PTSD. This measure moves to clarify this important issue.

S. 1547—ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009

S. 1547 seeks to amend title 38, United States Code, and the United States Housing Act of 1937 to enhance and expand the assistance provided by the VA and the Department of Housing and Urban Development (HUD) to homeless veterans and veterans at risk of homelessness. Enactment of this bill would create a five-year, $50 million per year "homelessness prevention" program and VA would directly carry out the prevention functions through their homeless veteran program coordinators by paying rent and mortgages, resolving credit problems, paying relocation costs, job assistance, and referrals to other agencies.

The bill would expand the purposes of the comprehensive service program for homeless veterans by prohibiting the VA from denying participation by organizations that receive money from other sources than VA if the entity demonstrates a private nonprofit organization will provide oversight and site control of the project. Also, it would require a study of the existing per diem program to determine if there is a better way for VA to support non-governmental organizations providing homeless assistance to veterans. Funding would be increased from the existing $150 million annually, to $200 million in FY 2010, and "such sums as may be necessary" for 2011–2014.

If enacted, the HUD-VASH (Veterans Affairs Supportive Housing Vouchers) program would increase the number of housing vouchers in annual increments of 10,000, up to 60,000 through the year 2013, and for the years thereafter. In regard to the HUD-VASH program, the bill would specify requirements on public housing agencies and for VA case management to ensure veterans in receipt of these vouchers also receive proper care and follow up, as well as supportive services.

The position of Special Assistant for Veterans Services at HUD would be established, with specific qualifications outlined for appointment and the duties of the position. It would create a homeless veterans management information system for collection of data on veterans using homeless assistance programs of the VA and HUD, with required reporting. Finally, the bill would require VA to submit a comprehensive plan to end homelessness among veterans to Congress within one year of enactment, including details on rural homeless veterans.

VA Secretary Shinseki has publicly stated that eliminating homelessness among veterans in the next five years is one of the Department's highest priorities and we concur that this is a worthy goal. We support this measure S. 1547, in accordance with DAV Resolution No. 249, which was reaffirmed at our most recent National Convention in Denver, Colorado. This resolution calls on Congress to provide suffi-

cient funding for VA mental health, substance-use disorder, vision and dental care services, and effective outreach so that VA might better meet the needs of homeless veterans. Additionally, the FY 2010 *IB* also calls on both Congress and VA to step up programs to stem, and to ultimately eliminate, homelessness in the veteran population.

S. 1518—CARING FOR CAMP LEJEUNE VETERANS ACT OF 2009

Section 2 of this bill would furnish hospital care, medical services, and nursing home care to veterans who were stationed at Camp Lejeune, North Carolina during a period, determined by the Secretary in conjunction with the Agency for Toxic Substances and Disease Registry, 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 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 DAV has two resolutions related to this bill: Resolution No. 252, urges congressional oversight and Federal vigilance to provide for research, health care and improved surveillance of disabling conditions resulting from military toxic and environmental hazards exposure, and Resolution No. 211, calls for supporting legislation to provide for service connection 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 dependents under section 3 of this bill should be provided under the Civilian Health and Medical Program of VA (CHAMPVA) service.

S. 1607—WOUNDED VETERAN JOB SECURITY ACT OF 2009

This bill would provide for certain rights and benefits for persons who are absent from positions of employment to receive medical treatment for service-connected disabilities.

DAV Resolution No. 239 seeks to protect veterans from employment discrimination when seeking health care for service-connected conditions; therefore, we support passage and enactment of this bill to better protect the jobs of our disabled veterans while they seek treatment for their wounds incurred during military service. Many of this Nation's young men and women have answered the call to service in the Armed Forces and Congress, through the Uniformed Services Employment and Reemployment Rights Act (USERRA), provides protection from employment discrimination for persons to perform military duty. During the current conflict and others, employers have released their employees to perform military duty and many sustained service-connected disabilities as a result of their honorable service. Currently, USERRA mandates employers to make reasonable accommodations regarding these disabilities; however, employers are not specifically required by law to allow veterans with service-connected disabilities to be absent from the workplace to receive treatment for these disabilities. This important legislation seeks to correct this inequity by extending legal protections when such distinguished employees seek medical treatment for their service-connected conditions.

Mr. Chairman, this concludes my testimony and I will be pleased to consider any questions by you or other Members of the Committee.

August 26, 2009

U.S. Senator Jack Reed
United States Senate
728 Hart Senate Office Building
Washington, DC 20510

Re: Endorsement of Zero Tolerance for Veterans Homelessness Act of 2009

Dear Senator Reed,

Give US Your Poor: The Campaign to End Homelessness is pleased to endorse the Zero Tolerance for Veterans Homelessness Act of 2009 introduced in the Senate by you and your colleagues.

When we estimate the costs of going to war in Congress or in public discussion, we almost never estimate the cost of the hundreds of thousands of American soldiers that become homeless after serving our country. We believe that it is unconscionable to ask men and women to serve our country as such—to leave their families and jobs, to risk their lives, to experience traumatic stress, to sometimes lose parts of their bodies, and carry the scars of war long after the last battle—and then allow them to become homeless regardless of the final reason.

Give US Your Poor, a national public education campaign based at UMass Boston's McCormack Graduate School of Policy Studies, exists to dispel myths about homelessness and promote structural solutions to the crisis. We strongly support the Zero Tolerance for Veterans Homelessness Act of 2009.

Veterans are dramatically overrepresented in the homeless population in the U.S. and this bill as currently crafted will go a long way helping correct this shameful reality.

Thank you for efforts on this issue and please let us know if Give US Your Poor can do anything to complement your efforts in promoting this bill and helping to ensure it becomes law.

Sincerely,

John McGah
Director, Give US Your Poor

MCCORMACK GRAD SCHOOL
UMASS BOSTON
100 MORRISSEY BLVD.
BOSTON, MA 02125

617 287 5532 617 287 5544 F

National Alliance to
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1518 K Street, NW, Suite 410 | Washington, DC 20005
Tel 202.638.1526 | Fax 202.638.4664

October 20, 2009

Hon. Jack Reed
United States Senate
Washington, DC 20510-3903

Dear Senator Reed:

I write to thank you and express our strong support for the Zero Tolerance for Veterans Homelessness Act of 2009, S. 1547. This bill takes what we've learned about effective approaches to homelessness, approaches that have lead to substantial reductions in homelessness; and gives the Department of Veterans Affairs the tools it needs to put those approaches to work for veterans.

We recognize that you, along with early cosponsors of the bill such as Senators Bond and Murray, have been central to the spread of these effective approaches. We believe that marshalling that expertise and commitment for the benefit of our nation's veterans is absolutely the right thing to do during this difficult time.

One extremely important impact of this bill will be to give the VA the authority to operate or contract for programs of homelessness prevention and rapid re-housing, building on the support for these program models found in HUD appropriations bills, the HEARTH Act and the American Reinvestment and Recovery Act. This provision fills the biggest gap in the current array of services at the VA.

Other important aspects of the bill are the expanded authorization for the HUD-VASH program, a key intervention that is already housing thousands of veterans and leveraging substantial policy change at the VA; modifications to the Homeless Grants and Per Diem program to align it with other housing programs; a new Special Assistant to the HUD Secretary on Veterans Affairs; better data; and a federal plan to end homelessness for veterans. These improvements will support the VA in expanding its mission to ensure that no veteran need become homeless or remain homeless.

Thank you for your leadership on this issue as on the issue of homelessness more generally. We remain committed to working with you to solve this problem.

Sincerely yours,

Steven R. Berg
Vice President for Programs and Policy

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Akaka, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the pending legislation for the Department of Veterans Affairs (VA) before the Committee today. These important bills will go a long way toward improving the lives of veterans and their families.

S. 977, THE "PRISONER OF WAR BENEFIT ACT OF 2009"

PVA supports S. 977, the "Prisoner of War Benefit Act of 2009." This legislation would provide certain improved benefits for veterans who are former prisoners of war. It would repeal the currently required thirty day minimum period of internment for presumption of service connection for certain diseases for purposes of the payment of veterans' disability compensation. PVA also welcomes the inclusion of Type 2 diabetes as one of the listed diseases. This bill would also make former POWs inflicted with disease, determined by the Secretary of Veterans Affairs, to have "positive association with the experience of being a prisoner of war" eligible to receive disability compensation, and would establish procedures, including the recommendations from the Advisory Committee on Former Prisoners of War that such presumption be established for a non-listed disease.

S. 1109, THE "PROVIDING REAL OUTREACH FOR VETERANS ACT OF 2009" OR THE "PRO-VETS ACT"

This legislation requires the VA and the Department of Defense (DOD) to enter into an agreement for the purpose of transferring information pertinent to the servicemembers' military service for improving the communication of veterans' benefits that servicemember has earned. PVA supports this effort to improve the current methods in which veterans learn about benefits. Often a veteran learns of available benefits during social conversations with other veterans, through a state employment office, reading a veterans service organizations newsletter, or communicating on line with other veterans. Of the thousands of military personnel leaving the service each year (320,000 in 2007 according to DOL testimony) there is not one uniform, standard, detailed message that these men and women receive. Currently the services offer the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP) to servicemembers leaving the military. In 2007 DOD and DOL were encouraged to work toward a goal of 85% of transitioning servicemember participation in TAP or DTAP workshops. In 2007 and 2008 the DOL Advisory Committee on Veteran's Employment, Training and Employer Outreach (ACVETEO) visited several TAP workshops in various parts of the country. They found that the best technical tools were not available to the facilitators to prepare separating servicemembers for the 21st Century. In particular, the use of computers was not observed in any classrooms thus denying servicemembers the opportunity to see real time how to use the internet in their job search or review other benefits they have earned. The Committee members also discovered that the TAP program would vary in length from one day, to two and a half days. Another challenge was that often the servicemember received this information in the last two or three weeks preceding their discharge.

Improving the TAP and DTAP presentations explaining medical assistance offered by the VA, veterans benefits, career opportunities with the Federal Government, or other employment information can be achieved with the combined effort of DOL and DOD. This legislation proposes requirements from DOD and VA that could require many years to implement and involve potential IT problems and unexpected costs. PVA would like to see more effort placed on the delivery of veterans' benefits information before the servicemember leaves the military. If a veteran is aware of a benefit, they can then inquire if they qualify.

S. 1118

PVA supports the intent and concept of S. 1118, that increases DIC to fifty-five percent of the one hundred percent rate under Title 38, Section 1114 (j) for survivors. However, we are disappointed that the legislation does not support higher rates for survivors of veterans who were rated for special monthly compensation under Section 1114 (k) through (s). PVA believes that the survivors of severely disabled veterans should be compensated at a higher rate commensurate with the level of disability.

For example, the spouse of a veteran who was rated under Section 1114 (r)(1) has made sacrifices and provided significant care for the veteran while he or she was alive due to the severity of the service-connected conditions. Consequently, we rec-

ommend amending the bill to provide for a rate of fifty-five percent of the rates from (k) through (s) provided the veteran was so entitled at the time of death.

S. 1155

PVA supports S. 1155, a bill that would establish a position of Director of Physician Assistant Services. This legislation is consistent with a recommendation included in the FY 2010 edition of *The Independent Budget*.

The Department of Veterans Affairs is the largest single Federal employer of physician assistants (PA), with approximately 1,800 full-time PA positions, and has utilized PAs since 1969 when the profession started. However, once Congress enacted Public Law 106–419, the "Veterans Benefits and Health Care Improvement Act of 2000," which directed that the Under Secretary for Health to appoint a PA advisor, the Veterans Health Administration (VHA) only assigned the PA position as a part-time, field-based employee. Finally, in April 2008, VHA made the position a full-time employee, but the position is still field-based and often does not receive travel funding until late in the second quarter each year, resulting in missed opportunities to attend VHA meetings. It is time to establish a real, permanent staff PA at the VA to oversee these critical care providers.

S. 1204, THE "CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2009"

PVA supports the provisions of S. 1204, the "Chiropractic Care Available to All Veterans Act of 2009." Chiropractic care has become a widely accepted and used medical treatment. It is a treatment covered by TRICARE, and it is only appropriate that it should be provided at VA facilities. But it is also important for the Committee to recognize that by providing this treatment benefit to veterans, it will entail a new type of care which is currently not considered in funding. When new treatments are authorized at VA facilities, they must be considered when determining VA appropriations to prevent those becoming unfunded mandates.

S. 1237, THE "HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009"

PVA fully supports S. 1237, the "Homeless Women Veterans and Homeless Veterans with Children Act of 2009" and appreciates Senator Murray expanding this program to include male veterans with minor children and correcting the oversight that only provided for support to women with minor children.

In addition, this legislation will provide targeted assistance to homeless women veterans and those with children, who face particular dangers and challenges on the street. PVA offers our assistance to the Secretary of Labor and the Assistant Secretary for Veterans' Employment and Training to support and promote this program when enacted.

S. 1302, THE "VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009"

Regarding S. 1302, the "Veterans Health Care Improvement Act of 2009", PVA recommends caution in proceeding with this legislation. While the findings presented in the legislation are valid, it may be detrimental to veterans if pay-for-performance measures are too quickly introduced without an assessment of the impact of such measures. While PVA fully supports accountability and the need to provide the highest quality services to veterans and we recognize that a pay-for-performance model does offer a promising approach to improve the outcome of services, it may have the opposite effect of negatively impacting veterans if implemented too quickly without adequate understanding on the part of service providers. PVA would ask that the Committee evaluate the impact before implementing such legislation.

S. 1394, THE "VETERANS ENTITLEMENT TO SERVICE ACT OF 2009"

PVA supports S. 1394, the "Veterans Entitlement to Service Act of 2009." This legislation would direct the Secretary of Veterans Affairs (VA) to acknowledge the receipt of any claim for medical services, disability compensation, or pension under laws administered by the Secretary, or other communication relating to such services, compensation, pension, within 30 days after its receipt. PVA believes the VA must keep the servicemember informed and up-to-date with timely communication during the compensation and pension process.

S. 1427, THE "DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT OF 2009"

Although PVA has no objection to the requirements for a Hospital Quality Report Card Initiative outlined in this legislation, we remain concerned that this wealth of information will go unused. As we testified in May 2007, collecting this information and assessing it without acting on any findings from that information would serve no real purpose. While the public might be more and better informed, we would hope that the congressional committees will use the information published in these reports each year to affect positive change within the VA. However, we must emphasize that additional resources will need to be provided to allow the VA to properly compile this information as we believe that this could be a major undertaking.

S. 1429, THE "SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT"

PVA strongly supports S. 1429, the "Servicemembers Mental Health Care Commission Act." As the wars in Afghanistan and Iraq continue, more and more veterans of the War on Terrorism are in need of mental health care. As the language of the legislation indicates, the rates of Post Traumatic Stress Disorder (PTSD) and depression are greatest among women veterans and members of the Reserves. While the Armed Forces are working hard to help those who remain on active duty, veterans who have left the service face particular challenges as they leave the military support groups critical to coping with the horrors of war.

Establishing a commission to oversee monitoring and treatment of veterans with PTSD, Traumatic Brain Injury and other mental health disorders caused by service and to study the long-term adverse consequences of these conditions is critical to determining treatments that may be most effective. And while PVA welcomes the requirement for annual reports to Congress, it will be unfortunate if this reporting remains simply an exercise and does not lead to Congressional action on recommendations. Too often Congress has the information to make changes, but is unable to enact legislation that truly impacts those who need care. As the wars in Afghanistan and Iraq continue, we ask that this legislation do more than just identify what we already believe, but be the first step in treating this serious effect of war.

S. 1444, THE "COMBAT PTSD ACT"

PVA supports S. 1444, the "Combat PTSD Act." This bill clarifies and defines the meaning of "combat with the enemy" for purposes of proof of service connection for veterans' disability compensation for service on active duty outlines as: (1) in a theater of combat operations during a period of war; or (2) in combat against a hostile force during a period of hostilities. This clarification will help to reduce confusion and ease the burden of proof when trying to prove a combat stressor when they file a claim for compensation for PTSD.

S. 1467, THE "LANCE CORPORAL JOSEF LOPEZ FAIRNESS FOR SERVICEMEMBERS HARMED BY VACCINES ACT OF 2009"

PVA supports S. 1467, the "Lance Corporal Josef Lopez Fairness for Servicemembers Harmed by Vaccines Act of 2009." This legislation would prohibit the Secretary of Veterans Affairs from excluding from coverage under the traumatic injury provisions with respect to the Servicemembers' Group Life Insurance program a veteran suffering a qualifying loss resulting from an adverse reaction to a vaccination administered by the Department of Defense (DOD). PVA believes every servicemember that is affected by traumatic loss or injury should be entitled to the traumatic injury benefits under SGLI.

S. 1483, THE "MAX J. BEILKE DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC"

PVA has no position on this bill. It deals specifically with naming issues and these should be considered by the local community with input from veterans organizations within that community.

S. 1518, THE "CARING FOR CAMP LEJEUNE VETERANS ACT OF 2009"

PVA supports S. 1518, the "Caring for Camp Lejeune Veterans Act of 2009." The intent of this legislation is to provide hospital care, medical services, and nursing home care to veterans and family members who were stationed at Camp Lejeune, NC, while the water was contaminated by volatile organic compounds, including known human carcinogens and probable human carcinogens, for any illness, to in-

clude a child who was in utero at the time. These servicemembers and their families have been suffering for decades and should be entitled to care and compensation.

S. 1531, THE "DEPARTMENT OF VETERANS AFFAIRS REORGANIZATION ACT OF 2009"

PVA supports S. 1531, the "Department of Veterans Affairs Reorganization Act of 2009," which will establish the position of Assistant Secretary for Acquisition, Logistics, and Construction. In 2008 the Secretary of Veterans Affairs, James B. Peake, reorganized the functions of acquisition, logistics, major construction and real property programs into the Office of Acquisition, Logistics, and Construction (OALC). The creation of this position will improve management oversight and performance of these critical programs.

S. 1547, THE "ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009"

PVA supports S. 1547, the "Zero Tolerance for Veterans Homelessness Act of 2009." PVA has always been a strong supporter of helping homeless veterans. While VA estimates nearly 131,000 veterans are homeless on any given night, and that approximately 200,000 veterans experience homelessness in a year, these numbers are lower than have been reported in the past and the Committee should be cautious of these numbers. But regardless of what the actual numbers are, this is clearly a massive problem that the VA, veterans service organizations, homeless providers, and similarly interested parties, have all tried to help overcome. This is a tragedy that continues to plague our Nation. PVA believes that this legislation may help to reduce these unfortunate numbers. We particularly appreciate that the legislation aims to address those veterans at risk of becoming homeless and not just those veterans who have already lost there homes.

S. 1556, THE "VETERAN VOTING SUPPORT ACT OF 2009"

PVA supports S. 1556, the "Veteran Voting Support Act of 2009." PVA advocates for the rights of veterans, persons with disabilities, and all Americans, which enable them to participate in the election process. Making the voting process accessible and available for paralyzed veterans has been a priority for our organization.

PVA supports the requirement of the VA to provide information relating to requesting an absentee ballot and making absentee ballots available upon request. PVA also supports the provision of the bill that would permit nonpartisan organizations to provide voter registration information at facilities of the VA.

S. 1607, THE "WOUNDED VETERAN JOB SECURITY ACT OF 2009"

S. 1607, the "Wounded Veteran Job Security Act of 2009" would amend Title 38, to provide for certain rights and benefits for persons who are absent from employment in order to receive medical treatment for service-connected disabilities. PVA supports this legislation to protect the employment of a veteran that has a disability, disease, or other medical condition that was a result from their service to the Nation. The legislation must also include treatment for medical conditions related to, or a result of that disability, disease, or medical condition. The veteran living with a spinal cord injury or disease, as a result of their service, may contract a urinary tract infection, a bladder infection, decubitus ulcer or other medical condition that may require treatment and time at home recuperating for several days or weeks. This new medical condition may be directly related to that veteran's spinal cord injury or disease, although it is not predisposed in the veteran's medical history. Veterans should not be at risk of losing their jobs when they seek medical care due to their service for this Nation.

S. 1668, THE "NATIONAL GUARD EDUCATION EQUITY ACT"

PVA fully supports S. 1668, the "National Guard Education Equity Act." Soldiers operating under Title 32 provisions perform in the exact same manner as Active Duty soldiers and airmen when called to active duty for homeland security, disasters or other missions in support of the United States. In addition, members of the Active Guard Reserve perform duties in the same capacity as active duty soldiers and deserve the same benefits and considerations as their active duty brothers and sisters.

S. 1752

PVA supports S. 1752, a bill to direct the Secretary of Veterans Affairs to provide wartime disability compensation of 10 percent or more for certain veterans with Parkinson's disease. In addition to direct compensation, PVA would like to propose

that VA should exhaust all available scientific research methods to provide any finding of long-term effects of the disease.

S. 1753, THE "DISABLED VETERANS CAREGIVER HOUSING ASSISTANCE ACT OF 2009"

PVA supports the intent of S. 1753, the "Disabled Veterans Caregiver Housing Assistance Act of 2009," that would increase assistance for disabled veterans who are temporarily residing in housing owned by a family member. However, this legislation is problematic to veterans in need of transitional housing who may have the intent of purchasing a home and using adaptive housing assistance at a later date. The Temporary Residing Assistance (TRA) grant is subtracted from the overall maximum benefit of $60,000 from Specially Adapted Housing (SAH) grant. For example: If a disabled veteran receives a TRA grant of $12,000, he/she would have only $44,000 available under the SAH grant, rather than $60,000, to adapt or build a permanent residence in the future. This legislation is not conducive as a benefit to disabled veterans who have temporary and ultimately permanent adaptive housing needs.

GAO reported (GAO–09–637R) on June 15, 2009 to Members of Congress that VA has processed nine TRA grants since it's creation on June 15, 2006 through a period ending February 28, 2009. During the same period, VA processed 2,431 SAH and SHA grants. This is a substantial difference in the number of applications for each program.

PVA recommends SAH and TRA become two separate grants due to having different objectives. This would exclude TRA deducting from the maximum benefit of SAH and substantially increasing the favorability of the TRA grant and its applicants. This will give a reason for veterans to use TRA and still allow them to adapt their own residence in the future. Additionally, this is something our severely disabled veterans desperately need and would provide a substantial difference in their quality of life and have less of a financial hardship on the veteran and their family.

S. 1779, THE "HEALTH CARE FOR VETERANS EXPOSED TO CHEMICAL HAZARDS ACT OF 2009"

PVA fully supports S. 1779, the "Health Care for Veterans Exposed to Chemical Hazards Act of 2009" to provide health care for veterans exposed to chemical hazards through their service. Military service often involved exposure to hazardous materials, whether fuels, insecticides or other chemicals regularly used during military operations. In addition, during deployments to areas with less stringent environmental regulation, the possibility of exposure to industrial or agricultural chemicals increases dramatically.

As with the previously discussed "Caring for Camp Lejeune Veterans Act of 2009," it is difficult to know what veterans may be exposed to during their service. By creating a registry of former members of the Armed Forces, VA can better track and identify those who may have been exposed to hazards allowing for rapid examinations and counseling. Only by knowing who may have been affected and providing prompt care can America provide the care that is due to our veterans.

This concludes PVA's my testimony and we would be happy to answer any questions the Committee may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

August 26, 2009

The Honorable Jack Reed
United States Senate
Senate Hart
Washington, DC 20510

Dear Senator Reed,

On behalf of the 2.2 million members of the Veterans of Foreign Wars and our Auxiliaries, I would like to offer our support for your bill, S. 1547, the *Zero Tolerance for Veterans Homelessness Act of 2009.*

Your important legislation proposes to institute flexible funding in which VA could provide short-term rental assistance, housing relocation and stabilization, security deposits, utility payments, and costs associated with moving for homeless veterans.

The *Zero Tolerance for Veterans Homelessness Act* would also allow for mixed financing for capital projects and would better align health care services payments with the actual health care cost. The bill would also authorize an increase of up to 60,000 HUD-VASH vouchers in which participating veterans receive case management services such as assistance locating housing and accessing benefits and health services.

S. 154 would create a Special Assistant for Veterans Affairs within HUD to ensure veterans have access to HUD's assistance programs while providing better data collection to accurately track and count the homeless veterans nationwide.

Finally, of great importance, your legislation would require the VA to develop a comprehensive plan for ending veterans' homelessness within one year of the bill's enactment.

Senator Reed, the VFW applauds your efforts to end homelessness in our United States. Service members who have given of themselves so selflessly ought not to be homeless in the country they sacrificed for. Your legislation is yet another way to take care of the men and women who serve our country so proudly. The VFW looks forward to working with you and your staff to ensure the passage of this legislation.

Thank you for your continued support of America's veterans.

Sincerely,

DENNIS CULLINAN, Director
National Legislative Service

VFW MEMORIAL BUILDING ● 200 MARYLAND AVE. N.E. ● WASHINGTON, D.C. 20002-5799
AREA CODE (202)-543-2239 ● FAX NUMBER (202)-543-6719

PREPARED STATEMENT OF RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Chairman Akaka, Ranking Member Burr, and other Members of this distinguished and important Committee, Vietnam Veterans of America (VVA) appreciates the opportunity to offer our statement for the record concerning several bills affecting veterans that are up for your consideration. Please know that VVA appreciates the efforts of this Committee for the work you are doing on behalf of our Nation's veterans and their families.

Mr. Chairman, as you have indicated that you are most interested in VVA's views on S. 1237 and S. 1547, we'll commence with these, and then follow with the other bills in the order in which they were introduced.

S. 1237, THE HOMELESS WOMEN VETERANS AND HOMELESS VETERANS WITH CHILDREN ACT OF 2009

Enactment of this legislation would expand the grant program for homeless veterans with special needs to include male veterans who are homeless with minor dependents, and to establish a grant program for reintegration of homeless veterans, both male and female, with children.

Vietnam Veterans of America (VVA) has a long history of promoting equal access to care, treatment, and benefits for all veterans. With the increasing number of new, and younger, veterans who find themselves without a home and with dependent children, it is essential that the agencies of government and the non-governmental entities funded to assist these men and women be given the mandate and the funding necessary to assist these veterans—before their homelessness becomes chronic. Job training and job skills enhancement and placement services can lead to employment possibilities that will otherwise likely escape these veterans. Providing funding for the care of their children, too, is a vital facet of this effort.

While VVA supports enactment of this legislation, we caution, though, that for many of these veterans, job counseling, training, and assistance need to be coupled with appropriate mental health and substance abuse services and housing. The VA needs to be held accountable for the tens millions of dollars that were supposed to go toward hiring new mental health clinicians. Were the clinicians actually hired? Have they been they properly trained and supervised? Are they following the recognized best practices protocols? We urge that the Congress do much more stringent oversight of the VA for how they actually use the funds they get. With this in mind, VVA urges that Congress take a holistic approach to the persistent issue of homelessness among veterans.

S. 1547, THE ZERO TOLERANCE FOR VETERANS HOMELESSNESS ACT OF 2009

This bill, with its almost utopian title, would enhance and expand the assistance provided by the Departments of Veterans Affairs and Housing and Urban Development to veterans who are homeless and veterans at risk of homelessness. President Obama recently stated that ending homelessness among veterans in five years will take a serious infusion of resources, coordination of services, and overhaul of the way we treat our vets after their service. While VVA supports enactment of this legislation, we would like to offer our comments on how this legislation can be strengthened to achieve the goal established by the President.

We might quibble with the numbers of homeless veterans estimated by the VA: It seems that the census of homeless veterans dipped from more than 200,000 to 153,000, and then in short order to 131,000, while at the same time there appears to be an increase in the number of homeless women veterans and homeless veterans, male and female, who served in Afghanistan and Iraq. The "numbers game" seems to have more to do with how one defines homeless than with any change in the number of veterans affected by this situation. (Incidentally, VVA argues that a veteran who has no permanent domicile is homeless. That is not the litmus test used by the VA.) However, the persistent problem of homelessness among veterans is all too real, and VVA applauds Congress for recognizing this fact and seeking solutions.

Certainly, the VA ought to be able to identify veterans receiving healthcare through VA medical facilities or disability compensation who are homeless or who are in danger of becoming homeless. We question, however, if this represents "all" of the target population. We would posit that the VA needs to formulate a strategic program of outreaching to veterans who otherwise do not utilize VA services, or receive monthly compensation from the Veterans Benefits Administration, the VBA.

The VA has legal authority as mandated by Public Law 110–389, the Veterans' Benefits Improvement Act of 2008, Section 532 to advertise in national media, and

an ethical obligation to reach out to all veterans and their families to inform them of the benefits to which they are entitled. While populating kiosks in VA medical centers and regional offices with booklets and pamphlets is fine, these do little good if they do not get into the hands of the very poor who do not use the system, the "middle class" who use private physicians and who may be living from paycheck to paycheck, and some who, so many reasons, either choose to or are forced to dissociate from society. To reach these folks, the VA has had no real strategic outreach plan. In fact, VA outreach to those who do not use VA facilities is negligible at best, and has been for a long, long time. A strategic plan, aided perhaps by the Ad Council with input from veterans service organizations and military unit associations, needs first to be well thought out, and then implemented. How much such an outreach effort will cost will be dependant in part on the media (TV and radio, billboards, electronic media) that are used. Part of such an outreach effort ought to include a "help line" modeled after the VA's suicide hotline.

We would offer, too, that a plan that targets the homeless, or those at risk of incipient homelessness, ought to be part of this larger, more inclusive outreach strategy that informs veterans of the benefits and services they have earned by virtue of their military service, and that informs veterans of any health conditions or health care risks that might derive from their time, and place, in service.

Sec. 3: That said, we caution that there will need to be a very close and collaborative interaction between those tasked by the Secretary of Veterans Affairs with identifying and assisting veterans who are homeless or at imminent risk of becoming homeless and their counterparts at HUD.

Sec. 4: In testimony provided by VVA in April 2008, we recommended that Congress go above the authorizing level for the Homeless Grant and Per Diem program and fund the program at $200 million and not the $150 million authorized. We are gratified that this funding increase is stipulated herein.

We would hope, however, that no consideration be given to provide per diem payments to entities that house veterans but offer no services. "Three hots and a cot" is little more than a very temporary palliative. Should this occur, it would open the door to funding "empty-shell shelters" in every city, municipality, or county in the country, and would defeat the purpose of this bill.

We would offer that a consolidation of the VA's Homeless Grant and Per Diem (HGPD) projects be included in this bill. This is a per diem issue for all existing programs that received a second grant for expansion of an existing original program. In the past, some successful VA HGPD residential programs identified a need for increased bed space because of the number of veterans requesting admission. These programs asked for additional beds under a "Per Diem Only" (PDO) grant process and were awarded the ability to increase their overall program beds. But because the original grant and the PDO grant were awarded at different times, they have separate project numbers, which leads to an accounting nightmare as everything related to the program has to be divided by percentages and every veteran who changes beds has to be tracked by not one but two project numbers. This does not make much sense to us. There should be a provision by which a modification of the original grant can accomplish the same purpose without adding "busy work" that actually does not increase accountability.

Sec. 5: Perhaps the key area in this section is the promise of case management services, without which far too many veterans who are homeless will inevitably drift back into homelessness even after they are afforded rental housing. Caring, informed case management is particularly critical in assisting those homeless veterans who have mental health and/or substance abuse issues. Yet herein is a conundrum: Many veterans do not meet the criteria for HUD-VASH because they require case management. They also do not meet the criteria for Mental Health Intensive Case Management (MHICM) included in this legislation. These compromised veterans are left without recourse to fend for themselves. Therefore, we would urge inclusion in this bill for case management services for those individuals who would otherwise be ineligible for HUD-VASH.

Sec. 6: The appointment of a Special Assistant for Veterans Affairs in the Office of the Secretary of Housing and Urban Development simply makes sense. HUD needs an individual who has the ear of the Secretary and who can coordinate all programs and activities at HUD relating to veterans. This position needs to be high enough within the HUD hierarchy to be taken seriously.

Sec. 7: Establishing a method for the collection and aggregation of data on homeless veterans participating in VA and HUD programs also makes sense.

Sec. 8: Researching and writing and devising a "comprehensive plan to end homelessness among veterans" sounds fine. It is likely, however, to result in yet another tome that does little more than gather dust. What may make more sense, of course, is to focus on preventing homelessness in the first place. But program managers

within HUD and the VA, along with key leaders working in non-governmental organizations that provide assistance to homeless veterans, perhaps need to form working groups on different facets of the homeless veteran issue, conclude what programs work and need enhancement and what programs ought to be consigned to the dust bin of history, and make recommendations to their respective Secretaries. The watch word of any such plan should be KISS (Keep It Simple, Soldier). Just because it is simple does not mean it is easy.

Whether we want to acknowledge this or not, our Nation is likely always to have some veterans who drift through life, without roots, many of them battling the demons of their wartime experiences. However, we can and must do a far better job than we are currently doing.

S. 977, THE PRISONER OF WAR BENEFITS ACT OF 2009

This bill would provide certain improved benefits for veterans who are former prisoners of war. It would repeal the minimum period of internment for presumption of service connection for certain diseases. It would make ex-POWs afflicted with diseases determined by the Secretary of Veterans Affairs to have "positive association with the experience of being a prisoner of war" eligible to receive disability compensation.

As long as any determination by the Secretary, as stipulated in the bill's language, is made based on sound medical and scientific information and analyses, VVA supports enactment of this bill, as there are so few former POWs left that the cost of the bill should be minimal, and therefore any "pay-go" implications not particularly onerous.

S. 1109, PROVIDING REAL OUTREACH FOR VETERANS ACT OR PRO-VETS ACT OF 2009

Should this bill be enacted, it would direct the Secretary of Veterans Affairs to enter into an agreement with the Secretary of Defense for the transfer of data to the VA to provide members of the Armed Forces as well as veterans with individualized information concerning veterans' benefits for which each member and veteran may be eligible. It would require the VA Secretary, after receiving such data, to: 1) compile a list of all benefits for which each member or veteran may be eligible; 2) notify the member or veteran (or their legal representative) of such benefits; and 3) provide a second notification if the member or veteran does not apply for a listed benefit within 60 days. It would provide for annual notifications thereafter. And it would require additional notifications based on changed circumstances, although it would allow each member or veteran the option to decline further notifications.

There are many difficulties in this proposed legislation, not the least of which is cost. The sheer effort to comply with the provisions of S. 1109 would bloat an already bloated central bureaucracy.

Yes, the VA as well as DOD needs to do a far better job of informing troops and veterans of their rights and benefits. But there are far better ways of accomplishing this. The VA could start with a much better search engine on their web site, as well as other enhancements to make their web site more user friendly. Many veterans, particularly the newest generation of veterans, get their info on the Internet. Why not provide veterans with a card listing key VA telephone numbers and web addresses? Why not incorporate information about benefits in an overall outreach strategy to be developed by the VA, one that would use billboards as well as public service announcements?

While this bill is very well meaning, taken alone it is not the answer.

S. 1118

S. 1118 would provide for an increase in the amount of monthly dependency and indemnity compensation (DIC) payable to surviving spouses by the Department of Veterans Affairs. One provision of this bill would reduce eligibility to receive DIC from age 57 to age 55, after which remarriage shall not terminate such compensation.

VVA endorses enactment of this legislation. Even as the fighting in Afghanistan and Iraq are adding surviving spouses almost daily, the majority of surviving spouses are women who are nearing retirement age, or have been retired for some time if they ever worked outside the home. Many of these women devoted themselves to caring for their spouse who may have been profoundly disabled as a result of his service in the military; many of these spouses did not have the opportunity to build a career of their own. Enactment of S. 1118 would in effect recognize their service, and sacrifice, even though DIC payments alone are inadequate to support an adult in most parts of the country.

S. 1155

S. 1155 would establish within the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) the position of Director of Physician Assistant Services in the Office of the Under Secretary for Health.

VVA endorses S. 1155 as we have endorsed its companion bill in the House, H.R. 1302. As we noted in testimony in the House, this bill seems to us a logical if somewhat belated effort to establish the position of Director of Physician Assistant Services under the Under Secretary of Veterans Affairs for Health. As stipulated in this bill, the director, who would be a qualified physician assistant, "shall be responsible to and report directly to the Under Secretary for Health on all matters relating to the education and training, employment, appropriate utilization, and optimal participation of physician assistants within the programs and initiatives of the Administration."

The last three individuals to occupy the position of Under Secretary for Health have refused to accord Physician Assistants, most of whom are veterans, equal prestige and respect with Nurse Practitioners (most of whom are not veterans). The reasons are puzzling, and to say the aforementioned individuals and their functionaries have been less than honest in discussing this issue with Congress, veterans service organizations, and organized labor would be an understatement. It is shameful that this bill needs to be enacted to get the VHA to act decently, honestly, and as common sense would dictate, but this is the case.

S. 1204, THE CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2009

This bill would amend the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require the provision of chiropractic care and services to veterans at all VA medical centers.

While VVA supports the enactment of this bill, we would suggest that this body consider looking into other alternative healthcare options that have shown varying degrees of effectiveness. These might include acupuncture. These might include as well such modern relaxation techniques as biofeedback, which has proven successful in treating fibromyalgia, hypertension and certain heart conditions, and even Traumatic Brain Injuries (TBI).

S. 1302, THE VETERANS HEALTH CARE IMPROVEMENT ACT OF 2009

This bill would provide for the introduction of pay-for-performance compensation mechanisms into contracts between the VA and community-based outpatient clinics (CBOCs) operated by private contractors for the provision of healthcare services.

VVA endorses S. 1302. It recognizes that, while the "top priorities for CBOCs should be to provide quality health care and patient satisfaction for America's veterans," in some instances "current contracts for CBOCs may create an incentive for contractors to sign up as many veterans as possible, without ensuring timely access to high quality health care for such veterans." It also would set in place mechanisms to "eliminate abuses in the provision of health care services by CBOCs under contracts that continue to utilize capitated-basis compensation mechanisms for compensating contractors." It would also set in place mechanisms to "ensure that veterans are not denied care or face undue delays in receiving care."

S. 1394, THE VETERANS ENTITLEMENT TO SERVICE ACT OR THE VETS ACT OF 2009

This legislation would direct the Secretary of Veterans Affairs to acknowledge the receipt of medical, disability, and pension claims and other communications submitted by claimants within 30 days of the receipt of the claim or other communication.

If enactment of this legislation can increase the efficiency and accountability of VA personnel, we would endorse it. We fear, however, that it has the potential to create more flurries of action and/or mounds of additional paperwork without increasing efficiencies in the adjudication of claims.

S. 1427, THE DEPARTMENT OF VETERANS AFFAIRS HOSPITAL QUALITY REPORT CARD ACT OF 2009

This bill would establish and implement a Hospital Quality Report Card Initiative to report on health care quality in VA medical centers.

VVA is in favor of much more disclosure of information by VA, especially as to resource allocation and quality measures. This report card has the potential to make every veteran and ombudsman.

Further, if this initiative can inspire a competition among VA medical centers to be the best, to get the highest rating, this could be a good thing, but only if the

VA is measuring the right things in the right way as to actually improve the quality of care.

S. 1429, THE SERVICEMEMBERS MENTAL HEALTH CARE COMMISSION ACT

This bill would establish a commission on veterans and members of the Armed Forces with Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or other mental health disorders, to enhance the capacity of mental health care providers to assist such veterans and members of the military, and to ensure that such veterans are not discriminated against.

Another commission! Although there are myriad efforts by both public and private entities to deal with the epidemic of mental health woes that afflict men and women who have served in a combat zone, there is no single entity extant to "oversee" this. Our skepticism about this bill, however, is based on the yet-another-commission attempt to deal with a problem or an issue. After the scandal at Walter Reed Army Medical Center was exposed by the *Washington Post* two and a half years ago, of a sudden there were task forces and commissions appointed by the President and hearings by Congress to ask how such a thing could happen and how we could prevent it from happening again.

Well, after all the heat, there was very little light. The heralded case management initiative for the severely wounded has had some successes but is, from all that we can see, a washout. Many of the same problems remain. The case management system at Walter Reed Army Medical Center still does not work very well, and the so-called pilot project for the Medical Evaluation Boards/Physical Evaluation Boards (MEB/PEB) is not working very well at all.

Will a commission enhance the treatment of servicemembers and veterans afflicted with PTSD or TBI or a host of other mental health issues? Not unless it is a permanent body, and answers directly to the White House, and has some actual power to help force positive change on this process.

S. 1444, THE COMPENSATION OWED FOR MENTAL HEALTH BASED ON ACTIVITIES IN THEATER POST-TRAUMATIC STRESS DISORDER ACT, OR THE COMBAT PTSD ACT

This bill attempts to "clarify the meaning of 'combat with the enemy' for purposes of service-connection of disabilities."

VVA can support this bill if its intent is that it be applied to veterans with a valid diagnosis of PTSD (i.e., in the manner called for as noted in the 2006 Institute of Medicine report at http://iom.CMS/3793/32410.aspx), and if the intent is that any veteran who served "in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during a period of war," or "in combat against a hostile force during a period of hostilities" be taken at their word that the event or incident which occurred in service gave rise to their disability.

As VVA has stated repeatedly in prior Congressional testimony, an appropriate process already exists for VA PTSD claims processing as mandated by Congress back in 2000 under the Veterans Claims Assistance Act. However, it doesn't work because the VA fails time and time again to provide for the uniformity, consistency, and efficiency that are necessary to ensure that the claims process works in a timely fashion for all veteran claimants.

The VA does not use the guidelines established by the IOM on the medical side, and does not use their own "Best Practices Manual for Adjudication of PTSD Claims." The problem is not with the law; rather, it's with the implementation of the law by the VA that's the issue.

S. 1467, THE LANCE CORPORAL JOSEF LOPEZ FAIRNESS FOR SERVICEMEMBERS HARMED BY VACCINES ACT OF 2009

If passed, this bill would provide coverage under Traumatic Servicemembers' Group Life Insurance for adverse reactions to vaccinations administered by the Department of Defense.

There can be no doubt that some members of the military who are given inoculations against certain diseases suffer adverse reactions. Some of these reactions are life-altering, even life-threatening. All such adverse reactions are covered under existing Traumatic Servicemembers' Group Life Insurance guidelines under DOD, but the Department of Veterans Affairs Insurance Center does not follow suit in all instances, as in the case of former Marine Lance Corporal Lopez.

Enactment of this bill would in effect close a loophole that would benefit Mr. Lopez and his family and perhaps countless others. It has the unqualified support of VVA.

S. 1518, THE CARING FOR CAMP LEJEUNE VETERANS ACT OF 2009

The intent of this bill is to furnish hospital care, medical services, and nursing home care to veterans who were stationed at Camp Lejeune, North Carolina, while the water there was contaminated by volatile organic compounds, including known and probable human carcinogens. It would provide the same services to a family member of a veteran who resided at Camp Lejeune during a given period, as well as to a child who was in utero at the time.

Passage of this legislation would provide a measure of justice to veterans and their families who, through no fault of their own, were harmed simply by being assigned to Camp Lejeune. It would be up to the Secretary of Veterans Affairs to prescribe the regulations that would specify which conditions are associated with exposure to the contaminants, and which disabilities are associated with such conditions. We hope that this bill receives swift passage.

S. 1531, THE DEPARTMENT OF VETERANS AFFAIRS REORGANIZATION ACT OF 2009

The purpose of this legislation is to establish within the VA the position of Assistant Secretary for Acquisition, Logistics, and Construction to provide policy direction and manage oversight with respect to acquisition and construction programs of VA facilities.

Although we think the title of this bill is far too broad, we strongly support its purpose. It is key that the individual named to this position have a strong and unwavering commitment to small business, particularly veteran-owned and service-disabled veteran-owned small business. We all want accountability and the best "bang for the buck" in Federal procurement. The fallacy is that we can achieve this by giving the majority of business to big firms. Competition is what creates innovation and ultimately drives down the prices, thereby increasing value for dollar invested.

S. 1556, THE VETERAN VOTING SUPPORT ACT OF 2009

This bill would require the Secretary of Veterans Affairs to permit facilities of the Department to be designated as voter registration agencies.

Enactment of S. 1556 would avoid what had been a brewing controversy prior to the 2008 Presidential election when the previous administration at first refused to let VA facilities act as voter registration agencies. While we support the intent of this bill, we do not endorse the provision in the bill that would require the Secretary to provide a mail voter registration application form to each veteran who seeks to enroll or is enrolled in the VA healthcare system. We do agree that the VA can and should provide voter registration information and assistance, as well as absentee ballots to veterans residing in a community living center or domiciliary to "the same degree of information and assistance with voter registration as is provided . . . with regard to the completion of its own forms, unless the applicant refuses such assistance."

We agree as well with the provision that would instruct the Secretary to permit nonpartisan organizations along with state and local election officials to provide voter registration information and assistance at facilities of the VA healthcare system, subject to reasonable time, place, and manner restrictions, including limiting activities to regular business hours and requiring advance notice.

S. 1607, THE WOUNDED VETERAN JOB SECURITY ACT OF 2009

The goal of this bill is to provide for certain rights and benefits for persons who are absent from positions of employment to receive medical treatment for service-connected disabilities.

To fight the war on terror, officials at the Department of Defense have bled the Reserves and National Guard, which comprise almost 50 percent of our military strength. Far too many Reservists and Guardsmen and—women have returned to find that they have lost their job, or have lost their seniority and other rights and benefits. This is wrong. This is un-American. It will make individuals think twice about enlisting or re-enlisting in the Guard or Reserves, to the detriment of the citizens in the states in which they are based.

The intent of this bill is noble; passage of this bill is needed. It has the endorsement of VVA.

In this same regard, VVA would note that a small minority of employers are helping to bear the cost of this war because it is their employees are being activated. There needs to be a system of tax breaks and re-training funds for these employers to make at least some effort of holding them harmless.

S. 1668, THE NATIONAL GUARD EDUCATION EQUALITY ACT.

This bill provides for the inclusion of certain active duty service in the reserve components as qualifying service for the Post-9/11 Educational Assistance Program.

This bill attempts to cover members of the Army National Guard or Air Force National Guard who had "full-time duty" in response to a domestic emergency; as part of the Active Guard Reserve; as part of the Air Sovereignty Alert; as part of Operation Jumpstart; in response to Hurricane Katrina; as part of an airport security mission; or as part of a counterdrug activity. It is a bill VVA would support so long as those who served in these capacities meet the minimum amount of active-duty service as any Guardsman or Reservist who was activated and sent to Iraq or Afghanistan.

S. 1753, THE DISABLED VETERAN CAREGIVER HOUSING ASSISTANCE ACT OF 2009

This bill would increase assistance for disabled veterans who are temporarily residing in housing owned by a family member.

Catastrophically disabled veterans need a significant amount of care. In many instances, their families will provide such care as best as they can. However, providing this care may entail not insubstantial reconstruction of a home. S. 1753 recognizes this, increasing the amount of financial assistance allowable and providing for future increases based on the residential cost-of-construction index for the preceding year.

VVA supports passage of this bill.

S. 1779, THE HEALTH CARE FOR VETERANS EXPOSED TO CHEMICAL HAZARDS ACT OF 2009

Last but not least, this bill would provide health care to veterans exposed in the line of duty to occupational and environmental chemical health hazards "notwithstanding that there is insufficient medical evidence to conclude that [a veteran's health condition or disability] may be associated with such exposure."

This bill derives from National Guardsmen taken ill after being exposed to a chemical burn pit in Iraq. We fear that their exposure may be only the tip of the iceberg, to borrow a cliché. VVA believes that enactment of this bill is critical if a new generation of veterans is to be taken care of for respiratory and other health conditions that have an excellent possibility of having been caused by exposure to the toxic soup of burn pits in Iraq.

Mr. Chairman, Vietnam Veterans of America sincerely appreciate the opportunity to provide our views on these bills, and we look forward to working with you and your distinguished colleagues to address the concerns of our Nation's veterans.

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