STATEMENT OF

GERALD M. CROSS, MD, FAAFP

PRINCIPAL DEPUTY
UNDER SECRETARY FOR HEALTH

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good Morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on a number of bills that would affect Department of Veterans Affairs (VA) programs of benefits and services. With me today are Walter A. Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director, Quality Standards, Office of Quality and Performance. I am pleased to provide the Department's views on 14 of the 17 bills under consideration by the Committee. Unfortunately, we received S. 2963 too late to include in our written statement, but we will provide views and costs for the record. In addition, the Administration's position is currently under review for S. 2969. Therefore, it is not included in our written statement and we will forward those views as they are available. Similarly, the Administration is still developing its position on S. 2926 and we will provide those views for the record. I will now briefly describe the 14 bills, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

Mr. Chairman, today's agenda includes four bills that consist of legislative proposals the Administration submitted to the Congress: S. 2273; S. 2797; S. 2889, and S. 2984. Thank you for introducing these bills at our request. We believe each bill would significantly enhance the health care services we provide to veterans as well as our means of furnishing these benefits. I will begin my testimony by addressing the major health care related provisions in these important bills.

S. 2273 "Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007"

S. 2273 would authorize VA to conduct two five-year pilot grant programs under which public and non-profit organizations (including faith-based and community organizations) would receive funds for coordinating the provision of local supportive services for very low income, formerly homeless veterans who reside in permanent housing. Under one of the pilot programs, VA would provide grants to organizations assisting veterans residing in permanent housing located on military property that the Secretary of Defense closed or slated for closure as part of the 2005 Base Realignment and Closure program and ultimately designated for use in assisting the homeless. The other pilot program would provide grants to organizations assisting veterans residing in permanent housing on any property across the country. Both programs would require the Secretary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

In 1987, when VA began its specific assistance to veterans who were homeless, few recognized that long-term or permanent housing with supportive services was necessary to return these veterans to full function. It is now well understood that the provision of long-term housing coupled with needed supportive services is vital to enable them to lead independent lives in their communities. Although supportive services are widely available to these veterans through VA and local entities, most housing assistance that is available to them is limited to temporary

or transitional housing. Generally sources of long-term housing for these veterans are lacking. Military facilities recently slated for closure or major mission changes may provide an excellent site for long-term or permanent housing for these vulnerable veterans who remain at risk of becoming homeless. Local redevelopment authorities could take these VA grant programs into account when designing their local plans to convert the property for use in assisting formerly homeless veterans. This would not only help the veterans but also enhance the community's efforts at economic revitalization. We estimate the costs associated with each of these pilots to be $375,000 in Fiscal Year (FY) 2009 and $11,251,000 over a five-year period.

S. 2797 Authorization of FY 2009 Major Medical Facility Projects

Section 1 would authorize the following four major medical construction projects:

- Construction of an 80-bed replacement facility in Palo Alto, California, in an amount not to exceed $54,000,000;
- Construction of an Outpatient Clinic in Lee County, Florida to meet the increased demand for diagnostic procedures, ambulatory surgery, and specialty care, in an amount not to exceed $131,800,000;
- Seismic Corrections on Building 1 in San Juan, Puerto Rico, in an amount not to exceed $225,900,000; and,
- Construction of a state-of-the-art poly-trauma healthcare and rehabilitation center in San Antonio, Texas, in an amount not to exceed $66,000,000.

Section 2 would authorize the following major medical facility projects:

- Replacement of the VA Medical Center in Denver, Colorado, in an amount not to exceed $769,200,000.
- Restoration, new construction or replacement of the medical center facility in New Orleans, Louisiana, in an amount not to exceed $625,000,000.

VA received authorization for lesser sums under Public Law 109-461 for these two major projects. In February 2008 we requested authorization in the amount of $769.2 million for the Denver-replacement project. However, the Department has identified an alternative option to purchase land and construct the new Denver VA facility while also leasing beds from the University of Colorado Hospital. Since our FY 2009 major-facility-authorization request was submitted in February, we met with officials of the University of Colorado and the new University of Colorado Hospital (UCH) to discuss how best to replace the services and improve the access now being provided by the aging VA Medical Center in Denver. We are still finalizing the details of this approach, but our preliminary analysis shows that it would be better, for several reasons, to lease space in the inpatient unit that UCH plans to build and to have VA's new state-of-the-art health care facility focus on the provision of primary and specialty care, outpatient surgery, and nursing home care. This proposed and innovative VA partnership with UCH would also extend to the sharing of certain adjunct inpatient resources, such as laboratory and medical-imaging services, and include VA's leasing research space from the University of Colorado Denver. The leased inpatient space would be staffed by VA health-care professionals and accessed via a separate VA entrance and lobby. In all respects to our patients, it would be a VA facility. This change in construction plans would more effectively increase and improve veterans' access to care throughout the Rocky Mountain region. As part of this strategy, we would need to additionally seek authority to enter into a contract for a lease for an outpatient clinic in Colorado Springs, Colorado; the revised amount for this lease would exceed the current request. We will provide Committee the final authorization amounts needed for these projects shortly.

Section 3 would authorize VA to enter into leases for the following twelve facilities:

- Brandon, Florida, Outpatient Clinic, $4,326,000;

- Colorado Springs, Colorado, Community-Based Outpatient Clinic, $3,995,000; (the final amount needed for this project is pending)
- Eugene, Oregon, Outpatient Clinic, $5,826,000;
- Green Bay, Wisconsin, Expansion of Outpatient Clinic, $5,891,000;
- Greenville, South Carolina, Outpatient Clinic, $3,731,000;
- Mansfield, Ohio, Community-Based Outpatient Clinic, $2,212,000;
- Mayaguez, Puerto Rico, Satellite Outpatient Clinic, $6,276,000;
- Mesa, Arizona, Southeast Phoenix Community-Based Outpatient Clinic, $5,106,000;
- Palo Alto, California, Interim Research Space, $8,636,000;
- Savannah, Georgia, Expansion of Community-Based Outpatient Clinic, $3,168,000;
- Sun City, Arizona, Northwest Phoenix Community-Based Outpatient Clinic, $2,295,000; and,
- Tampa, Florida, Primary Care Annex, $8,652,000.

Section 4 would authorize for appropriation the sum of $477,700,000 for FY 2009 for construction of the four major medical projects listed in Section 1 and $1,394,200,000 for the two projects listed in Section 2. Section 4 would also authorize for appropriation for FY 2009 $60,114,000 from the Medical Facilities account for the leases listed in Section 3. However, we will likely revise our request for both those Section 2 construction projects and the Section 3 leases. Our final recommendation on the amounts will be provided to the Committee shortly.

S. 2889 "Veterans Health Care Act of 2008"

Mr. Chairman, you have asked us to testify on sections 2, 3, 4, 5, and 6, of S. 2889. Section 2 would authorize VA to contract for specialized residential care and rehabilitation services for veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) who: (1) suffer from traumatic brain injury, (2) have an accumulation of deficits in activities of daily living and instrumental

activities of daily living that affects their ability to care for themselves, and (3) would otherwise receive their care and rehabilitation in a nursing home. These veterans do not require nursing home care, but they generally lack the resources to remain at home and live independently. This legislation would enable VA to provide them with long-term rehabilitation services in a far more appropriate treatment setting than we are currently authorized to provide. VA estimates the discretionary cost of section 2 to be $1,427,000 in FY 2009 and $79,156,000 over a 10-year period.

Section 3 would require VA to provide full-time VA physicians and dentists the opportunity to continue their professional education through VA-sponsored continuing education programs. It would also authorize VA to reimburse these employees up to $1000 per year for continuing professional education that is not available through VA-sources. Currently, VA is required by statute to reimburse each of these individuals up to $1000 per year for expenses they incur in obtaining continuing education, even though VA has the capacity and resources to meet most of their professional continuing education needs in-house. Enactment of section 3 would result in cost-savings to VA, while serving as an effective recruitment and retention tool for the Veterans Health Administration. We estimate section 3 would result in discretionary savings of $8,700,000 in FY 2009 and a total discretionary savings of $87,000,000 over a 10-year period.

Section 4 would eliminate co-payment requirements for veterans receiving VA hospice care either in a VA hospital or at home on an outpatient basis. In 2004, Congress amended the law to eliminate copayment requirements for hospice care furnished in a VA nursing home. Section 4 would result in all VA hospice care being exempt from copayment requirements, regardless of setting. Projected discretionary revenue loss is estimated to be $149,000 in FY 2009 and $1,400,000 over 10 years.

Section 5 would repeal outdated statutory requirements that require VA to provide a veteran with pre-test counseling and to obtain the veteran's written informed consent prior to testing the veteran for HIV infection. Those requirements are not in line with current guidelines issued by the Centers for Disease Control and Prevention and other health care organizations, which, with respect to the issue of consent, consider HIV testing to be similar to other blood tests for which a patient need only give verbal informed consent. According to many VA providers, the requirements for pre-test counseling and prior written consent delay testing for HIV infection and, in turn, VA's ability to identify positive cases that would benefit from earlier medical intervention. As a result, many infected patients unknowingly spread the virus to their partners and are not even aware of the need to present for treatment until complications of the disease become clinically evident and, often, acute. Testing for HIV infection in routine clinical settings no longer merits extra measures that VA is now required by law to provide. Many providers now consider HIV to be a chronic disease for which continually improving therapies exist to manage it effectively. Repealing the 1988 statutory requirements would not erode the patient's rights, as VA would, just like with tests for all other serious conditions, still be legally required to obtain the patient's verbal informed consent prior to testing. VA estimates the discretionary costs associated with enactment of section 5 to be $73,680,000 for FY 2009 and $301,401,000 over a 10-year period.

Section 6 would amend sections 5701 and 7332 of title 38, United States Code, to authorize VA to disclose individually-identifiable patient medical information without the prior written consent of a patient to a third-party health plan to collect reasonable charges under VA collections authority for care or services provided for a non-service-connected disability. The section 5701 amendment would specifically authorize disclosure of a patient's name and address information for this purpose. The section 7332 amendment would authorize disclosure of both individual identifier information and medical information for purposes of carrying out the Department's collection responsibilities. VA estimates that enactment of

section 6 will result in net discretionary savings of $9,025,000 in FY 2009 and $108,858,000 over ten years.

S. 2984 Veterans Benefits Enhancement Act of 2008

This bill includes several important program authority extensions, including VA's mandate to provide nursing home care to veterans with service-connected disabilities rated 70 percent or more and to veterans whose service-connected disabilities require such care; VA's authority to establish research corporations; and VA's mandate to conduct audits of payments made under fee basis agreements and other medical services contracts. We urge the Committee to take action on all of the expiring authorities contained in the bill. Costs associated with these extensions will be paid from future discretionary appropriations. In the case of the audit-recovery program, we estimate discretionary recoveries in the amount of $9 million for FY 2008 and a ten-year total in recoveries of $70 million.

A significant provision of S. 2984 would permit VA health care practitioners to disclose the relevant portions of VA records of the treatment of drug abuse, alcoholism and alcohol abuse, infection with the human immunodeficiency virus, and sickle cell anemia to surrogate decision makers who are authorized to make decisions on behalf of patients who lack decision-making capacity, but to whom the patient had not specifically authorized release of that legally protected information prior to losing decision-making capacity. It would, however, allow for such disclosure only under circumstances when the practitioner deems such content necessary for the representative to make an informed decision regarding the patient's treatment. This provision is critical to ensure that a patient's surrogate has all the clinically relevant information needed to provide full and informed consent with respect to the treatment decisions that the surrogate is being asked to make.

Another key provision would authorize VA to require that applicants for, and recipients of, VA medical care and services provide their health-plan contract information and social security numbers to the Secretary upon request. It would also authorize VA to require applicants for, or recipients of, VA medical care or services to provide their social security numbers and those of dependents or VA beneficiaries upon whom the applicant or recipient's eligibility is based. Recognizing that some individuals do not have social security numbers, the provision would not require an applicant or recipient to furnish the social security number of an individual for whom a social security number has not been issued. Under this provision, VA would deny the application for medical care or services, or terminate the provision of, medical care or services, to individuals who fail to provide the information requested under this section. However, the legislation provides for the Secretary to reconsider the application for, or reinstate the provision of, care or services once the information requested under this section has been provided. Of note, this provision makes clear that its terms may not be construed to deny medical care and treatment to an individual in a medical emergency.

Although VA has authority under 38 U.S.C. § 1729 to recover from health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities, there is no permanent provision in title 38 to require an applicant for, or recipient of, VA medical care to provide information concerning health insurance coverage. This provision would ensure that VA obtains the health-plan contract information from the applicant for, or recipient of, medical care or services.

Moreover, social security numbers enable VHA to make accurate and efficient medical care eligibility determinations and to instantaneously associate medical information with the correct patient by matching those social security numbers against records of other entities. Medical care eligibility determinations may be based on such factors as qualifying military service, service-connected

disabilities, and household income. VHA may obtain or verify such information from internal VA components such as the Veterans Benefits Administration (VBA) which currently has authority to require social security numbers for compensation and pension benefits purposes, and outside sources, such as the Department of Defense (DoD), Internal Revenue Service and Social Security Administration. The availability of social security numbers ensures accurate matches of an individual's information with both internal and external sources. The income verification match programs are wholly dependent on social security numbers.

Be assured that VA will provide the same high degree of confidentiality for the beneficiaries' health plan information and social security numbers as it provides to patients' medical information in its records and information systems. There are no direct costs associated with this provision other than administrative costs associated with collecting revenue. Those costs will be paid from future discretionary appropriations.

Mr. Chairman, I now move to address the other bills on the agenda today.

S. 2377 "Veterans Health Care Quality Improvement Act"

S. 2377 is an excessively prescriptive bill that would impede the fundamental operations and structure of VHA. We have very recently provided the Committee with a copy of the Department's views on H.R. 4463, the identical House companion bill. Our views letter provides our detailed discussion of every provision. We would like to take this opportunity to discuss the provisions that cause us the most concern.

The requirement that within one year of appointment each physician practicing at a VA facility (whether through appointment or privileging) be licensed to practice medicine in the State where the facility is located is particularly troubling and we believe harmful to the VA system. VA strongly objects to enactment of this provision. VHA is a nationwide health care system. By current statute, to

practice in the VA system, VA practitioners may be licensed in any State. If this requirement were enacted, it would impede the provision of health care across State borders and reduce VA's flexibility to hire, assign and transfer physicians. This requirement also would significantly undermine VA's capacity and flexibility to provide telemedicine across State borders. VA makes extensive use of telemedicine. In addition, VA's ability to participate in partnership with our other Federal health care providers would be adversely impacted in times such as the aftermath of Hurricanes Katrina and Rita, where we are required to mobilize members of our medical staff in order to meet regional crises.

Currently, physicians who provide medical care elsewhere in the Federal sector (including the Army, Navy, Air Force, U.S. Public Health Service Commissioned Corps, U.S. Coast Guard, Federal Bureau of Prisons and Indian Health Service) need not be licensed where they actually practice, so long as they hold a valid State license. Requiring VA practitioners to be licensed in the State of practice would make VA's licensure requirements inconsistent with these other Federal healthcare providers and negatively impact VA's recruitment ability relative to those agencies. In addition, many VA physicians work in both hospitals and community-based outpatient clinics. Many of our physicians routinely provide care in both a hospital located in one State and a clinic located in another State. A requirement for multiple State licenses would place VA at a competitive disadvantage in recruitment of physicians relative to other health care providers.

Although the provision would allow physicians one year to obtain licensure in the State of practice, many States have licensing requirements that are cumbersome and require more than one year to meet. Such a requirement could disrupt the provision of patient care services while VA physicians try to obtain licensure in the State where they practice or transfer to VA facilities in States where they are licensed. The potential costs of this disruption are unknown at this time.

Further, we are not aware of any evidence of a link between differences in State licensing practices and quality of patient care. In 1999, the General Accounting Office reviewed the effect on VA's health care system that a requirement for licensure in the State of practice would have. The GAO report concluded, in part, that the potential costs to VA of requiring physicians to be licensed in the State where they practice would likely exceed any benefit, and that quality of care and differences in State licensing practices are not directly linked. See GAO/HEHS-99-106, "Veterans' Affairs Potential Costs of Changes in Licensing Requirement Outweigh Benefit" (May 1999).

Another provision would provide that physicians may not be appointed to VA unless they are board certified in the specialties of practice. However, this requirement could be waived (not to exceed one year) by the Regional Director for individuals who complete a residency program within the prior two year period and provide satisfactory evidence of an intent to become board certified. VA strongly opposes this provision of S. 2377. Current law does not require board certification as a basic eligibility qualification for employment as a VA physician. VA policy currently provides that board certification is only one means of demonstrating recognized professional attainment in clinical, administrative or research areas, for purposes of advancement. However, we actively encourage our physicians to obtain board certification. Facility directors and Chiefs of Staff must ensure that any non-board certified physician, or physician not eligible for board certification, is otherwise well qualified and fully capable of providing high-quality care for veteran patients. VA should be given considerable flexibility regarding the standards of professional competence that it requires of its medical staff, including the requirement for specialty certification. Were this measure enacted, it could have a serious chilling effect on our ability to recruit very qualified physicians. At this point in time, VA has physician standards that are in keeping with those of the local medical communities.

Moreover, the bill would provide that the board certification and in-State licensure requirements would take effect one year after the date of the Act's enactment for physicians on VA rolls on the date of enactment. This would at least temporarily seriously disrupt VA's operations if physicians are unable to obtain board certification and in-State licensure within one year, or are unable to transfer to a State where they are licensed.

Mr. Chairman, we want to emphasize that we support the intent of several provisions of S. 2377 and have already been taking actions to achieve many of the same goals. We would welcome the opportunity to meet with the Committee to discuss recent actions we have undertaken to improve the quality of care across the system, including program oversight related measures.

S. 2383 Pilot Program Providing Mobile Health Care and other Services

S. 2383 would require the Secretary, acting through the Director of the Office of Rural Health (DORH), to conduct a pilot program to furnish outreach and health care services to veterans residing in rural areas through the use of a mobile system equipped with appropriate program staff and supplies. The mobile system would have to be capable of furnishing the following services:

- counseling and education services on how to access VA health care, educational, pension, and other VA benefits;
- assistance to veterans in completing paperwork needed to enroll in VA's health care system;
- prescriptions for, and delivery of, medications;
- mental health screenings to identify potential mental health disorders, particularly for veterans returning from deployment overseas in OEF/OIF;
- job placement assistance and information on employment or training opportunities;
- substance abuse counseling; and
- bereavement counseling for families of active duty service members who were killed in the line of duty while on active service.

Staffing for the mobile system would be required to include VA physicians; nurses; mental health specialists; casework officers; benefits counselors, and such other personnel deemed appropriate by the Secretary. To the extent practicable, personnel and resources from area community- based outpatient clinics could be used to assist in this effort. The bill sets forth a number of requirements related to the development and coordination of the pilot program as well as to the conduct of the mobile system (including the minimum frequency of visits to rural areas participating in the pilot programs).

S. 2383 would also mandate that the Secretary act jointly with the Secretary of Defense to identify veterans not enrolled in, or otherwise being cared for by, VA's health care system. VA would be further required to coordinate efforts with county and local veterans service officers to inform those veterans of upcoming visits by the mobile unit and the concomitant opportunity to complete paperwork for VA benefits. The bill would authorize $10 million to be appropriated for the mobile system each of FYs 2008 through 2010.

VA does not support S. 2383, because it is not necessary and is duplicative of ongoing efforts by the Department. VA's Office of Rural Health is already in the process of standing up a mobile system by which to provide medical care and services to veterans residing in rural areas, and VA's Vet Centers are already using mobile units to furnish readjustment counseling services. The Vet Centers and VBA also have in place extensive outreach program targeted at these veterans. VA has recently created a Task Force to review the adequacy of the assets and resources dedicated to these efforts thus far. Particularly with respect to the mobile system, we urge the Committee to refrain from taking action on the bill until we have sufficient experience with this model of delivery to ascertain its effectiveness and to identify and cure any deficiencies. We would be glad to brief the Committee on our activities to date.

As a technical matter, the duration of the pilot program is unclear, but we assume it is three years based on the terms of the bill's provision authorizing appropriations for FYs 2008-2010. Additionally, medications are currently mailed to these veterans and so it is not necessary to provide those benefits through a mobile system.

S. 2573 "Veterans Mental Health Treatment First Act"

Mr. Chairman, S. 2573 is a very ambitious bill that would provide the Department with significant new tools to maximize and reward a veteran's therapeutic recovery from certain service-related mental health conditions, and, to the extent possible, reduce the veteran's level of permanent disability from any of the covered conditions. The goal of the legislation is to give the veteran the best opportunity to reintegrate successfully and productively into the civilian community.

Specifically, S. 2573 would require the Secretary to carry out a mental health and rehabilitation program for a veteran who has been diagnosed by a VA physician with any of the following conditions:

- post-traumatic stress disorder (PTSD);
- depression; or
- anxiety disorder

that is service-related, as defined by the bill. The bill would also cover a diagnosis of a substance use disorder related to service-related PTSD, depression, or anxiety. For purposes of this program, a covered condition would be considered to be service-related if: 1) VA has previously adjudicated the disability to be service-connected; or 2) the VA physician making the diagnosis finds the condition plausibly related to the veteran's active service. S. 2573 would also require the Secretary to promulgate regulations identifying the standards to be used by VA physicians when determining whether a condition is plausibly related to the veteran's active military, naval, or air service.

The bill sets forth conditions of participation for the veterans taking part in the program. If a veteran has not filed a VA claim for disability for the covered condition, the veteran would have to agree not to submit a VA claim for disability compensation for the covered condition for one year (beginning on the date the veteran starts the program) or until the date on which the veteran completes his or her treatment plan, whichever date is earlier.

If the veteran has filed a disability claim but it has not yet been adjudicated by the Department, the veteran could elect either to suspend adjudication of the claim until he or she completes treatment or to continue with the claims adjudication process. As discussed below, the stipend amounts payable to the veteran under the program will depend on which election the veteran makes.

If the veteran has a covered condition that has been adjudicated to be service-connected, then the individual would have to agree not to submit a claim for an increase in VA disability compensation for one year (beginning on the date the veteran starts the program) or until the date the veteran completes treatment, whichever is earlier.

S. 2573 would establish a financial incentive in the form of "wellness" stipends to encourage participating veterans to obtain VA care and rehabilitation before pursuing, or seeking additional, disability compensation for a covered condition. The amount of the stipend would depend on the status of the veteran's disability claim. If the veteran has not filed a VA disability claim, VA would pay the veteran $2000 upon commencement of the treatment plan, plus $1500 every 90 days thereafter upon certification by the VA clinician that the veteran is in substantial compliance with the plan. This recurring stipend would be capped at $6000. The veteran would receive an additional $3000 at the conclusion of treatment or one year after the veteran begins treatment, whichever is earlier.

If the veteran has filed a disability claim that has not yet been adjudicated, the participating veteran who elects to suspend adjudication of the claim until he or she completes treatment would receive "wellness" stipends in the same amounts payable to veterans who have not yet filed a disability claim. If the participating veteran elects instead to continue with the claims adjudication process, the veteran would receive "wellness" stipends in the same amounts payable to veterans whose covered disabilities have been adjudicated and found to be service-connected: $667 payable upon the veteran's commencement of treatment and $500 payable every 90 days thereafter upon certification by the veteran's clinician that the individual is in substantial compliance with the plan. Recurring payments would be capped at $2000, and the veteran would receive $1000 when treatment is completed or one year after beginning treatment, whichever is earlier.

If the Secretary determines that a veteran participating in the program has failed to comply substantially with the treatment plan or any other agreed-upon conditions of the program, the bill would require VA to cease payment of future "wellness" stipends to the veteran.

Finally, S. 2573 would limit a veteran's participation in this program to one time, unless the Secretary determines that additional participation in the program would assist in the remediation of the veteran's covered condition.

VA does not support S. 2573. While philosophically we discern and appreciate the aims of the bill, particularly the holistic and integrated approach to the receipt of VA benefits, this is a very complex proposal that requires further in-depth study of all of the bill's implications, including those related to cost. In addition, we have numerous concerns with the bill as currently drafted.
S. 2573 assumes that early treatment intervention by VA health care professionals for a covered condition would be effective in either reducing or stabilizing the veteran's level of permanent disability from the condition, thereby

reducing the amount of VA disability benefits ultimately awarded for the condition. No data exist to support or refute that assumption.

With the exception of substance abuse disorders, we are likewise unaware of any data to support or refute the bill's underlying assumption that paying a veteran a "wellness stipend" will ensure the patient's compliance with his or her treatment program. Although there is a growing trend among health insurance carriers or employers to provide short-term financial incentives for their enrollees or employees to participate in preventive health care programs (e.g., reducing premiums for an enrollee who participate in a fitness program, loses weight, or quits smoking), we are unaware of any data establishing that these and similar financial incentives produce long-term cost-savings to the carrier or employer. It would be extremely difficult, if not impossible, to quantify savings or offsets because there is no way to know whether a particular patient's health status would have worsened without VA's intervention and whether the intervention directly resulted in a certain or predictable total amount in health care expenditure savings. We would experience the same difficulties trying to identify what would have been the level of disability and costs of care for a particular veteran had he or she not participated in the early clinical intervention program established by S. 2573.

Providing these mental health care benefits independent of the medical benefits package provided to enrolled veterans gives rise to other concerns. A veteran's mental health and physical health are integral, and it would be very difficult to discern if certain conditions or physical manifestations that may result from or be related to a mental health condition are covered by S. 2573. As a provider, VA would need to assume that this bill would cover needed care for physical conditions that result from, or are associated with, the covered mental health condition under treatment. (Our approach would be similar to the approach taken under the Department's authority in 38 U.S.C. §1720D to provide both counseling and care needed to treat psychological conditions resulting from

sexual trauma.) For instance, recent scientific literature has linked heart disease to stress. Heart disease might at some point be linked to depression, PTSD and/or anxiety disorder. We believe that unless the scientific literature conclusively rules out an association between a covered mental health condition and the veteran's physical condition, the veteran should receive the benefit of the doubt. This could expand the scope of S. 2573 beyond the drafter's intent, because the types of physical conditions considered by the scientific community to be associated with mental health conditions could expand over time. Should this happen, S. 2573 could lead to VA essentially operating two different health care systems based on separate sets of eligibility criteria, undermining the accomplishments achieved under VA health care reform.

It is also troubling to us that S. 2573 would require VA to treat specific diseases and not the veteran as a whole. This approach places VA practitioners in the difficult and untenable position of being able to identify conditions they cannot treat. This creates a particularly serious ethical dilemma for the practitioner who knows that his or her veteran-patient has no other access to the needed health care services. In our view, authority to treat specific diseases --and not the person-- is counter to the principles of patient-centered and holistic medicine.

The "wellness" stipends, themselves, raise several complex issues. None of VA's current benefits systems is equipped to administer such a novel benefit, and no current account appears to be an appropriate funding source from which to pay them. After much grappling with the issue, we have concluded that because the bill would amend only chapter 17 of title 38, United States Code, these stipends would have to be administered by VHA and paid from funds made available for medical care.

There would be significant indirect costs as well. VHA currently lacks the IT infrastructure, expertise, and staff to administer monetary benefits. Administering the easiest of monetary benefits would be challenging for VHA, but it is nearly

insurmountable in connection with this bill, which calls for a very complex, nation-wide patient tracking and monitoring system that also has the capacity to administer payments at different points in time for veterans participating in the program. The fact that the duration of each veteran's treatment plan is highly individualized only complicates the requirements of such a system-design, as does the fact that the bill would permit some veterans to receive treatment (and payment) extensions.

As a result, we do not believe that S. 2573 would be cost-effective as currently drafted. The maximum we could pay any veteran under the bill would be $11,000; however, it is reasonable to assume that the costs associated with designing, operating, and administering such a complex benefit program would far surpass the actual amounts we would pay out to the veterans (individually or collectively).

S. 2573 also places our physicians and practitioners in the difficult position of determining whether their patients will receive wellness stipends available under the program. It is quite atypical for a VA physician's clinical determination to have direct financial implications or consequences for his or her patients. VA physicians and practitioners seek to help their veteran-patients attain maximum functioning as quickly as clinically possible. S. 2573 would create potential conflict for our health care practitioners. They should focus solely on issues of health care and not feel pressure to grant requests for extensions of treatment in order to maximize the amount of money patients receive under the program.

It would also be difficult to define "substantial compliance," for purposes of S. 2573, in a way that is measurable and objective as well as not easily amenable to fraud or abuse. For instance, substantial compliance could be defined in part by a veteran stating that he or she took prescribed medications as ordered by the physician and VA could confirm the veteran obtained refills in a timely manner. But that information does not actually verify that the patient in

fact ingested the medication or did so as prescribed. There would unavoidably be some patients whose motivation for participating in this program is strictly financial, and they would invariably find ways to circumvent whatever criteria we establish in order to receive their stipends. Although these payments would not be sizeable, they are sufficient to entice some patients who would not otherwise access VA's health care system to participate in the program. We fear these patients would cease their treatment and stop accessing needed VA services once their treatment and payments end.

Finally, if the use of "wellness" stipends were able to produce reliable, positive results in terms of patients' compliance or outcomes, there would then be a demand to extend this reward system to other VA treatment programs. And once a benefit is provided, it is difficult to ever repeal it. We say this only to point out that the cost implications in the out-years could be very difficult to estimate accurately.

Costing this bill is very complex, as there is no way for us to determine the total number of veterans who would participate in the pilot program, in which year they would enter the program, their ultimate disability status, and the amount of medical care they would each require. We estimate the increase in medical administrative costs for every 40,000 new veterans entering the VA system to be $280 million per year in addition to $293,340,000 per year in maximum stipend payments. The estimated one-time cost for eligible living veterans is $6,712,891,046. These costs do not factor in the costs of developing the IT infrastructure needed to administer the benefit. In light of these serious concerns and the bill's unknown total cost implications, we are unable to supports its enactment.

S. 2639 "Assured Funding for Veterans Health Care Act"

S. 2639 would establish, by formula, the annual level of funding for all VHA programs, activities, and functions (excluding the construction, acquisition, and

alteration of VA medical facilities and provision of grants to assist States in the construction or alteration of State home facilities).

VHA funding for FY 2008 (the first fiscal year covered by the bill) would be automatically established at 130% of the amounts obligated by VHA (for all its activities, programs, and functions) for FY 2006. Thereafter, VHA funding would be automatically determined by a fixed formula. The formula would, generally speaking, be based on the number of enrollees each year and the number of other persons receiving VA care during the preceding year multiplied by a fixed per capita amount. The per capita amount would be adjusted annually in accordance with increases in the Consumer Price Index.

It has been VA's long-standing position that we do not support the concept of using a fixed formula to determine VHA funding. We believe that it is inappropriate and unworkable to apply an inflexible formula to a health care system that, by its very nature, is dynamic. The provision of care evolves continually to reflect advances in state of the art technologies (including pharmaceuticals) and medical practices. It is not possible to estimate the concomitant costs or savings resulting from those evolving changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. The proposed formula would not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be appropriate to the demands that will be placed on VA's health care system in the upcoming years.

Use of an automatic funding mechanism would also eliminate the valuable opportunity that members of the Congress and the Executive Branch have to carry out their responsibility to identify and directly address the health care needs of veterans through the budget process. It could also depress the Department's incentive to improve its operations and be more efficient. It is important to note

that S. 2639 would not ensure open enrollment, as the Department would still be required to make an annual enrollment decision. That decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Finally, references to "guaranteed funding" in the legislation may give the public the false impression that VA is being provided full funding for VA health care. It is not possible to determine whether the amount determined by the formula would be adequate. Because of S. 2639's potential for all of these unanticipated and unintended serious consequences, we continue to favor the current discretionary funding process that uses actuarially-based budget estimates to project the future health care needs of enrolled veterans.

S. 2796 Pilot Program Using Community Based Organizations to Increase the Coordination of VA Services to Transitioning Veterans

S. 2796 would require the Secretary to carry out a two-year pilot grant program (at five VA medical centers) to assess the feasibility of using community-based organizations to increase the coordination of VA benefits and services to veterans transitioning from military service to civilian life, to increase the availability of medical services available to these veterans, and to provide their families with their own readjustment services. Specifically, grantees could use grant funds to operate local telephone hotlines; organize veterans for networking purposes; assist veterans in preparing applications for VA benefits; provide readjustment assistance to families of veterans transitioning from military life to civilian life; provide outreach to veterans and their families about VA benefits; and coordinate the provision of health care and other benefits being furnished to transitioning veterans.

VA does not support S. 2796, because it is duplicative of the Department's on-going efforts. Vet Centers are already providing much of the outreach, readjustment counseling services, and family support services that would be required by this bill. Additionally, VA case managers and federal recovery coordinators already coordinate the delivery of health care and other VA services

available to veterans transitioning from military service to civilian life, including supportive services for their families. VA is committing ever increasing resources to these ends. Use of grant funds to establish local hotlines would duplicate and dilute the effectiveness of VA's central hotlines. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary. Further, funding family readjustment services wholly unrelated to the veteran's readjustment needs would divert medical care funds needed for veterans' health care.

To the extent the Secretary determines external resources are necessary to provide the services described in the bill, VA already has the necessary authority to contract for them. We favor using contracts instead of grants, as the former allow VA to respond to changing local needs. That approach also gives us an accurate way to project the cost of the services. S. 2796, on the other hand, would not. It would also not be cost-effective as it is likely that a grant awarded under the program would be for an amount significantly less than the cost VA incurs in administering the grant. We also note the bill would not include authority for VA to recapture unused grant funds in the event a grantee fails to provide the services described in the grant.

We note further that when selecting pilot sites the Secretary would have to consider medical centers that have "a high proportion of minority groups and individuals who have experienced significant disparities in the receipt of health care." We are uncertain what this language means and on what basis such a determination would be based.

Although the proposed pilot project is limited to five VA medical centers, the scope of the uses for the grant funds is very broad, and the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost estimate of S. 2796 due to the bill's lack of specificity.

S. 2799 "Women Veterans Health Care Improvement Act of 2008"

In general, title I of S. 2799 would require VA to conduct a number of studies related to health care benefits for women veterans. Section 101 would require VA, in collaboration with VHA's War-Related Injury and Illness Study Centers, to contract for an epidemiologic cohort (longitudinal) study on the health consequences of combat service of women veterans who served in OEF/OIF. The study would need to include information on their general, mental, and reproductive health and mortality and include the provision of physical examinations and diagnostic testing to a representative sample of the cohort.

The bill would require VA to use a sufficiently large cohort of women veterans and require a minimum follow-up period of ten years. The bill also would require VA to enter into arrangements with the Department of Defense (DoD) for purposes of carrying out this study. For its part, DoD would be required to provide VA with relevant health care data, including pre-deployment health and health risk assessments, and to provide VA access to the cohort while they are serving in the Armed Forces.

Mr. Chairman, we do not support section 101. It is not needed. A longitudinal study is already underway. In 2007, VA initiated its own 10-year study, the "Longitudinal Epidemiologic Surveillance on the Mortality and Morbidity of OIF/OEF Veterans including Women Veterans." Several portions of the study mandated by section 101 are already incorporated into this project and planning for the actual conduct of the study is underway. The study has already been approved to include 12,000 women veterans. However, section 101 would require us to expand our study to include women active duty service members. We estimate the additional cost of including these individuals in the study sample to be $1 million each year and $3 million over a 10-year period.

Section 102 would require VA to conduct a comprehensive assessment of the barriers to the receipt of comprehensive VA health care faced by women

veterans, particularly those experienced by veterans of OEF/OIF. The study would have to research the effects of 9 specified factors set forth in the bill that could prove to be barriers to access to care, such as the availability of child care and women veterans' perception of personal safety and comfort provided in VA facilities.

Neither do we support section 102. It is not necessary because a similar comprehensive study is already underway. VA contracted for a "National Survey of Women veterans in FY 2007-2008," which is a structured survey based on a pilot survey conducted in VISN 21. This study is examining barriers to care (including access) and includes women veterans of all eras of service. Additionally, it includes women veterans who never used VA for their care and those who no longer continue to use VA for their health care needs. We estimate no additional costs for section 102 because VA's own comparable study is underway, with $975,000 in funding committed for FYs 2007 and 2008.

Section 103 would require VA to conduct, either directly or by contract, a comprehensive assessment of all VA programs intended to address the health of women veterans, including those related to PTSD, homelessness, substance abuse and mental health, and pregnancy care. As part of the study, the Secretary would have to determine whether the following programs are readily available and easily accessed by women veterans: health promotion programs, disease prevention programs, reproductive health programs, and such other programs the Secretary specifies. VA would also have to identify the frequency such services are provided; the demographics of the women veteran population seeking such services; the sites where the services are provided; and whether waiting lists, geographic distance, and other factors obstructed their receipt of any of these services.

In response to the comprehensive assessment, section 103 would further require VA to develop a program to improve the provision of health care services to

women veterans and to project their future health care needs. In so doing, VA would have to identify the services available under each program at each VA medical center and the projected resource and staffing requirements needed to meet the projected workload demands.

Section 103 would require a very complex and costly study. While we maintain data on veteran populations receiving VA health care services that account for the types of clinical services offered by gender, VA's Strategic Health Care Group for Women Veterans already studies and uses available data and analyses to assess and project the needs of women veterans for the Under Secretary for Health. Furthermore, we lack current resources to carry out such a comprehensive study within the 18-month time-frame. We would therefore have to contract for such a study with an entity having, among other things, significant expertise in evaluating large health care systems. This is not to say that further assessment is not needed. We recognize there may well be gaps in services for women veterans, especially given that VA designed its clinics and services based on data when women comprised a much smaller percentage of those serving in the Armed Forces. However, the study required by section 103 would unacceptably divert significant funding from direct medical care. Section 103 would have a cost of $4,354,000 in FY 2008.

Section 104 would require VA to contract with the Institute of Medicine (IOM) for a study on the health consequences of women veterans' service in OEF/OIF. The study would need to include a review and analysis of the relevant scientific literature to ascertain environmental and occupational exposure experienced by women who served on active duty in OEF/OIF. It would then have to address whether any associations exist between those environmental and occupational exposures and the women veterans' general health, mental health, or reproductive health.

We do not object to section 104. We suggest the language be modified to allow VA to decide which organization is best situated to carry out this study (taking into account the best contract bid). While IOM has done similar studies in the past, this provision would unnecessarily foreclose the possibility of using other organizations. We estimate the one-time cost of section 104 to be $1,250,000, which can be funded from existing resources.

Section 201 would authorize VA to furnish care to a newborn child of a woman veteran who is receiving VA maternity care for up to 30 days after the birth of the child in a VA facility or a facility under contract for the delivery services. We can support this provision with modifications. As drafted, the provision is too broadly worded. We believe this section should be modified so that it applies only to cases where a covered newborn requires neonatal care services immediately after delivery. The bill language should also make clear that this authority would not extend to routine baby well-baby services.

We are currently unable to estimate the costs associated with section 201 without data on projected health care workload demands and future utilization requirements. We have contracted for that data and we will forward the estimated costs for this section as soon as they are available.

Section 202 would require the Secretary to establish a program for education, training, certification and continuing medical education for VA mental health professionals furnishing care and counseling services for military sexual trauma (MST). VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based treatment. The provision would establish extremely detailed reporting requirements. VA would also have to establish education, training, certification, and staffing standards for VA health care facilities for full-time equivalent employees who are trained to provide MST services.

We do not support the training-related requirements of section 202 because they are duplicative of existing programs. In FY 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related training and education opportunities nationwide. VA also hosts an annual four-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. VA has recently unveiled the MST Resource Homepage, a webpage that serves as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to the requirement for staffing standards. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population, workload, staffing, and other capacity issues. Retaining this flexibility is essential to permit VA and individual facilities to respond to changing needs and available resources. Imposition of national staffing standards would be an utterly inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 203 would require the Secretary to establish, through the National Center for PTSD, a similar education, training, and certification program for health care professionals providing evidence-based treatment of PTSD and other co-morbid conditions associated with MST to women veterans. It would require VA to

provide these professionals with continuing medical education, regular competency evaluations, and mentoring.

VA does not support section 203 because it is duplicative of, and would divert resources from, activities already underway by the Department. VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans and this is a key component of VA's Mental Health Strategic Plan. We are currently working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout our health care system. There are also two programs underway to provide clinical training to VA mental health staff in the delivery of certain therapies shown to be effective for PTSD, which are also recommended in the VA/DoD Clinical Practice Guidelines for PTSD. Each training program includes a component to train the professional who will train others in this area, to promote wider dissemination and sustainability over time.

Section 204 would require the Secretary, commencing not later than six months after the date of enactment, to carry out a two-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of child care they incur to travel to and from VA facilities for regular mental health services, intensive mental health services, or other intensive health care services specified by the Secretary. The provision is gender-neutral. Any veteran who is a child's primary caretaker and who is receiving covered health care services would be eligible to participate in the pilot program. VA does not support this provision. Although the inability to secure child care may be a barrier to access to care for some veterans, funding such care would divert those funds from direct patient care. We estimate the cost of section 204 to be $3 million.

Section 205 would require VA, not later than six months after the date of enactment, to conduct a pilot program to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting to women

veterans recently separated from service after a prolonged deployment. Participation in the pilot would be at the election of the veteran. Services provided under the pilot would include, for instance, traditional VA readjustment counseling services, financial counseling, information on stress reduction, and information and counseling on conflict resolution.

VA has no objection to section 205; however, we are unclear as to the purpose of and need for the bill. We note the term "group retreat setting" is not defined. We would not interpret that term to include a VA medical facility, as we do not believe that would meet the intent of the bill. We also assume this term would not include Vet Centers as we could not limit Vet Center access to any one group of veterans. Moreover, many Vet Centers, such as the one in Alexandria, Virginia, are already well designed to meet the individual and group needs of women veterans. Section 205 would have no costs.

Section 206 would require the Secretary to ensure there is at least one full-time employee at each VA medical center serving as a women veterans program manager. We strongly support this provision. The position of the women veterans program manager has evolved from an overseer of local programs to ensure access to care for women veterans to a position requiring sophisticated management and administrative skills necessary to execute comprehensive planning for women's health issues and to ensure these veterans receive quality care as evidenced, in part, by performance measures and outcome measurements. The duties of this position will only continue to grow as we strive to expand services to women veterans. Thus, we believe there is support for the dedication of a full-time employee equivalent at every VA medical center. We estimate section 206 would result in additional costs of $7,131,975 for FY 2010 and $86,025,382 over a 10-year period.

Next, section 207 would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are

recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. These requirements would apply to committee appointments made on or after the bill's enactment. We support section 207. Given the expanded role of women and minority veterans serving in the Armed Forces, the Committees should address the needs of these cohorts in carrying out their reviews and making their recommendations to the Secretary. Having their perspective may help project both immediate and future needs.

S. 2824 Collective Bargaining Rights for Review of Adverse Actions

The major provision of S. 2824 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. It would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines concern the professional conduct or competence, peer review, or compensation of Title 38 employees. The Secretary would also be required to bargain over direct patient care and clinical competency issues, the processes VA uses to assess Title 38 professionals' clinical skills, and the discretionary aspects of Title 38 compensation, including performance pay, locality pay, and market pay. Because they would be negotiable these matters would also be subject to non-clinical, non-VA third party review.

VA strongly opposes this provision. Prior to 1991, Title 38 professionals did not have the right to engage in collective bargaining at all. The current restriction on collective bargaining rights is a sound compromise between VA's mission – best serving the needs of our nation's veterans – and the interest of Title 38 physicians, nurses, and other professionals in engaging in collective bargaining. Importantly, Congress recognized that the Secretary, as the head of the VA healthcare system, would be in the best position to decide when a particular proposal or grievance falls within one of the statutory areas excluded from bargaining. Such determinations should not be legislated. Neither should they

be made by a non-clinical third party who is not accountable for assuring the health and safety of the veterans the Department is responsible for. If the Secretary and the Under Secretary for Health are going to be responsible and accountable for the quality of care provided to and the safety of veterans, they must be able to determine which matters affect that care. They must be able to establish standards of professional conduct by and competency of our clinical providers based on what is best for our veterans rather than what is the best that can be negotiated or what an arbitrator decides is appropriate. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. VA has not abused this discretionary authority. Since 1992, there have been no more than 13 decisions issued in a one-year period and, in most cases, even far fewer decisions than that. This is particularly striking given the number of VA healthcare facilities and bargaining unit employees at those facilities. We are therefore at a loss to understand the need for this provision.

S. 2824 would also transfer VA's Title 38 specific authorities, namely the right to make direct patient care and clinical competency decisions, assess Title 38 professionals' clinical skills, and determine discretionary compensation for Title 38 professionals, to independent third-party arbitrators and other non-VA non clinical labor third parties who lack clinical training and understanding of health care management to make such determinations. For instance, labor grievance arbitrators and the Federal Service Impasses Panel would have considerable discretion to impose a clinical or patient care resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of the clinical or patient care issue. The exceptions to collective bargaining rights for Title 38 employees identify areas that directly impact VA's ability to manage its healthcare facilities and monitor the professional conduct and competence of its employees; management actions concerning these areas must be reserved for VA professionals.

This bill would allow unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the manner by which an employee is disciplined and the determination of the amount of an employee's compensation. That would be unprecedented in the Federal government. Such a significant change in VA's collective bargaining obligations would adversely impact VA's budget and management rights; it would also skew the current balance maintained between providing beneficial working conditions for Title 38 professionals and meeting patient care needs, jeopardizing the lives of our veterans. There would be no costs associated with this provision.

S. 2921 Caring for Wounded Warriors Act of 2008

Section 2 would require the Secretary to conduct up to three pilot programs, in collaboration with the Secretary of Defense, to assess the feasibility of training and certifying family caregivers to be personal care attendants for veterans and members of the of the Armed Forces suffering from TBI. VA would be required to determine the eligibility of a family member to participate in the pilot programs, and such a determination would have to be based on the needs of the veteran or service member as determined by the patient's physician. The training curricula would be developed by VA and include applicable standards and protocols used by certification programs of national brain injury care specialist organizations and best practices recognized by caregiver organizations. Training costs would be borne by VA, with DoD required to reimburse VA at TRICARE rates for the costs of training family members of service members. Family caregivers certified under this program shall be eligible for VA compensation and may receive assessments of their needs in the role of caregiver and referrals to community resources to obtain needed services.

VA does not support section 2. Currently, we are able to contract for caregiver services with home health and similar public and private agencies. The contractor trains and pays them, affords them liability protection, and oversees

the quality of their care. This remains the preferable arrangement as it does not divert VA from its primary mission of treating veterans and training clinicians.

Section 3 would require VA, in collaboration with DoD, to carry out a pilot program to assess the feasibility of providing respite care to family caregivers of service members and veterans diagnosed with TBI, through the use of students enrolled in graduate education programs in the fields of mental health or rehabilitation. Students participating in the program would, in exchange for graduate course credit, provide respite relief to the service member's or veteran's family caregiver, while also providing socialization and cognitive skill development to the service member or veteran. VA would be required to recruit these students, train them in the provision of respite care, and work with the heads of their graduate programs to determine the amount of training and experience needed to participate in the pilot program.

We do not support section 3, which we recognize is an effort to compel VA to use existing arrangements with affiliated academic institutions as a novel means of providing respite care to family caregivers of TBI patients. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care is an unskilled type of service that does not qualify for academic credit or serve to meet any curricula objectives in the graduate degree programs related to mental health or rehabilitation. Further, section 3 would require VA to use graduate students in roles that are not permissible under academic affiliation agreements, and we have serious doubts this proposal would be acceptable to graduate schools.

Moreover, VA has a comprehensive respite care program. We also have specialized initiatives underway for TBI patients to reduce the strain on their caregivers, which overlap with this bill. Plus we provide respite care by placing the veteran in a local VA facility for the duration of the respite period. Veterans

may receive up to 30 days of respite care per year. We estimate the costs of S. 2921 to be $39,929,000 for FY 2010 and $790,374,000 over a ten-year period.

S. 2899 "Veterans Suicide Study Act"

S. 2899 would require the Secretary to conduct a study to determine the number of veterans who have committed suicide between January 1, 1997, and the date of the bill's enactment. The study would have to be carried out in coordination with the Secretary of Defense, Veterans Service Organizations, the Centers for Disease Control and Prevention, and State public health offices and veterans agencies. The bill would require the Secretary to submit a report to Congress on his findings within 180 days of the bill's enactment.

VA understands the intent of the Senate in proposing S. 2899. However, we would like to make the Senate aware of the difficulties in accomplishing the legislation's intent—and what VA is doing, and intends to do, to improve our ability to obtain and report on suicide numbers.

At present, determining suicide rates among veterans is a challenging puzzle. Multiple data sources must be used, and data must be carefully checked and rechecked. Each system helps obtain a piece of the complicated puzzle that constitutes the process of accurately estimating rates of veteran suicides. These are time-consuming processes—but they are the best ways VA knows to obtain aggregate data on suicide.

VA relies on multiple sources of information to identify deaths that are potentially due to suicide. This includes VA's own Beneficiary Identification and Records Locator Subsystem, called BIRLS; records from the Social Security Administration; and data compiled by the National Center for Health Statistics in its National Death Index (NDI)

Calculating suicide rates specifically for veterans is made even more difficult by the fact that the National Death Index does not include information about whether a deceased individual is a veteran or not. NDI is simply a central computerized index of death record information on file in the vital statistics offices of every state. The Index is compiled from computer files submitted by State vital statistics offices. Death records are added to the file annually, about twelve months after the end of a calendar year.

Given that the NDI does not indicate veteran status, VA regularly submits requests for information to NDI. VA sends NDI a list of all patients who have not been treated at any VA medical centers in the past twelve months and before, to see if they are still among the living. NDI checks this list against their records, and tells VA which veterans have died, and the cause of their death as listed on the veterans' death certificates. From this information, VA is able to learn the approximate number of veterans under its care who have died of suicide, and to use that information to make comparisons on rates of suicide among those veterans and all other Americans.

This information tells VA about the suicide rates among veterans under its care, but says nothing about the rates of suicide among veterans who are not currently in the system. For those veterans, an even more complicated process has to be followed in order to estimate rates. VA obtains regular updates from the Department of Defense's Defense Manpower Data Center on soldiers separating from the military. Those new veterans immediately become part of total population and suicide calculations.

Additionally, the Department will, among other things, also systematically assess its efforts to inform funeral directors about the importance of determining whether or not a person who has died of suicide is or is not a veteran, and what sorts of information to consider in making that determination. Finally, VA will investigate

working directly with state vital records offices, as the NDI does, to obtain information on veteran suicides directly from them.

VA asks that the Senate give us time to complete these actions before requiring any study of the numbers of suicides among veterans. We are "pushing the envelope" to get the most accurate data available on suicides in the shortest possible time frame, and we commit to sharing that data with Congress as soon as it becomes available.

We estimate the cost of this bill to be $1,580,006 in FY 2008 and $2,078,667 over a 10--year period.

S. 2937 Permanent Treatment Authority for Veterans Who Participated in Certain DoD Testing

Section 1 would make permanent the Secretary's authority to provide needed inpatient, outpatient, and nursing home care to a veteran who participated in a test conducted by the Department of Defense (DoD) Deseret Test Center as part of its chemical and biological warfare testing program conducted from 1962-1973, for any condition or illness possibly associated with such testing at no cost to the veteran. This authority will expire after December 31, 2008.

VA supports section 1, which we note is identical to our own proposal in S. 2984. We estimate the discretionary cost of this provision to be $4,458,000 in FY 2009 and $144,434,000 over a 10-year period.

Section 2 would require the Secretary, not later than 90 days after the date of the Act's enactment, to enter into a contract with IOM to conduct an expanded study on the health impact of participation in Project Shipboard Hazard and Defense (Project SHAD). Such a study should include, to the extent practicable, all veterans who participated in Project SHAD. VA does not support this provision, as we doubt that an expanded study could be conducted by IOM or any other

organization because IOM has already thoroughly studied the health of SHAD veterans and made a concerted attempt to identify all involved veterans for its study.

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