LEGISLATIVE HEARING ON H.R. 1293, H.R. 1197, H.R. 1302, H.R. 1335, H.R. 1546, H.R. 2734, H.R. 2738, H.R. 2770, H.R. 2898 AND DRAFT DISCUSSION LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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THURSDAY, JUNE 18, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Deborah Halvorson presiding.

Present: Representatives Teague, McNerney, Halvorson, Perriello, Boozman, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN MICHAUD, AS PRESENTED BY HON. DEBORAH L. HALVORSON

Mrs. HALVORSON [presiding]. This hearing will now come to order.

Before I go into my opening statement, I would like to welcome to the hearing today a distinguished group of law students who are spending the summer with the Board of Veterans' Appeals. Many fine law schools are represented and there are veterans, members of the National Guard, and a Marine spouse among the group.

So, again, welcome to the hearing today. If you would like to stand up, I would like to welcome you, if anybody is here in the audience today. Thank you.

[Applause.]

Mrs. HALVORSON. Thank you for being with us today. I would like to thank everyone for coming.

Actually, before I start on my opening remark, I want to tell the audience that we are scheduled for votes somewhere between 10:15 and 10:30. And it is not like there will be one or two votes. There will be about 27 of them. What we do not get done, I am going to ask all the panelists to submit their testimony for the record. And anybody else, any questions that they have will be answered by staff.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA, and other interested parties to provide their views on and discuss draft legislation as well as recently introduced legislation within this Subcommittee's jurisdiction in a clear and orderly process.

So I do not necessarily agree or disagree with the bills here today, but I do believe that this is an important part of the legislative process.

So I welcome frank, open discussions from all parties that this legislation would affect.

We have 11 bills before us today. And obviously we will probably be submitting most of them for the record. And each of the bills addresses important issues affecting our veterans and their families.

These bills address a wide range of issues including help for family caregivers of wounded veterans, improving the nonprofit research and education corporations, establishing a position of Director of Physician Assistant, and creating a Committee on Care of Veterans with Traumatic Brain Injury.

[The prepared statement of Chairman Michaud appears on p. 15.]

Mrs. HALVORSON. We will also consider a lot of other important bills. But at this time, I would like to allow Mr. Hare a chance—oh, I am sorry. Mr. Bilirakis, would you like to give an opening remark, please?

OPENING STATEMENT OF HON. GUS M. BILIRAKIS

Mr. BILIRAKIS. Just very brief. Thank you very much, I appreciate it, Madam Chair.

I appreciate you holding this legislative hearing and welcome the opportunity to discuss the 11 legislative proposals before us today.

Knowing we have a full schedule, and of course votes coming up this morning, I will keep my remarks very brief.

Our Ranking Member, Steve Buyer, is a sponsor of one of the bills on the agenda, H.R. 1293, the "Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009."

Unfortunately, Steve is unable to be here this morning, and I ask unanimous consent, Madam Chair, that his statement be included in the record.

Mrs. HALVORSON. So ordered.

[The prepared statement of Congressman Buyer appears on p. 27.]

Mr. BILIRAKIS. Thank you.

In his absence, I would like to take a few moments to explain this bill.

H.R. 1293 would increase the amount available for grants under the Home Improvement and Structural Alteration (HISA) Program. The HISA program provides grants as part of the U.S. Department of Veterans Affairs' (VA's) Home Health Services to make home improvements that are necessary to continue care in the veteran's home.

Both veterans with service-connected and nonservice-connected disabilities are eligible to receive this benefit.

H.R. 1293 would raise the authorized grant amount from $4,100 to $6,800 for service-connected veterans and from $1,200 to $2,000 for nonservice-connected veterans.

It is a good, bipartisan bill and I urge my colleagues to support it.

In closing, I want to thank all the Members who have introduced the bills we will consider today and all of our witnesses for taking time to provide their views. I look forward to a productive discussion and I yield back.

Thank you, Madam Chair.

Mrs. HALVORSON. Thank you, Mr. Bilirakis, for being here and for being a part of this.

So we will start with Mr. Hare and then we will go to Mr. Mitchell.

STATEMENTS OF HON. PHIL HARE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS, AND HON. HARRY E. MITCHELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Madam Chair. Good morning.

And let me just say before I give the testimony how very much I appreciate having the opportunity to be here today. I miss this Subcommittee and I miss the full Committee. It is an incredible Committee and it works in a very wonderful, bipartisan way.

So thank you for having me.

Ranking Member Bilirakis, thank you, too, for allowing me to be here today.

I am very pleased to provide testimony in support of H.R. 1302, a bill that I introduced to elevate the current physician assistant (PA) Advisor, also known as the PA Advisor, to a full-time Director of PA services in the VA's Central Office.

I would like to thank my colleagues, Representative Jerry Moran for his leadership with me on this bill as well as Chairman Filner, Chairman Michaud, Ranking Member Buyer and Brown and many other VA Committee colleagues joining us as co-sponsors.

PAs have long been a key component in the Veterans Health Administration, with over 1,800 PAs currently employed there, roughly 30 percent of whom are veterans.

While the PA Advisor position established by Congress in the year 2000 has been valuable, many problems still exist.

For example, as the AAPA explained in their written testimony of October 18, 2007, "In one case, a local facility decided that a PA could not write out patient 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 inconsistencies and restrictions not only hinder PAs currently employed by the VA, but also discourage PAs from even entering the VA system. Quite simply, this is a position that needs to be made permanent and based at the VA Central Office.

The lack of a Director of PA services at the VA prevents necessary recruitment and retention of the PA workforce in the VA, all at a time when the Veterans Administration needs more health care professionals to provide medical care for our veterans.

Considering the fact that nearly 40 percent of all VA PAs are projected to retire in the next 5 years, the VA is in danger of losing its PA workforce unless some attention is directed toward recruiting and retention of this critical group of people.

PAs are the fourth fastest-growing profession in the country, yet the VA is simply not competitive with the private sector for new PA graduates and is missing an opportunity to improve the quality of veterans' health care.

One of the biggest challenges facing current and future PAs in the VA system is their exclusion from recruitment and retention efforts and benefits.

The VA designates physicians and nurses as critical occupations and so priority, scholarships and loan repayment programs to those critical occupations.

However, the PA profession has not been determined to be a critical occupation at the VA despite the fact that the VA has determined that PAs and Nurse Practitioners (NPs) are functionally interchangeable and that they perform equal work.

A permanent Director at the Veterans Affairs Central Office (VACO) would serve as an advocate on behalf of the physician assistants and work to ensure their fair treatment.

Additionally, VA medical facilities at times post vacant positions for NPs only, excluding physician assistants. There is also a hiring trend in the VA of NPs outpacing PAs nearly three to one, again despite the interchangeability between the NPs and the physician assistants.

Finally, PAs are not included in any of the VA's special locality pay bands, so PAs' salaries are not regularly tracked and reported by the VA. There is evidence that this has resulted in lower pay for physician assistants employed by the VA compared to other health care professionals. This only serves as yet another deterrent to PAs to enter the VA system.

The physician assistant profession is invaluable to the VA and it is time for the VA to devote some serious attention to the profession's recruitment and retention.

Enactment of my bill, H.R. 1302, is a very good start. There is no significant cost to elevating and relocating the position. This change is common sense and it promotes quality medical care for our veterans.

H.R. 1302 is nearly identical to a bill that was reported by your Committee in the 110th Congress, which passed the House by a unanimous voice vote.

This bill, which also has been endorsed in the Senate by Senator Susan Collins of Maine and Daniel Inouye of Hawaii, is supported by the Veterans Affairs Physician Assistant Association, the American Academy of Physician Assistants, and the Blinded Veterans Association.

Madam Chairman and Ranking Member, thank you again for allowing me to testify on the importance of physician assistants in the VA health care system. I appreciate your giving me the time and would be happy to answer any questions you may have.

Thank you again very much for having me this morning.

Mrs. HALVORSON. Do the Members have any questions?

[No response.]

At this time, we will go to Mr. Mitchell for his 5 minutes.

STATEMENT OF HON. HARRY E. MITCHELL

Mr. MITCHELL. Thank you, Madam Chair. And I want to thank you for inviting me to speak this morning in support of H.R. 1197, the "Medal of Honor Health Care Equity Act of 2009."

The Congressional Medal of Honor is awarded for conspicuous gallantry and intrepidity at the risk of life above and beyond the

call of duty. It is the military's highest honor. Today there are only 98 living recipients.

Last year, a medal recipient was injured in Chandler, Arizona. This veteran, Fred Ferguson, was awarded the Medal of Honor for flying his helicopter into enemy fire over Hue' Vietnam. Despite his valor, which saved the lives of five fellow soldiers, he was ineligible for health care through the VA when he was injured.

The VA uses a priority scale to determine eligibility for health care services. Top priority is given to veterans with service-connected disabilities, former prisoners of war, and Purple Heart recipients. Priority is also given to those who have rendered special service or who demonstrate financial need.

Each of these categories of veterans should be ensured priority access to health care. Unfortunately, Medal of Honor recipients do not automatically fall into any of these priority categories and some of them fall through the cracks.

Now Fred Ferguson may not need medical care from the VA. In fact, he received excellent care at Scottsdale Healthcare Osborn's Hospital.

But in order to ensure that the 98 living Medal recipients and all future Medal of Honor recipients have guaranteed access to high-quality health care, Dr. Roe, my Republican counterpart on the Oversight and Investigation Subcommittee, joined me in introducing the "Medal of Honor Health Care Equity Act."

We are not talking about a large population of veterans, but they deserve access to medical care from the VA no matter what.

H.R. 1197 has been endorsed by the Disabled American Veterans (DAV) and I appreciate your support for this bill.

Madam Chair, thank you again for permitting me to appear before the Subcommittee today and I will be very glad to answer any questions. Thank you.

Mrs. HALVORSON. Are there any questions?

[No response.]

At this time, I would like to bring up panel two, which includes myself, Mr. McNerney, Mr. Perriello, and Mr. Teague.

Thank you for not waiting for me to dismiss you. You would have been sitting there for a while.

Gentlemen, since I am here, I will go last.

Mr. McNerney, if you would like to proceed with your 5 minutes.

STATEMENTS OF HON. JERRY MCNERNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. HARRY TEAGUE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO; AND HON. DEBORAH L. HALVORSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

STATEMENT OF JERRY MCNERNEY

Mr. MCNERNEY. Thank you, Chairwoman Halvorson.

I would like to thank the Chairman of the Committee, Mr. Filner, the Ranking Member, Mr. Buyer, leadership from Mr. Boozman, and Mr. Michaud for their hard work on behalf of our veterans and all Members of the Committee for being on the Com-

mittee and working hard and looking out for our veterans' best interests.

I am going to be speaking on behalf of traumatic brain injury (TBI), a bill which I introduced last year and passed by unanimous consent.

More than 1.6 million troops have served in Iraq and Afghanistan and about half of those brave men and women are now veterans. Traumatic brain injury or TBI has become the signature wound of the wars in Iraq and Afghanistan.

A RAND Corporation study estimates that up to 320,000 troops who served in these conflicts suffer from brain trauma. Milder forms of TBI can result, this is milder forms, can result in cognitive problems such as headaches, difficulty in thinking, memory problems, abnormal speech or language, and limited functioning of arms and legs.

TBI's effects on veterans and their families can be devastating.

I have met personally with several veterans in my district who suffer from severe brain injury in Iraq. One is doing well in my hometown with a 4-year scholarship from the Sentinels of Freedom. I just had lunch with him a couple of weeks ago and I am very pleased to see how well he has adjusted.

Unfortunately, many wounded veterans face an even more arduous path to recovery.

The brain is probably the most adaptable organ of the body, but any time there is a traumatic injury or section of the brain that is damaged, it takes time to adjust and compensate.

When a soldier is wounded, he or she is first transported to a trauma center to treat brain swelling. Brain swelling is the biggest and most immediate risk from a brain injury.

After being stabilized, soldiers may face invasive surgical procedures and painful cooling treatments to combat inflammation, followed by extensive physical and psychological therapy.

I have seen firsthand how difficult this treatment is and we owe our veterans the very best.

Blasts from improvised explosive devices have become one of the most common causes of injury for troops currently serving in combat zones. And recent studies show that 59 percent of blast exposed patients at Walter Reed have been found to have some form of TBI.

In April of 2007, the Veterans Administration began screening veterans who served in Iraq and Afghanistan since the beginning of October 2001 for symptoms that may be associated with TBI. Of the 61,285 veterans that the VA screened for TBI, 11,804 or 19 percent of those veterans screened positive for TBI symptoms.

U.S. Department of Defense (DoD) and Veterans Administration experts note that TBI can occur even if a victim does not suffer from an obvious physical injury which sometimes takes place when a person is within the vicinity of powerful detonation.

In these instances, signs and symptoms of TBI, such as the ones I mentioned earlier, are not often readily recognized.

According to the Department of Defense and the Veterans Administration mental health experts, mild TBI can also produce behavioral symptoms similar to post-traumatic stress disorder or other mental health conditions. And TBI almost always causes post-traumatic stress.

The relationship between TBI and post-traumatic stress can further complicate diagnosis and treatment. As a result, further research must be conducted to examine the long-term effects of these injuries, which are not yet fully understood, and the best treatment models to address TBI and improve coordination of care for injured veterans.

Traumatic brain injuries have often affected a large number of female servicemembers. And as the number of women enlisted in the Armed Forces continues to grow, we must ensure that our focus on health care continues to encompass all veterans.

I hope we can continue to collect data to ensure that the women veterans receive the same quality of care as their male counterparts, and I am committed to working on this Committee to assist in that endeavor.

When a soldier is transitioning to civilian life, it is imperative that we have a system in place that is able to properly evaluate and assess the risks and challenges, if any, these veterans and their families might face.

Given that evidence suggests that combat-related TBI is an increasingly frequent occurrence and that the effects of TBI are still poorly understood, prioritizing research and oversight will help plan for addressing treatment and long-term care.

Research into TBI is also particularly important for understanding post-traumatic stress because the amnesia that often occurs as a result of TBI increases the challenges of post-traumatic stress treatment.

Studies have shown that in the absence of factual recall, individuals may have delusional or reconstruct memories of trauma. These individuals may retain false memories rather than factual results.

Closely related to cognitive impairment are mental health issues such as depression and anxiety disorders. These psychological issues often interact with physical injury to decrease patients' overall health status and adherence to medical regimes.

Those who experience TBI may behave impulsively because of damage that removes many of the brain checks on the regulation of behavior. Without the limits provided by these higher brain functions, these individuals may overreact to seemingly innocent or neutral stimuli.

For these reasons, I was compelled to introduce legislation to address these critical issues. H.R. 1546, the "Caring for Veterans with Traumatic Brain Injury Act," directs the Secretary of Veterans Affairs to establish within the Veterans Health Administration a Committee on Care of Veterans with Traumatic Brain Injury to continually assess the Veterans Health Administration's capability to meet the treatment and rehabilitation needs of veterans suffering with TBI.

In addition, this legislation will help TBI specific education and training programs for VA health professionals in order to better serve our Nation's veterans.

Though money has been allocated by Congress to help study and combat the effects of TBI, there is still room for improvement, something I hope H.R. 1546 will be able to help address.

The bipartisan "Caring for Veterans with Traumatic Brain Injury Act" passed the House unanimously in the 110th Congress as a part of Chairman Michaud's H.R. 2199, the "Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007."

TBI has become one of the signature injuries of the wars in Afghanistan and Iraq. As the Department of Veterans Affairs transitions to a 21st century institution that better meets its mission of serving veterans, it is imperative that it addresses the 21st century injuries such as TBI.

I appreciate the testimony and comments expressed by all groups on the panel today and I am grateful for their service to this great country.

I thank you for the opportunity to testify here today.

Mrs. HALVORSON. Mr. Teague?

STATEMENT OF HON. HARRY TEAGUE

Mr. TEAGUE. Yes. Madam Chairwoman Halvorson, thank you.

Ranking Member and fellow Subcommittee Members, thank you all for allowing me the opportunity to speak on behalf of H.R. 2738.

It was my honor and pleasure to introduce this bill and I believe that this legislation will provide some needed relief for the families who care for our Nation's veterans.

H.R. 2738 would allow family caregivers to get some of their travel expenses paid for when they are accompanying veterans to medical treatment facilities.

This bill would provide lodging payments, a common cost that a veteran's family incurs when they are trying to ensure that their loved ones are receiving the care that they need.

The bill also provides for some flexibility on the definition of caregivers, realizing that in this day and age, a veteran may not have immediate family members caring for them.

This bill also recognizes not only the immediate family caregivers that reside with the veteran but also extended family members and stepchildren that may not reside with the veteran.

Ms. Chairwoman, I do not need to tell anyone in this room or in this Congress that access to health care is not as easy as it should be or in my district and in many other districts that are rural, it is even harder.

While my district is roughly the same geographic size as the State of Pennsylvania, there is no VA hospital located within its boundaries.

Veterans who live in Silver City, New Mexico, are often forced to meet at the local VA clinic's parking lot at 1 o'clock in the morning so that a DAV van can take them to the State's only VA hospital in Albuquerque.

While this legislation does not create new hospitals, it helps to make travel easier for all of our veterans living in rural areas. They can make a trip to the VA facility and have their family assist them with that journey and not have the added worry of wondering how they will pay for such a trip during these difficult financial times.

If an examination at the hospital takes a bit longer than usual, they do not have to rush back home late at night. We can now give them some peace of mind with this bill.

Madam Chairwoman, I believe that this measure is the least we can do for our Nation's veterans after they have given so much in defense of our country.

I do not think that forcing a veteran to take money out of his pocket or her pocket while they are accessing benefits that they have earned makes sense. And I do not think it is the right thing to do. We should not make it more difficult for our veterans to get to VA facilities. We should take steps to make it easier on them.

I think that all of my colleagues would agree with me on that statement and I hope that I can have their support on this bill.

Madam Chairwoman and Ranking Member, I thank you for the time that you have given me to speak on behalf of this bill today.

I would also like to thank the staff of the Health Subcommittee for their assistance, expertise, and insight on this matter.

This concludes my testimony and I am ready to answer any questions you may have regarding H.R. 2738. Thank you.

[The prepared statement of Congressman Teague appears on p. 15.]

Mrs. HALVORSON. Thank you, Mr. Teague.

Last on panel two are my two bills. But before I do that, we have some testimony on H.R. 1302 from Congressman Jerry Moran. I would like unanimous consent to include that in the record.

[The prepared statement of Congressman Moran appears on p. 37.]

STATEMENT OF HON. DEBORAH L. HALVORSON

Mrs. HALVORSON. My first bill is H.R. 1335, which would prohibit the collection of co-payments and other fees from catastrophically disabled veterans who receive medical or nursing home care from the Department of Veterans Affairs.

Right now some catastrophically disabled veterans are thrown into financial hardship because of the health care co-payment that they must pay to the VA.

Catastrophically disabled veterans have severely disabling conditions that compromise their ability to carry out activities of daily living, including such basics as self-care tasks, such as eating, bathing, and dressing.

Disabled veterans in situations like this have enough challenges to face on a daily basis and scraping together enough money to make their co-payment should not be another challenge that they have to deal with.

I will allow the rest of my testimony to be included in the record.

The other bill is H.R. 2898, which authorizes the VA to make available supportive services to family caregivers who provide critical health care services to our wounded warriors.

My bill would provide counseling, better training, and respite care for family caregivers and it would make sure that the VA conducts community outreach through PSAs, brochures and information pamphlets.

Finally, it would assist caregivers with locating support services from the public, private, and nonprofit agencies.

Last year, my stepson was severely injured while serving in Afghanistan. At first, we were just relieved that he was simply alive. That, of course, was our number one priority. After that, it was

clear that he would make it through all of his surgeries at Walter Reed. Our immediate concern then became how are we going to take care of him.

He was not in a good state and needed constant care. We were blessed to have the resources and the time available to drive him to his rehabilitation every day and take care of him at home as he recuperated.

Thankfully, after time and rehabilitation, he is back on his feet and going to be fine. But it was that experience, however, that has given me the insight to understand the sacrifice that family caregivers, and gladly so, give and make for our America's wounded warriors 24 hours a day and 7 days a week.

H.R. 2898 is a strong step in the right direction. And I am so pleased that this was a bill that we were able to bring forward.

So at this time, if anybody has questions for any of the bills that are before us.

[No response.]

If not, we will bring up panel three, Fred Cowell, Senior Health Policy Analyst, Paralyzed Veterans of America (PVA); Joy Ilem, Deputy National Legislative Director of the Disabled American Veterans; Mr. Joseph Wilson, Deputy Director of Veterans Affairs and Rehabilitation Commission of the American Legion; Mr. Christopher Needham, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars; and Bernard Edelman, Deputy Director for Policy and Government Affairs, Vietnam Veterans of America.

We will start with Mr. Cowell. I apologize if they start votes. What we will have you do is then submit all of your testimony for the record.

So, please, Mr. Cowell, you will be recognized for 5 minutes.

STATEMENT OF FRED COWELL, SENIOR HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA

Mr. COWELL. Thank you, Madam Chairperson, Ranking Member, Members of the Subcommittee.

Paralyzed Veterans of America would like to thank you for the opportunity to provide testimony today on legislation pending before the Subcommittee and other draft legislation concerning the needs of caregivers who assist veterans on a daily basis.

H.R. 1335, PVA would like to thank Member Halvorson for introducing this important bill. As you know, PVA members are some of the most frequent users of VA health care. In fact, PVA members receive 85 to 90 percent of their medical care through the VA health care system.

With this in mind, PVA supports H.R. 1335 to prohibit the Secretary of VA from collecting co-payments from catastrophically disabled, Priority Group 4 veterans. However, we would like to recommend that the Subcommittee make a change to the legislative language prior to the markup of this bill.

In examining this bill, we realized that the current language that refers to hospital and nursing home care does not meet the intent of the legislation. This language is very narrow in scope and would seemingly only benefit veterans in inpatient settings.

However, the intent has always been to relieve these severely disabled veterans of all burdensome co-payments. To that end, we have recommended that Subcommittee staff change the language to hospital and medical care services so as to properly meet Congressional intent.

This change would ensure that catastrophically disabled veterans who often require extensive VA outpatient rehabilitative care, VA inpatient and outpatient preventive services, and who often experience prolonged inpatient hospital stays will be protected.

Catastrophically disabled veterans were pleased when the House Committee on Veterans' Affairs approved, and the House of Representatives passed H.R. 6445 during the 110th Congress to eliminate VA co-pays for catastrophically disabled veterans.

In fact, the House bill received unanimous support from both sides of the aisle. Unfortunately, the Senate never took action on the measure.

This year, however, the Senate Committee on Veterans' Affairs has approved S. 801, which includes the elimination of co-pays for Priority Group 4 veterans. The Senate version also includes the recommended language change.

Together with H.R. 1335, PVA members and other catastrophically disabled veterans now have real hope that financial relief will soon be forthcoming.

H.R. 1293, the HISA grant increase. First, Mr. Chairman, PVA would like to thank Congressman Buyer for introducing this important piece of legislation. PVA strongly supports H.R. 1293, the "Disabled Veterans Home Improvement and Structural Alteration Grant of 2009."

These increases will help defray the constantly rising cost for accessibility modifications to veterans' homes. This VA benefit enables veterans to maximize their functional abilities and return to a home following medical treatment that meets their needs.

PVA certainly hopes that Congress will give this legislation favorable consideration as it will benefit America's most severely disabled veterans.

PVA applauds the draft legislation to expand caregiver assistance opportunities. PVA actually believes that each of the four draft bills that take into consideration the needs of family caregivers should be combined into a single comprehensive bill as we believe that each of these bills has important aspects to assist veterans and their caregivers.

Particularly we believe training assistance is a critical aspect in supporting caregivers who care for veterans.

A particular focus on respite care mentioned in one of the draft bills is also an important part of any comprehensive caregiver assistance legislation.

Respite care allows time for caregivers to ease their emotional and physical burdens for a period of time and it helps ensure that the caregiver will maintain their commitment to the disabled veteran and his or her needs.

Additionally, PVA has no objection to the legislation that would provide health care services to caregivers through opening of CHAMPVA. In some cases, caregivers do not have other care options available to meet their own needs, particularly if the provi-

sion of caregiver services is essentially their job. This draft legislation will remedy this significant concern that many caregivers have.

Regarding travel expenses for family caregivers accompanying veterans to medical treatment facilities, PVA strongly supports this draft legislation.

As the Committee knows, many of our veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom have significant disabling injuries, including TBI. Many of these individuals require constant care.

PVA appreciates the efforts of the Committee to ensure that travel expenses for these needed assistants are provided.

One disappointment that PVA would like to point out is the exclusion of any type of caregiver allowance from the draft bills being considered. Providing a financial benefit has been one of the important issues that we have advocated for in addressing caregiver issues.

We hope that the Subcommittee will examine ways to incorporate this important idea into final legislation.

And, finally, Mr. Chairman, PVA supports H.R. 2770's language to make improvements that will streamline the operations, increase the effectiveness, and maintain accountability of nonprofit research and education corporations.

These entities provide extremely valuable services to VA, to VA researchers, and ultimately to the veterans who benefit from research breakthroughs.

Madam Chairman and Members of the Subcommittee, PVA would like once again to thank you for the opportunity to provide our views on this important legislation. We look forward to working with you to continue to improve the health care services available to veterans.

I will be happy to answer any questions that you might have.

[The prepared statement of Mr. Cowell appears on p. 16.]

Mrs. HALVORSON. And before we go on to Mr. Edelman, Mr. Perriello would like to make a statement. He has a bill. He was somewhere else. He just made it. Before we head out.

STATEMENT OF HON. TOM PERRIELLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. PERRIELLO. Thank you very much, Chairlady.

Good morning, everyone. Let me begin by thanking Chairman Michaud and Ranking Member Brown for holding this hearing on bills aimed at addressing some of the health care concerns faced by veterans and those who care for them.

I appreciate the opportunity to offer testimony in support of H.R. 2734, the "Health Care for Family Caregivers Act of 2009."

In the words of former First Lady Rosalyn Carter, quote, "There are only four kinds of people in the world, those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers."

Mrs. Carter's observations are particularly telling when considering our brave men and women in uniform.

Today more than ever revolutionary advances in military medicine have significantly increased a servicemember's chances of sur-

viving a catastrophic injury sustained in combat. But in many cases, surviving such injuries is only half the battle.

Recovering requires a long-term commitment not only from the veteran but also from those who love and care for the veteran.

Simply stated, taking care of our veterans means taking care of those who care for them when they are unable to care for themselves.

Once an injured veteran returns home from treatment at a DoD or VA hospital, it is often a spouse, mother, father, or other loving family member who steps up to the challenge of providing ongoing care. And while this care is provided out of a sense of love, compassion, and duty, it oftentimes shifts into a full-time commitment requiring the caregiver to make significant personal decisions regarding professional goals, commitments, and obligations.

H.R. 2734, the "Health Care for Family Caregivers Act," would help provide some relief to those family caregivers faced with the difficult decisions related to caring for a veteran confronting a catastrophic injury.

The bill would extend CHAMPVA benefits to eligible family caregivers of a select group of veterans defined as those who receive special monthly compensation for aid and attendant care and homebound care under Title 38. The expanded CHAMPVA benefit is limited to the primary family caregiver who lacks health care coverage.

Family members are defined to include nuclear and extended family members as well as step family members. And there is no residency requirement whereby the family member must live with the veteran.

Because many family caregivers leave their positions of employment to undertake the full-time task of caring for the veteran, the bill also exempts eligible family caregivers from deductibles and copayments required of other CHAMPVA beneficiaries.

As a Nation, we have an obligation to care for those who have stood in the defense of freedom. H.R. 2734 is a commonsense bill which continues our commitment to American veterans.

I would like to thank all of the veterans services organizations for their continued support. I would also like to thank the Department of Veterans Affairs for their testimony and willingness to work cooperatively to advance responsible legislation which effectively addresses the needs of veterans and those who care for them.

I look forward to meeting with leaders and subject matter experts from the Veterans Health Administration this month to discuss this important matter in a comprehensive manner.

I thank the Subcommittee for holding this hearing and look forward to answering any questions you may have. Many thanks.

Mrs. HALVORSON. At this time, I would like to acknowledge Mr. Boozman for comments.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. Thank you.

We appreciate you all being here, and I apologize that we have to interrupt. Yet, we do not want to have you have to wait around forever.

The only thing that we have to do here, there are lots of things that we can get out of, but we do have to go vote when we are supposed to.

I do want to congratulate you, Ms. Ilem, on your promotion to Deputy National Legislative Director. We all appreciate your hard work for the DAV. I know that you have been invaluable in many cases in providing some very, very good information. So we do want to congratulate you on behalf of, I think, all of us very much so, and especially our staffs. We appreciate your help and appreciate your hard work on behalf of veterans.

I yield back.

Mrs. HALVORSON. Thank you, Mr. Boozman.

Since there are 7 minutes left for us to vote, instead of making panels 3 and 4 wait until we are done with our 27 votes or somewhere around there, we are going to have you all submit your testimony for the record.

And anybody who has questions, we will submit them and we will make sure everybody has a record of that.

With that, I would like to adjourn the Subcommittee.

[Whereupon, at 10:43 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming today.

Today's legislative hearing is an opportunity for Members of Congress, veterans, the VA and other interested parties to provide their views on and discuss recently introduced legislation within the Subcommittee's jurisdiction in a clear and orderly process.

I do not necessarily agree or disagree with the bills before us today, but I believe that this is an important part of the legislative process that will encourage frank discussions and new ideas.

We have 11 bills before us today. Each of the bills address important issues affecting our veterans and their families. These bills address a wide range of issues including help for family caregivers of wounded veterans; improving the nonprofit research and education corporations; establishing a position of Director of Physician Assistant; and creating a Committee on Care of Veterans with Traumatic Brain Injury. We will also consider important bills to enhance health care and other benefits to veterans. This includes updating the benefit amount for the Home Improvement and Structural Alteration grant; eliminating the co-payments from veterans who are catastrophically disabled; extending health care benefits to Vietnam era herbicide exposed veterans and Gulf-War era veterans; and assigning Medal of Honor recipients to the Priority Group 3 category.

I look forward to hearing the views of our witnesses on these bills before us.

Prepared Statement of Hon. Harry Teague, a Representative in Congress From the State of New Mexico

Mr. Chairman and Ranking Member Brown and fellow Subcommittee Members, thank you for allowing me the opportunity to speak on behalf of H.R. 2738. It was my honor and pleasure to introduce this bill, and I believe that this legislation will provide some much needed relief for the families who care for our Nation's veterans.

H.R. 2738 would allow family caregivers to have some of their travel expenses paid for when they are accompanying veteran to medical treatment facilities. This bill would provide lodging payments, a common cost that a veteran's family incurs when they are trying to ensure that their loved ones are receiving the care that they need. The bill also provides for some flexibility on the definition of "caregivers," realizing that in this day and age, a veteran may not have immediate family members caring for them. This bill also recognizes not only the immediate family caregivers that reside with the veteran, but also extended family members and step-children that may not reside with the veteran.

Mr. Chairman, I don't need to tell anyone in this room or in this Congress that access to health care is not as easy as it should be. In my district, and in many other districts that are rural, it's even harder. While my district is roughly the same geographic size as the State of Pennsylvania, there is no VA hospital located within its boundaries. Veterans who live in Silver City, New Mexico are often forced to meet in the local VA clinic's parking lot at one in the morning so that a DAV van can take them to the State's only VA hospital in Albuquerque.

While this legislation does not create new hospitals, it helps to make travel easier for all of our veterans living in rural areas. They can make a trip to the VA facility and have their family assist them with that journey, and not have the added worry of wondering how they will pay for such a trip during these difficult financial times. If an examination at the hospital takes a bit longer than usual, they don't have to rush back home late at night. We can now give them some peace of mind with this bill.

Mr. Chairman, I believe that this measure is the least we can do for our Nation's veterans, after they have given so much in defense of our country. I don't think that forcing a veteran to take money out of his or her pocket while they are accessing benefits that they've earned makes sense, and I don't think it's the right thing to do.

We shouldn't make it more difficult for veterans to get to VA facilities. We should take steps to make it easier on them.

I think that all of my colleagues would agree with me on that statement, and I hope that I could have their support on this bill.

Mr. Chairman and Ranking Member Brown, I thank you for the time that you've given me to speak on behalf of this bill today. I would also like to thank the staff of the Health Subcommittee for their assistance, expertise and insight on this matter.

This concludes my testimony and I am ready to answer any questions you may have regarding H.R. 2738.

Prepared Statement of Fred Cowell,
Senior Health Policy Analyst, Paralyzed Veterans of America

Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to provide testimony today on legislation pending before the Subcommittee and other draft legislation concerning veterans health care needs. We hope that the Subcommittee will take our concerns under consideration as it moves its legislation forward in the 111th Congress. Mr. Chairman, we appreciate the legislative successes that veterans have realized under your leadership and we look forward to continued success in the future. PVA is particularly pleased with the emphasis on meeting the needs of veterans' caregivers.

H.R. 1335, Co-Payments for Catastrophically Disabled Priority Group 4 Veterans

As you know, PVA members are some of the highest users of VA health care. In fact, catastrophically disabled veterans, like PVA members, receive 85 to 90 percent of their care from the VA.

With this is mind, PVA supports H.R. 1335, to prohibit the Secretary of VA from collecting co-payments from catastrophically disabled Priority Group 4 veterans. However, we would like to recommend that the Subcommittee make a change to the legislative language prior to the markup for this bill. In examining this bill, we realized that the current language that refers to "Hospital and Nursing Home Care" does not really meet the intent of the legislation. This language is very narrow in scope and would seemingly only benefit veterans in inpatient settings. However, the intent has always been to relieve this important segment of the veteran population of all burdensome co-payments. To that end, we have recommended that the Subcommittee staff change the language to "Hospital and Medical Care Services" so as to properly meet congressional intent. This would ensure that catastrophically disabled veterans who often take advantage of outpatient rehabilitative, preventive, and other health services will be protected.

In 1985, Congress approved legislation which opened the VA health system to all veterans. In 1996, Congress again revised that legislation with a system of rankings establishing priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities would be placed in a higher enrollment category. To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Priority Group 4 even though their disabilities were nonservice-connected and regardless of their incomes. However, unlike other Priority Group 4 veterans, if they would otherwise have been in Priority Group 7 or 8, due to their incomes, they would still be required to pay all fees and co-payments, just as others in those categories do now for every service they receive from VA.

PVA believes this is unjust. VA recognizes these veterans' unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. The system then makes them pay for those services. Unfortunately, these veterans are not casual users of VA health care services. Because of the nature of their disabilities they require a lot of care and a lifetime of services. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, and yet, these veterans, supposedly placed in a high-

er priority enrollment category, have to pay fees and co-payments for every service they receive as though they had no priority at all.

We were pleased when the House Committee on Veterans' Affairs approved and the House of Representatives eventually passed legislation—H.R. 6445—during the 110th Congress to eliminate this financial burden placed on catastrophically disabled veterans. In fact, the House bill received unanimous support from Republicans and Democrats as well as the VA. Unfortunately, the Senate never took action on the measure and the legislation was never enacted. This year, the Senate Committee on Veterans' Affairs has approved S. 801 which includes the elimination of co-payments for Priority Group 4 veterans. The Senate version also includes the recommended language change. Together with H.R. 1335, PVA members have real hope that we will finally be able to resolve this issue during the 111th Congress.

H.R. 1293, the "Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009"

PVA strongly supports H.R. 1293, the "Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009." The costs for improvements and modifications for homes have continued to go up dramatically, in spite of the recent downturn in housing construction. There have been anecdotes of great deals now available for home improvements. But it can be expected that as we come out of the current recession, home improvement costs will continue to go up.

The Home Improvement and Structural Alterations (HISA) grant is provided through local VA medical facilities and is often critical to allowing an injured veteran to leave the hospital setting and return home. The HISA grant allows these veterans to make basic modifications without having to tap into the benefit available through the Specially Adapted Housing grant. We certainly hope that Congress will give this quick and favorable consideration as it will particularly benefit the most severely disabled veterans.

H.R. 1546, the "Caring for Veterans With Traumatic Brain Injury Act of 2009"

PVA fully supports the provisions of H.R. 1546, the "Caring for Veterans With Traumatic Brain Injury Act of 2009."

The RAND Corporation Center for Military Health Policy Research recently completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services To Assist Recovery*. RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it. The study evaluated the prevalence of mental health and cognitive problems of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) servicemembers; the existing programs and services available to meet the health care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

According to RAND, 57 percent of those reporting a probable TBI had not been evaluated by a physician for brain injury. Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DoD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of powerful detonations and that signs and symptoms are often not readily recognized but can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, and depression.

Emerging literature (including the RAND study) strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DoD and VA mental health experts, mild TBI can also produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI.

On July 12, 2006, the VA Office of the Inspector General (OIG) issued *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report found that better coordination of care between DoD and VA health care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow on interviews to determine changes since the initial interviews were conducted in 2006. The OIG concluded that 3 years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities and, although case management has improved, it is not uniformly provided to these patients.

The creation of a Committee on Care of Veterans with Traumatic Brain Injury may help to improve this coordination and identify best practices for care for these injured warriors. However, Congress must be aggressive with its oversight to ensure that the Committee does not simply identify the issues, but works to implement them throughout the VA system.

H.R. 1302, Director of Physician Assistant Services

PVA supports H.R. 1302, 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 P.L. 106–419, the "Veterans Benefits and Health Care Improvement Act of 2000," which directed that the Under Secretary for Health 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.

H.R. 1197, the "Medal of Honor Health Care Equity Act of 2009"

PVA strongly supports the provisions of H.R. 1197, the "Medal of Honor Health Care Equity Act of 2009." It is clear that veterans who have been awarded our Nation's highest military award for valor should be afforded any and all benefits possible in recognition of their service.

H.R. 2722, the "Veterans Nonprofit Research and Education Corporations Enhancement Act of 2009"

PVA strongly supports the provisions of draft legislation regarding Nonprofit Research and Education Corporations. This bill should allow these corporations (also known as NPCs) to fulfill their full potential in supporting VA research and education, which ultimately results in improved treatments and high quality care for veterans, while ensuring VA and congressional confidence in NPC management.

Since passage of P.L. 100–322 in 1988 (codified at 38 U.S.C. § 7361–7368), the NPCs have served as an effective "flexible funding mechanism for the conduct of approved research and education" performed at VA medical centers across the nation. NPCs provide VA medical centers with the advantages of on-site administration of research by nonprofit organizations entirely dedicated to serving VA researchers and educators, but with the reassurance of VA oversight and regulation. During 2007, 85 NPCs received nearly $230 million and expended funds on behalf of approximately 5,000 research and education programs, all of which are subject to VA approval and are conducted in accordance with VA requirements.

NPCs provide a full range of on-site research support services to VA investigators, including assistance preparing and submitting their research proposals; hiring lab technicians and study coordinators to work on projects; procuring supplies and equipment; monitoring the VA approvals; and a host of other services so the principal investigators can focus on their research and their veteran patients.

Beyond administering research projects and education activities, when funds permit, these nonprofits also support a variety of VA research infrastructure expenses. For example, NPCs have renovated labs, purchased major pieces of equipment, staffed animal care facilities, funded recruitment of clinician-researchers, provided seed and bridge funding for investigators, and paid for training for compliance personnel.

Although the authors of the original statute were remarkably successful in crafting a unique authority for VA medical centers, differing interpretations of the wording and the intent of Congress, gaps in NPC authorities that curtail their ability to fully support VA research and education, and evolution of VA health care delivery systems have made revision of the statute increasingly necessary in recent years. This draft legislation should allow the NPCs to better serve VA research and education programs while maintaining the high degree of oversight applied to these nonprofits.

This legislation reinforces the idea of "multi-medical center research corporations" which provides for voluntary sharing of one NPC among two or more VA medical centers, while still preserving their fundamental nature as medical center-based or-

ganizations. Moreover, accountability will be ensured by requiring that at a minimum, the medical center director from each facility must serve on the NPC board. This authority will allow smaller NPCs to pool their administrative resources and to improve their ability to achieve the level of internal controls now required of nonprofit organizations.

The legislation also clarifies the legal status of the NPCs as private sector, tax exempt organizations, subject to VA oversight and regulation. It also modernizes NPC funds acceptance and retention authorities as well as the ethics requirements applicable to officers, directors and employees and the qualifications for board membership. Moreover, it clarifies and broadens the VA's authority to guide expenditures.

PVA has been a strong supporter of the NPCs since their inception, recognizing that they benefit veterans by increasing the resources available to support the VA research program and to educate VA health care professionals.

Draft Legislation to Direct the Secretary of Veterans Affairs to Provide Care for Certain Vietnam-era and Persian Gulf Veterans

PVA fully supports the draft legislation that would require the VA to provide hospital care, medical services, and nursing home care for certain Vietnam-era veterans exposed to herbicide and veterans of the Persian Gulf War without expiration. These veterans have certainly earned this benefit through their dedicated service to this nation and due to the nature of the injuries and illness which they suffer.

Draft Legislation to Address the Needs of Family Caregivers (H.R 2734, H.R. 2738, and Proposed Bills)

PVA applauds the draft legislation to expand caregiver assistance opportunities. PVA actually believes that each of the four draft bills that take into consideration the needs of family caregivers should be combined into a single comprehensive bill as we believe that each of these bills have important aspects to address this issue. Particularly, we believe training and assistance is a critical aspect of supporting caregivers who care for veterans. We also applaud the fact that the legislation requires the Secretary to provide training through the use of the word "shall" instead of "may." While seemingly a trivial concern, such language will ensure that the Secretary does not have the option of reducing these services if VA is faced with the budget challenges that inevitably will occur.

As the veteran community is aware, family caregivers also provide mental health support for veterans dealing with the emotional, psychological, and physical effects of combat. Many PVA members with spinal cord injury also have a range of co-morbid mental illnesses; therefore, we know that family counseling and condition specific education is fundamental to the successful reintegration of the veteran into society. Providing education and training to family caregivers will pay dividends in care well beyond any costs associated with the program.

The aspects of personal independence and quality care are of particular importance to veterans with spinal cord injury/dysfunction. Paralyzed Veterans has over 60 years of experience understanding the complex needs of spouses, family members, friends, and personal care attendants that love and care for veterans with lifelong medical conditions. These veterans need the health care expertise and care from a health team comprised of medical professionals, mental health professionals, and caregivers. As a part of the health care team, caregivers must receive ongoing support to provide quality care to the veteran. Legislation to provide these services is critically needed. But while the current draft text emphasizes "interactive training session" and "Internet-based" services, we want to ensure that this does not preclude VA from providing more effective "in person training" for those who may need it to provide the quality of care needed by veterans. The VA must also work to enforce and maintain an efficient case management system that assists veterans and family caregivers with medical benefits and family support services.

A particular focus on respite care, mentioned in one of the draft bills, is also an important part of any comprehensive caregiver assistance legislation. Providing for the needs of catastrophically disabled veterans in particular can exact a heavy toll on the caregiver. Respite care allows that caregiver to ease the emotional, psychological, and physical burden for a period of time, and it ensures that the caregiver will maintain a real commitment to the disabled veteran and his or her needs.

PVA has no objection to the legislation that would provide health care services to caregivers through the opening of CHAMPVA. In some cases, caregivers do not have other health care options available to meet their own needs, particularly if the provision of caregiver services is essentially their job. The draft legislation will remedy this significant concern that many caregivers have.

There are approximately 44 million individuals across the United States that serve as caregivers on a daily basis. The contributions of caregivers in today's society are invaluable economically as they obviate the rising costs of traditional institutional care. The services rendered by caregivers are also priceless socially and emotionally, as they allow ailing and disabled veterans to live more independently and often in the comfort of their own homes with their friends and family. Unfortunately, VA can only estimate how many of these caregivers serve veterans. By conducting a survey of these valuable caregivers and the services they provide, VA can better estimate their impact and any associated costs to increase support to these individuals. Without this information, it will be difficult for VA to honestly provide recommendations on funding caregiver programs to the White House and Congress.

Regarding travel expenses for family caregivers accompanying veterans to medical treatment facilities, PVA supports the draft legislation. As the Committee knows, many of our veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom have significant disabling injuries including TBI. Many of these individuals require constant care. PVA appreciates the efforts of the Committee to ensure the travel expenses for these needed assistants are provided. We also understand and accept the VA's need to limit the number of attendants and use certain travel services, but we ask the Committee to use its oversight to ensure that regulations prescribed by VA are not so restrictive as to preclude family support activities.

Our experience has shown that when the veteran's family unit is left out of the treatment plan, the veteran suffers with long reoccurring medical and social problems. However, when family is included in the health plan through services such as VA counseling and education services, veterans are more apt to become healthy, independent, and productive members of society.

One disappointment that PVA would like to point out is the exclusion of any type of caregiver allowance from the draft bills being considered. Providing a financial benefit has been one of the important issues that we have advocated for in addressing caregiver issues. We hope that the Subcommittee will examine ways to incorporate this important idea in final legislation.

Mr. Chairman and Members of the Subcommittee, PVA would once again like to thank you for the opportunity to provide our views on this important legislation. We look forward to working with you to continue to improve the health care services available to veterans. I would be happy to answer any questions that you might have.

Prepared Statement of Robert A. Petzel, M.D.,
Acting Principal Deputy Under Secretary for Health,
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on 11 bills and drafts that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. We appreciate the opportunity to discuss the bills on today's agenda, and are also pleased to support most of the proposed legislation. We believe that we could carry out the new authorities we are supporting within the funding levels proposed in the 2010 and 2011 budget requests.

H.R. 1197—"Medal of Honor Health Care Equity Act of 2009"

Mr. Chairman, the first bill on the agenda is **H.R. 1197**. This bill would amend 38 U.S.C. 1705 to give Medal of Honor recipients eligibility to receive VA medical care at the Priority 3 level. VA supports H.R. 1197. We estimate the increased cost to be insignificant and can be funded within existing funding levels.

H.R. 1293—"Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009"

VA also supports **H.R. 1293** which would increase the amount available to disabled veterans for home improvements and structural alterations (HISA) furnished as part of home health services. This bill represents the first increase in the HISA grant rate in 17 years. VA also recommends to the Chairman that the Subcommittee increase the rate periodically so that the grant amount keeps pace with the rate of inflation and the rising cost of materials and installation. We estimate the cost for H.R. 1293 to be $5.8 million in FY 2010, $5.9 million in FY 2011, $29.8 million over 5 years, and $61.4 million over 10 years. VA will provide a cost estimate to the Subcommittee for the record that assumes the additional cost of increasing the payments with inflation.

The Veterans Benefits Administration offers the Specially Adapted Housing (SAH) and Special Housing Adaptations (SHA) grants, which are distinct from HISA grants administered through the Veterans Health Administration. With a cap of $60,000, the SAH grant is the largest and is for the most severely, service-connected, disabled veterans and servicemembers entitled to compensation for permanent and total disability due to:

- The loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair;
- Blindness in both eyes, having only light perception, plus loss or loss of use of one lower extremity;
- The loss or loss of use of one lower extremity together with (1) residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity, which so affect the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair;
- The loss or loss of use of both upper extremities such as to preclude use of the arms at or above the elbows; or
- A severe burn injury.

SHA grant is the next largest at $12,000 and is for veterans and servicemembers who are entitled to disability compensation for permanent and total service-connected disability that:

- Includes loss or loss of use of both hands;
- Is due to Blindness in both eyes with 5/200 visual acuity or less; or
- Is due to a severe burn injury.

HISA grants are the only grants available for nonservice-connected veterans and conditions (currently limited to $1,200). An increased amount is available for service-connected veterans (currently $4,100). Although not required, the HISA grant can be used in conjunction with the SAH or SHA grant to help cover some of the additional costs a veteran may be facing when building or adapting a home to meet his/her unique needs. The HISA grant may be a stand alone project for veterans who are also receiving the SAH/SHA grant, or in most cases, used by veterans who are not eligible for the SAH or SHA grants.

In October, the SAH and SHA grant amounts will be linked to a new cost-of-construction index that will adjust annually for inflation. Conversely, the HISA amounts have not been increased in several years and have not kept up with inflation. The proposed legislation serves to increase the amount available to veterans who are not covered by the SAH and SHA grants to make some modifications to their homes to accommodate their various disabilities. Those who are eligible for the SAH and SHA grant are our most severely injured, service-connected veterans, and these additional funds supporting modification or construction of their home is justified.

H.R. 1302—"To Establish a Director of Physician Assistant Services"

H.R. 1302 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 all 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. Moreover, such a realignment would create a disparity and an artificial distinction between physician assistants and nurse practitioners. This situation could result in unnecessary friction or tension between these two categories of employees. The cost of implementing this bill is insignificant.

H.R. 1335—"Prohibition on Collection of Certain Co-payments"

H.R. 1335 would amend 38 U.S.C. 1710 to prohibit a veteran who is catastrophically disabled from making any payment for the receipt of hospital care or nursing home care provided pursuant to that section.

VA supports this proposal; however, we note it is unclear if this proposal is intended to eliminate nursing home care co-payments since the legislation refers only

to section 1710 of title 38 and authority for nursing home care falls under 38 U.S.C. 1710A. We believe any co-payment requirements under this section would remain in place. We further note that the bill does not address pharmacy co-payments. The projected cost would be about $2.6 million for FY 2010 and 2011, $13.3 million over 5 years, and $28 million over 10 years. VA will provide a cost estimate to the Subcommittee for the record that assumes the legislation eliminates all co-payments for this population.

H.R. 1546—"Caring for Veterans with Traumatic Brain Injury"

VA also supports **H.R. 1546**, which would establish a committee on the Care of Veterans with Traumatic Brain Injury to evaluate the care provided to veterans, identify problems in caring for such veterans, identify successful models of treatment, and advise the Secretary accordingly. The committee would be comprised of VA employees. The cost of this bill would be insignificant and can be absorbed within existing funding levels.

H.R. 2722—"Veterans Nonprofit Research and Education Corporation Enhancement Act of 2009"

H.R. 2722 would update the law applicable to VA's nonprofit research and education corporations (corporations). VA-affiliated nonprofit research corporations are critical to VA's overall research program because they provide flexible funding mechanisms for the administration of non-VA funds for the conduct of VA-approved research.

A key provision of this bill would authorize a single corporation to facilitate the conduct of research and education at more than one VA medical center. H.R. 2722 would also make it clear that corporations may reimburse a VA laboratory for the preliminary costs it incurs before a research project has been officially approved by the Secretary. VA would also be authorized to reimburse corporations for costs incurred for the assignment of corporation employees to VA under the Intergovernmental Personnel Act of 1970 (IPA). This would ensure that, in this respect, corporations are treated like any other qualified nonprofit corporations under the IPA.

Additionally, this bill would clarify that corporations may set fees for certain education and training programs they administer and retain those funds to offset program expenses. The legal prohibition on a corporation accepting fees derived from VA appropriations would remain.

VA fully supports H.R. 2722. The authority to establish multi-medical center research corporations would significantly advance VA research activities. Currently a corporation is established in only one medical center and can provide support as a flexible-funding mechanism for that facility. Small VA research programs that are currently unable to support the existence of a corporation at their facility would be able to obtain needed support from a multi-medical center research corporation. While providing the authority for this expanded utility of the nonprofit corporations, the bill would, nonetheless, ensure that all medical centers involved in a multi-medical center arrangement maintain a voice on the board of directors of the research corporation.

The utility of the corporations to VA would also be increased by permitting them to reimburse the Department for research planning costs that are necessarily incurred prior to approval of a research project by VA. Currently corporations are prohibited from funding research projects that are not officially approved by VA. As a result, VA laboratories are responsible for the preliminary costs of any research project before it is officially approved, and they bear those costs entirely for projects that are ultimately disapproved. This paradigm creates a financial disincentive for VA laboratories to initiate research and a chilling effect on the conduct of innovative VA research. The bill would appropriately solve this problem.

VA does have one technical concern with H.R. 2722. Section 7 of the bill attempts to rectify an impracticable extension of the criminal conflicts of interest laws to non-Government employees working for a non-Government employer. The proposed revisions to 38 U.S.C. 7366 remove the words "laws and," effectively subjecting covered persons to only the Federal ethics regulations. However, the Federal ethics regulations are also unenforceable in the NPC context. VA recommends replacing the current language in section 7366 with a new provision requiring all NPCs to adopt an enforceable code of conduct, reviewable by the VA, which prohibits conflicts of interest.

There would be no costs associated with enactment of the H.R. 2722.

H.R. 2734—"Health Care for Family Caregivers Act of 2009"

H.R. 2734 would amend 38 U.S.C. 1781 to medical care under Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to family caregivers who serve as the "primary family caregiver" for veterans receiving com-

pensation under 38 U.S.C. 1114(r) or (s) and who have no entitlement to care or services under certain health-plan contracts. In addition, these family caregivers would not be subject to deductibles, premiums, co-payments, cost-sharing, or other fees for medical care. The bill would also amend 38 U.S.C. 1701 to define the term caregiver services and the term family caregiver. The term family caregiver is defined as members of the disabled veteran's family (including parents, spouses, children, siblings, step-family members, and extended family members) who provide caregiver services to the veteran for their disability.

VA would like to address the Subcommittee's specific questions regarding CHAMPVA. Currently, VA has the authority to provide medical care for the survivors and dependents of certain veterans through CHAMPVA. In Fiscal Year (FY) 2008, approximately 317,000 beneficiaries were enrolled in CHAMPVA, and VA projects this number will increase to 329,000 in FY 2009. Approximately 17 percent of CHAMPVA beneficiaries are under 23 years of age (approximately 54,000 children) and 83 percent are over 23 years of age (approximately 263,000 spouses or surviving spouses). In FY 2009, these numbers are expected to increase to 56,000 children and 273,000 spouses or surviving spouses. In FY 2008, just over 219,000 enrollees used CHAMPVA. Approximately 63,000 of these users were survivors of veterans, and about 156,000 receive benefits with a living veteran. In FY 2009, VA anticipates 230,000 total users, 68,500 of whom will be survivors of a veteran and 161,500 who will receive benefits with a living veteran.

VA shares the Committee's desire to enhance the level of VA support provided to caregivers. To that end, the Department is currently undertaking a comprehensive review of existing benefits to determine potential gaps. We would like to ask that the Committee defer action on this bill until our work is complete. In addition, we would like to note a few immediate concerns with this bill. First, the legislation would authorize the primary family caregivers to receive care as CHAMPVA beneficiaries. CHAMPVA is a cost-sharing program. VA is concerned the bill specifies family caregivers would not be subject to the same deductibles, premiums, co-payments, cost-sharing, or other fees for medical care that are applicable to the existing population. Second, there is no scope or limitation to this benefit. If a veteran died or no longer needed caregiver services, the legislation as written would allow this individual to continue receiving benefits for the course of his or her lifetime. Third, the legislation provides eligibility to those veterans who receive special monthly compensation (SMC) under subsection (r) or (s) of section 1114 of title 38, some of who may not need caregiver support. The legislation as written would extend benefits to some veterans without clinical need. We anticipate the costs of this provision would be $261 million in FY 2010, $1.59 billion over 5 years and a 10 year total of $3.8 billion.

H.R. 2738—"Travel Expenses for Family Caregivers Accompanying Veterans to Medical Treatment Facilities"

H.R. 2738 would amend 38 U.S.C. 111, which authorizes payments for certain beneficiaries' travel, to clarify that an attendant includes a family caregiver. Furthermore, it would make clear that the expenses of attendant travel include lodging and subsistence for the period of time a qualified person is traveling to and from a treatment facility as well as during the treatment episode for such person. In addition, the bill would amend 38 U.S.C. 1701 to define the term caregiver services and the term family caregiver. The term family caregiver in this draft is limited to members of the disabled veteran's family (including parents, spouses, children, siblings, step-family members, and extended family members) who provide caregiver services to the veteran for their disability. However, VA notes only those attendants who would otherwise be eligible under VA's beneficiary travel authority would qualify. If a veteran is not eligible for attendant benefits under VA's existing authority, his or her caregiver would not be eligible to receive the benefits available under this legislation.

VA shares the Committee's desire to enhance the level of VA support provided to caregivers. As stated above, the Department is currently undertaking a comprehensive review of existing benefits to determine potential gaps. We would like to ask that the Committee defer action on this bill until our work is complete. The projected cost of this provision would be $314 million in FY 2010, $1.8 billion over 5 years, and $4.3 billion over 10 years.

Discussion Draft 1: Provision of Care and Services for Certain Veterans Exposed to Herbicide and Veterans of the Persian Gulf War

VA supports the draft bill to provide, without expiration, hospital care, medical services, and nursing home care for certain Vietnam-era veterans exposed to herbicide and for veterans of the Persian Gulf War, notwithstanding that there is insuffi-

cient medical evidence to conclude their disability is associated with their service. This legislation would restore statutory eligibility for care that existed from 1981 to 2002. Since VA has continued to provide care under this authority, there are no additional costs associated with this bill.

The Department cannot comment on the remaining discussion draft bills at this time. We will submit our views and cost estimates at a later date.

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

Prepared Statement of American Academy of Physician Assistants

On behalf of the more than 75,000 clinically practicing physician assistants (PAs) in the United States, the American Academy of Physician Assistants (AAPA) is pleased to submit comments in support of H.R. 1302, 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. The AAPA is very appreciative of Representatives Phil Hare and Jerry Moran for their leadership in introducing this important legislation. The Academy also wishes to thank Chairman Michaud, Chairman Filner, Ranking Member Buyer, and other Members of the Subcommittee and Committee for co-sponsoring H.R. 1302.

AAPA believes that enactment of H.R. 1302 is essential to improving patient care for our Nation's veterans, ensuring that the more than 1,800 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 Academy believes that enactment of H.R. 1302 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 their supervising 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. More than 1,800 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. 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 Mayo 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 moneys 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 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 PA 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. The challenge for the VA is that the growth and demand for PAs is in the private sector, not the VA.

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 percent of the total profession was employed by the Federal Government. This percentage dropped to approximately 9 percent in 2008. New graduate census respondents were even less likely to be employed by the government (17 percent in 1991 down to 5 percent 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 P.L. 106–419 and has been filled as a part-time, field position. Prior to that time, 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 underutilization of PA skills and abilities. The PA profession's scope of practice was not uniformly understood in all VA medical facilities and clinics, and unnecessary confusion existed regarding such issues as privileging, supervision, and physician countersignature.

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 can not use PAs and will not hire PAs. These restrictions 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 for the opportunity to submit a statement for the hearing record in support of H.R. 1302. AAPA is eager to work with the House Committee on Veterans Affairs Subcommittee on Health to improve the availability and quality of medical care to our Nation's veteran population.

Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on these various pieces of legislation: H.R. 2722; H.R. 1197; H.R. 1293; H.R. 1302; H.R. 1335; H.R. 1546; H.R. 2734; H.R. 2738; and Draft Discussions on Extending Health Care to Vietnam-era Veterans Exposed to Herbicides and Gulf War Era Veterans; Providing Supportive Services for Family Caregivers Accompanying the Veteran on Visits to VA; and Requiring the Department of Veterans Affairs (VA) to Collect Survey Data on Family Caregivers.

H.R. 2722

This bill seeks to amend title 38, United States Code (U.S.C.), to modify and update provisions of law relating to nonprofit research and education corporations, and for other purposes.

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

H.R. 1197

This bill seeks to assign priority status for hospital care and medical services provided through the Department of Veterans Affairs (VA) to certain veterans who are recipients of the Medal of Honor.

The Medal of Honor is the highest military decoration awarded to a member of the United States Armed Forces. The recipients have earned this award by displaying heroism and bravery while risking their lives during service to this great Nation.

In addition to supporting H.R. 1197, The American Legion would support legislation to place Medal of Honor recipients in Priority Group 1 for VA health care.

H.R. 1293

This bill seeks to amend title 38, U.S.C., to improve the quality of care provided to veterans in VA medical facilities, to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities, and for other purposes.

The American Legion supports legislation that seeks to improve the quality of care for veterans, to include medical and structural accommodations that also improve quality of life. The American Legion feels section 2c of H.R. 1293 is unclear and thereby requests clarification.

H.R. 1302

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 Director of Physician Assistant (PA) services in the Department of Veterans Affairs (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 programs and initiatives.

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

H.R. 1335

This bill seeks to amend title 38, U.S.C., to prohibit the Secretary of Veterans Affairs from collecting certain co-payments from veterans who are catastrophically disabled.

The American Legion supports this piece of legislation.

H.R. 1546

This bill seeks to amend title 38, U.S.C., to direct the Secretary of Veterans Affairs to establish the Committee on Care of Veterans with Traumatic Brain Injury (TBI).

It is The American Legion's position that TBI is usually accompanied by various injuries to include Post Traumatic Stress Disorder (PTSD). We also contend that policies supporting care for this "Signature Wound" must be implemented and communicated from the policy level to the field. The American Legion supports this piece of legislation.

H.R. 2734

This bill seeks to amend section 1781 of title 38, U.S.C., to provide medical care to family members of disabled veterans who serve as caregivers to such veterans.

The American Legion supports any legislation that accommodates those who care for this Nation's veterans.

H.R. 2738

This bill seeks to amend title 38, U.S.C., to provide travel expenses for family caregivers accompanying veterans to medical treatment facilities.

The American Legion supports any legislation that accommodates those who care for this Nation's veterans. Veterans who injure themselves while serving this great Nation are entitled to all that places them in the best of care. We also contend that expenses and support should be provided by VA to all who participate in care for the veteran.

Draft Discussion on Extending Health Care to Vietnam Era Herbicide Exposed Veterans and Gulf-War Era Veterans

The American Legion believes adequate and quality care should be provided for those who sustained illnesses and injuries while serving honorably. We also believe such discussion should be implemented expeditiously as there is no pause button for this Nation's veterans. As time progresses, so does the extent of pain of our Nation's veterans.

The American Legion reaffirms its support for Vietnam veterans with Agent Orange exposure in VA Priority Group 6 for VA health care. The American Legion also supports legislation to give VA the authority to include ill Gulf War veterans in Priority Group 6 for VA health care.

The American Legion supports the measures outlined in this bill which would provide health care, medical services and nursing home care for certain Vietnam era veterans exposed to herbicide and veterans of the Persian Gulf War.

Draft Discussion on Providing Supportive Services for Family Caregivers

The American Legion supports legislation that adequately provides for those who are unselfishly caring for our Nation's veterans and believes such legislation should be implemented immediately.

Draft Discussion on Requiring VA to Collect Data on Family Caregivers of Veterans Through Surveys

It is The American Legion's position that the Department of Veterans Affairs maintains a database of those who are caring for this Nation's veterans. Collecting such data is only part of the accountability process. It's also imperative that VA, upon collecting this data, accurately assess services rendered and compensate caregivers adequately.

Conclusion

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony on the above mentioned pieces of legislation and looks forward to working with you and your colleagues on these very important issues. Thank you.

Prepared Statement of Hon. Steve Buyer,
Ranking Republican Member, Committee on Veterans' Affairs,
and a Representative in Congress from the State of Indiana

On March 4, 2009, I introduced H.R. 1293, the Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009. This bill would provide an increase in the amount payable to veterans under the Department of Veterans Affairs (VA) Home Improvement and Structural Alteration Program.

Known as the HISA program, this important VA benefit provides grants to veterans who require home adaptations to provide access to in-home medical care.

Typically, HISA grants are used for such things as widening doors; putting in handrails or special lighting; making kitchens, bathrooms, windows, or electrical outlets and switches more accessible; building ramps or improving entrance paths and driveways.

The benefit is paid from the medical care appropriation and is available to both veterans with service-connected and non-service connected disabilities. A service-connected veteran can receive a HISA grant in addition to other home adaptations grants available through the Veterans Benefits Administration.

Congress first authorized VA to establish the HISA program as part of outpatient care for home health services in 1973. We have been engaged in the Global War on Terror for nearly 8 years and are seeing an increasing number of servicemembers returning from Iraq and Afghanistan utilizing VA health care. It is especially important that this program remains relevant and can meet the needs of our newest generation of veterans.

The current maximum amount of a HISA grant is $4,100 for service-connected veterans and $1,200 for non-service connected veterans. This amount was established by Congress in 1992 and has not been raised in 17 years.

My bill would increase the maximum amount of a grant to $6,800 for service-connected veterans and $2,000 for non-service connected veterans. This is a 66 percent increase. It would reflect a 3 percent increase for each year since 1992 to account for inflation and the increased cost of home modifications.

This increase is long overdue, and I urge my colleagues to support this legislation. It would have a direct and immediate impact on improving health care and the quality of life for our disabled veterans.

Prepared Statement of Joy J. Ilem
Deputy National Legislative Director, Disabled American Veterans

Mr. Chairman and other Members of the Subcommittee:

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

H.R. 1197—Medal of Honor Health Care Equity Act of 2009

This bill would assign a higher priority status to Medal of Honor recipients for VA medical services and hospital care, by virtue of their extraordinary service to our country.

Mr. Chairman, our Nation owes a tremendous debt to the individuals awarded the Medal of Honor. As of June 2009, only 96 recipients of this medal are still living. The Medal of Honor is the highest military award for valor in action against an enemy of the United States. This bill would uphold our Nation's commitment to these select few by conveying to them a higher enrollment priority status for access to VA hospital care and medical services. While the DAV has no national resolution from our membership that endorses this particular legislation, we would offer no objection to its enactment and we appreciate the effort being made on behalf of these extraordinary heroes.

H.R. 1293—Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009

This bill is intended to increase VA payments for improvements and structural alterations furnished as part of home health services to severely disabled veterans enrolled in VA health care. This bill would increase the amount payable to service-connected veterans from $4,100 to $6,800, and for nonservice-connected veterans from $1,200 to $2,000.

Structural alterations to homes enable the chronically sick and disabled to remain in their homes rather than be institutionalized at much higher overall cost to the government. The existing payment limitations have not been increased for many years, and unless the amounts of these grants are periodically adjusted, inflation erodes these benefits. The *Independent Budget* (IB) for fiscal year (FY) 2010 recommends doubling the existing grant rate of payment in the case of service-con-

nected veterans residing temporarily in homes owned by others and this similar proposed rate increase is fully consistent with our concerns as expressed therein. This measure would be beneficial to severely disabled veterans; therefore, we support the purposes of this bill and urge its enactment. Additionally, given that the rate has remained stagnant for so many years, we also ask the Subcommittee to consider amending the bill to include a periodic index to enable this rate to be adjusted from time to by the administration to reflect inflation in construction costs.

H.R. 1302—To establish the position of Director of Physician Assistant Services Within the Office of the Under Secretary of Veterans Affairs for Health

This measure would amend title 38, United States Code, section 7306(a) to require the current position of Director of Physician Assistant Services within the office of the Under Secretary of Veterans Affairs for Health to serve in a full-time capacity at the Central Office of the Department. The bill would require the individual who serves in this position to encumber the full-time position in VA Central Office not later than 120 days after the date of enactment.

The VA is the largest Federal employer of physician assistants (PAs), with approximately 1,800 full-time PA positions. In the VA health care system, PAs are essential primary care providers literally in millions of outpatient and inpatient encounters 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 veteran service organizations that produce the IB have urged that this position be made full-time within Veterans Health Administration (VHA) headquarters. This would allow for:

- an increase in scope of PA-specific clinical and human resources policy issues;
- the opportunity to participate in major health care VA strategic 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 Care.

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 addition to supporting this bill, we urge that this occupation be included in any recruitment and retention legislation the Subcommittee reports because, 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 challenges. Although we do not have a specific resolution in support of this measure, the bill is consistent with recommendations outlined in the 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.

H.R. 1335—To Prohibit the Secretary of Veterans Affairs From Collecting Certain Co-payments From Veterans Who Are Catastrophically Disabled

This bill would prohibit the Secretary of Veterans Affairs from collecting co-payments from catastrophically disabled veterans in receipt of VA hospital or nursing home care.

Mr. Chairman, thousands of veterans survive catastrophic traumas in civilian life. Some of them have been able to overcome the tremendous challenges imposed on them by accidents or disease and have been able to rejoin the workforce and be productive, taxpaying citizens. We believe that catastrophically injured veterans should not face the double jeopardy of disability and an additional financial penalty of paying VA co-payments in order to access VA health care and services for which they are fully eligible. These veterans, many wheelchair-bound and spinal-cord injured, already spend thousands of dollars annually on health-related supports and services (such as personal attendants, adapted housing and automobiles, special equipment, etc.) that able-bodied veterans do not need to bear, or even consider. If a catastrophically ill or spinal-cord injured veteran succeeds in the daunting personal quest to

remain in, or re-join, the labor force, we believe where possible the government should provide that veteran proper incentives to remain employed. Setting aside co-payments would be one such appropriate incentive.

In reviewing H.R. 1335, we note the language in the bill specifically refers to hospital and nursing home care. However, we would hope the bill is intended to exempt these designated veterans from co-payments for hospital care *and medical services* under title 38, United States Code, § 1710. We are concerned that if left as currently crafted, the intent of the bill would be construed to include an exemption only from co-payments for inpatient services, forcing these targeted beneficiaries to continue paying co-payments for outpatient care and prescription medications. We recommend clarification in the bill to reflect Congressional intent.

In conjunction with DAV's national resolution from our membership, resolution number 172, calling for legislation to repeal all co-payments for military retirees and veterans' medical services and prescriptions, and as a partner organization constituting the FY 2010 IB, the DAV fully supports this provision. This bill also corresponds to the IB's recommendation that veterans designated by VA as being catastrophically disabled for the purpose of enrollment in health care eligibility Priority Group 4 should be made exempt from health care co-payments and other fees.

H.R. 1546—Caring for Veterans with Traumatic Brain Injury Act of 2009

This measure would direct the Secretary of Veterans Affairs to establish the Committee on Care of Veterans with Traumatic Brain Injury (TBI) in the VHA. The bill would require the Under Secretary for Health to appoint to the Committee employees of the Department with expertise in the care of veterans with TBI.

The bill would task the Committee with initially and continually assessing the capability of the VA to treat and rehabilitate veterans with TBI by evaluating the care provided and identifying systemwide problems and specific VA facilities where program enrichment would be needed to improve TBI treatment and rehabilitation. The bill would require the Committee to identify successful model programs in the treatment and rehabilitation of veterans with TBI that should be implemented more widely in or through VA facilities.

The Committee would be required to advise the Under Secretary for Health regarding the development of policies for TBI care and rehabilitation, make recommendations for improving programs of care at specific facilities throughout the VA, and for establishing special programs of education and training for VHA employees relevant to caring for veterans with TBI. The Committee would also concern itself with the research needs and priorities related to caring for veterans with TBI as well as the appropriate allocation of resources to underwrite such activities.

Beginning June 1, 2010 and for each subsequent year thereafter, the bill would require the Secretary to submit a report on the activities of the TBI committee to the Committees on Veterans' Affairs of the Senate and House of Representatives. Under the bill, the Secretary's report would be required to include a list of the members of the committee; the assessment of the Under Secretary for Health after reviewing the initial findings of the committee regarding the capability of the VA to effectively meet the treatment and rehabilitation needs of veterans with TBI on a systemwide and facility by facility basis; the plans of the Committee for further assessments, the findings and recommendations made by the Committee to the Under Secretary and the view of the Under Secretary on such findings and recommendations; a description of the steps taken, plans made including a timetable for the execution of such plans; and resources to be applied toward improving the capability of the VA to effectively meet the treatment and rehabilitation needs of veterans with TBI.

Mr. Chairman, DAV has no resolution that specifically identifies the need for this committee, but we do have a resolution, number 164, which calls for the VA and the Department of Defense (DoD) to coordinate efforts to address mild and moderate TBI and concussive injuries and establish a comprehensive rehabilitation program and standardized protocol utilizing appropriately formed clinical assessment techniques to recognize and treat neurological and behavioral consequences of all levels of TBI. It also calls for any TBI studies or research undertaken by VA and DoD to include older veterans of past military conflicts who may have suffered similar injuries that went undetected, undiagnosed, and untreated. We believe the intent to effectively care for and treat those with TBI is commendable, and that an advisory committee with this charter would be consistent with that important and timely goal. Therefore, DAV offers no objection to the purposes of this bill and we look forward to its enactment.

H.R. 2722—Veterans Nonprofit Research and Education Corporations Enhancement Act of 2009

This bill would modernize and enhance oversight and reporting requirements of nonprofit research and education corporations that support VA biomedical research by managing extramural grant funds made available to VA principal investigators. It would also provide new guidance and policy requirements for the operation of these corporations within the VA research program, and would be responsive to recent recommendations made by the VA Inspector General for improved accountability within some of these corporations.

The basic statutory authority for these corporations was enacted in 1988, so this bill would be the first significant amendment to that statute. If enacted, this bill would authorize the corporations to fulfill their full potential in supporting VA biomedical research and education, the results of which would improve treatments and promote high quality care for veterans, while underwriting VA and Congressional confidence in these corporations' management of public and private funds.

Mr. Chairman, VA's research and education corporations, operating in almost 90 VA locations, provide an important element in VA's overall Medical and Prosthetic Research programs, and provide major support for its myriad health professions educational programs. Absent these corporations, VA principal investigators, the majority of whom are clinicians, would not be able to accept or use grant funds from numerous Federal granting agencies (*e.g.*, National Institutes of Health, National Science Foundation, etc.) and VA would not be able to participate in numerous clinical trials, education and specialized clinical training programs sponsored by the pharmaceutical industry, medical equipment manufacturers, and other sponsors. Funded research from outside VA's annual discretionary appropriation makes up almost one-third of VA's global research budget. This legislation is endorsed by Friends of VA Medical Care and Health Research (FOVA), as well as the National Association of VA Research and Education Foundations (NAVREF).

While DAV has no adopted resolution on this particular matter, DAV is a strong supporter of a robust VA biomedical research and development program, and we believe enactment of this bill would be in that program's best interest. Therefore, DAV would have no objection to enactment of this bill.

Draft Bill—To Direct the Secretary of Veterans Affairs to Provide, Without Expiration, Hospital Care, Medical Services, and Nursing Home Care for Certain Vietnam-era Veterans Exposed to Herbicide and Veterans of the Persian Gulf War

This bill would permanently authorize hospital care, medical services and nursing home care to Vietnam veterans exposed to herbicides while deployed, and for all veterans of the Persian Gulf War. Title 38, United States Code, § 1710(e)(3)(A) and (B) provided VA the authority to enroll in VA health care Vietnam War veterans who may have been exposed to herbicides while serving in Vietnam and for Persian Gulf War veterans who served in the Southwest Asia theater of operations. Both authorities expired on December 31, 2002.

Mr. Chairman, Congress saw fit to provide "special treatment authority" in 1981 (P.L. 97–72) to provide care to Vietnam veterans who may have been exposed to herbicides, notwithstanding that there was insufficient medical evidence to conclude that their disabilities were associated with exposure to herbicides while serving in Vietnam. Congress repeatedly extended the authority through 1996 (P.L. 104–262) with certain limitations.

Similarly, veterans who served in the Persian Gulf War in the Southwest Asia theater of operations were provided special treatment authority in 1993 [1] to provide care to Persian Gulf veterans exposed to toxic substances or environmental hazards. In 1997, P.L. 105–114 removed the requirement that the veteran had been exposed to toxic substances or environmental hazards, only requiring service in the Southwest Asia theatre of operations during the Persian Gulf War. In 1998,[2] Congress extended the authority through 2001, and subsequently through 2002.[3]

The DAV applauds VA for continuing to enroll veterans in these circumstances. Based on wartime service and the often unknown hazards of military duty, these veterans deserve access to VA health care, a system dedicated to the unique needs of veterans. The DAV believes this is an important bill and looks forward to the Subcommittee's approval and its eventual passage into law.

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[1] Pub. L. 103–210 (1993).
[2] Pub. L. 105–368 (1998).
[3] Pub. L. 107–135 (2002).

FAMILY CAREGIVER SUPPORT SERVICES

Mr. Chairman, we note in the remaining four bills on which we offer testimony, that each legislative measure directed at family caregivers of disabled veterans would propose a standard definition for "family caregiver." While we recognize the importance of defining a program's target population, we ask the Subcommittee to consider VA's position, with which the DAV agrees, that "[f]amily structures are changing in all facets of society, and VA is sensitive to the fact that a specific list or a strict definition of family members may not be appropriate for many veterans. Discretion is needed to ensure that veterans retain autonomy in designating caregivers who are competent and in whom they are confident. . . . We believe the definition of caregiver should be broadly defined to encompass a variety of potential caregivers, thus eliminating the need for a discrete list that may inadvertently exclude a candidate (such as a friend, neighbor, or significant other) that meets the veteran's needs and preferences. Leaving discretion to the Secretary to approve any potential caregiver would ensure this adaptability." [4]

Family caregiving is a complex role that bridges both quality of care and quality of life of disabled veterans. Caregivers play a critical role in facilitating recovery and maintaining the veteran's independence and quality of life while residing in their community, and are an important component in the delivery of health care by the VA. Research has found that all too often the role of informal caregiver exacts a tremendous toll on that caregiver's health and well-being. Family caregiving has been associated with increased levels of isolation, depression and anxiety, higher use of prescription medications, compromised immune function, poorer self-reported physical health, and increased mortality. Research also suggests that caregiver support services can help to reduce adverse health outcomes arising from caregiving responsibilities, can improve overall health status of the caregiver and care recipient, and delay placement into a more costly nursing home care setting.[5]

The DAV believes caregivers of severely disabled veterans should be seen as a resource and supported in their role. Accordingly, the delegates to our most recent National Convention, held in Las Vegas, Nevada, August 9–12, 2008, approved resolution number 165, calling for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to family caregivers of veterans severely injured, wounded or ill from military service.

Draft Bill—To Amend Title 38, United States Code, To Provide Support Services for Family Caregivers of Disabled Veterans, and for Other Purposes

This bill would establish a new section 1786 of title 38, United States Code, to authorize a series of new and enhanced benefits for caregivers of disabled veterans, and would establish a broadened definition of the term "family caregiver" to include persons such as parents who would become eligible under its terms. The new section would require the Secretary to make interactive training sessions available on an Internet Web site for family caregivers of disabled veterans. Under the bill, the training would teach family caregivers techniques, strategies, and skills for recording details regarding the health of a veteran and in general for caring for a disabled veteran, to include those with post-traumatic stress disorder (PTSD) or TBI, including those who have returned from deployments in Operations Enduring or Iraqi Freedom (OEF/OIF).

The bill would also require the Secretary to provide family caregivers with information regarding public, private and nonprofit agencies that might offer support, and to work with the Assistant Secretary for Aging in the Department of Health and Human Services (HHS) to provide family caregivers of disabled veterans with access to the HHS Aging and Disability Resource Centers. Also the bill would require the establishment of an Internet-based service to include a directory of available services, an electronic message board, other tools for family caregivers to interact with each other to create areas of peer support, and comprehensive health-related information on issues relevant to the needs of disabled veterans and their family caregivers.

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[4] Madhulika Agarwal (Chief Officer, Patient Care Services, Veterans Health Admin., U.S. Dept of Veterans Affairs). Testimony on Meeting the Needs of Family Caregivers before the House Veterans Affairs Committee, Subcommittee on Health. (June 4, 2009). *http://veterans.house.gov/hearings/hearing.aspx?NewsID=412*.

[5] Mittelman, M.S., et al. *A Family Intervention to Deplay Nursing Home Placement of Patients with Alzheimers Disease—A Randomized Controlled Trial.* JAMA 276(21), 1725–1731. (April 2, 1997).

The bill would require outreach to inform disabled veterans and their families of the services that would be provided under this bill, to include public service announcements, brochures, pamphlets, participation in social networking sites; methods for reaching rural families; and a dedicated Web page on VA's existing Web site that focuses on caregiver support. The bill would require VA's Web site to launch new interactive elements for caregivers, including furnishing information based on the location of the person using the Web site.

This measure also would make technical and conforming changes to section 1782 of title 38, United States Code, pertaining to counseling and mental health services for family caregivers, by authorizing these services for family caregivers as defined in the new section 1786 otherwise crafted in this bill. Also, this expanded definition of family caregiver would be technically extended by the bill to section 1720B of title 38, United States Code, in order that respite care could be available for newly defined family caregivers. The final provision of the bill would require the Secretary to ensure that the needs of the veterans receiving family caregiver services are being met, and that respite facilities providing such care are appropriate, including age-appropriate, for the veterans concerned.

We believe the intent of this bill is laudable and as this Subcommittee is aware, VA has eight caregiver support pilot programs that the DAV believes should be evaluated for effectiveness and feasibility and if implemented, would be affected by this measure. For example, the pilot program being conducted in Long Beach, CA, works with a community coalition to provide interventions that support caregivers for veterans with TBI, PTSD and dementia across the State of California using telehealth, Web, telephone and video tele-conferencing. Interventions are provided by the VA Cares Caregiver Center; California Caregiver Resource Centers; the "Powerful Tools" Caregiver Training program; and Stanford University's Internet-based Caregiver Self Management Program. The program will assess the effectiveness of a 6-week-long online workshop, called "Building Better Caregivers," that provides training to at-home caregivers of veterans who suffer from TBI, PTSD, Alzheimer's disease or other forms of dementia. The interactive online workshop will also provide a forum in which small groups of caregivers can share personal experiences and insights on solving problems, handling difficult emotions and celebrating milestones. Each week, participants will be asked to log on at least three times and spend 2 hours on lessons and homework.

We are pleased the bill mandates VA to provide training; and, while we believe training is a critical aspect of supporting family caregivers of disabled veterans, we ask the Subcommittee to ensure that online training will not be the only venue offered by VA.

VA respite care is one of the few services available with a primary focus on supporting family caregivers to provide them temporary relief from their care responsibilities. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. In fact, respite care is considered the dominant service strategy to support and strengthen family caregivers under the HHS Aged/Disabled Medicaid Home and Community-Based (HCBS) waiver program. A survey conducted on these programs where respondents were asked to choose from a list of 20 items which services their program provides specifically to family caregivers, respite care received a 92 percent response.[6]

While the VA policy allows respite care services to be provided in excess of 30 days, it requires unforeseen difficulties. Additionally, local facilities treat 30 days as a ceiling by requiring the approval of the medical center Director rather than the treating physician or treatment team. Moreover, for veterans who are required to make co-payments, long-term care co-payments apply to respite care regardless of the setting. The DAV believes VA should improve its national respite care program to make it age appropriate, more flexible, and more readily available to all severely injured veterans and their caregivers. We believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing a veteran's primary treating physician to approve respite care in excess of 30 days; making more flexible the number of hours/days available for use; providing overnight and weekend respite care to veterans for relief of their caregivers; and eliminating applicable long-term-care co-payments. Three of the eight VA caregiver pilot programs previously noted use respite care as their primary focus. The DAV appreciates the bill's requirement, rather than a discretionary authority, to ensure the respite care needs of family caregivers of young and old severely injured veterans will be met.

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[6] Feinberg, L and Newman, S. *Medicaid and Family Caregiving: Services, Supports and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S.* Rutgers Center for State Health Policy. (May 1, 2005).

In addition, HHS announced in September 2008 it would provide VA with over $19 million to provide consumer-directed home and community-based services to veterans regardless of age (designed to reach people who are not eligible for Medicaid). Under this arrangement, VA is already working with local, State, and Federal agencies including the Aging and Disability Resource Center (ADRC) unlike this proposed bill, which requires VA to only collaborate with HHS for access to ADRC, which has its own limitations for including in their network nonprofit and other community agencies.

As noted above, this bill requires the VA to contract with a private entity to provide family caregivers with an Internet-based service to provide a directory of caregiver support services at the county level; online tools to allow family caregivers to interact with their peers and create support networks; and provide comprehensive information to meet the needs of disabled veterans and family caregivers. As part of the IB, the DAV believes caregiver support services should include family counseling and family peer groups so they can share solutions to common problems. One recommendation in the IB[7] calls for VA to develop support materials for family caregivers, including a social support and advocacy support for the family caregivers of severely injured veterans. Such support should include: peer support groups, facilitated and assisted by committed VA staff members; appointment of caregivers to local and VA network patient councils and other advisory bodies within the VHA and Veterans Benefits Administration (VBA); and a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My Health*e*Vet or other appropriate Web-based platform.

Mr. Chairman, as noted above, DAV resolution number 165 calls for legislation that would provide comprehensive supportive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to family caregivers of veterans severely injured, wounded or ill from military service. Also, the IB for FY 2010 recommends a series of supportive services and benefits for family caregivers of disabled veterans. Therefore, DAV strongly supports this bill and urges its enactment as soon as possible. On a final note, in light of the current VA caregiver pilot initiatives, we ask the Subcommittee to ensure the provisions outlined in the bill would not restrict or otherwise limit ongoing efforts by VA.

H.R. 2734—The Health Care for Family Caregivers Act of 2009

This bill would amend section 1781, title 38, United States Code, to extend eligibility for benefits under the Civilian Health and Medical Program of Veterans Affairs (CHAMPVA), to certain family caregivers of the most severely disabled veterans, as determined under subsections (r) or (s) of section 1114, title 38, United States Code, who are not currently eligible dependents of those veterans for that CHAMPVA benefit. The bill would exempt these family caregivers from the payment of deductibles, co-payments, cost sharing or other fees associated with their care under CHAMPVA.

Eligibility for CHAMPVA services would be limited to those caregivers without other entitlements to care under a health-plan contract as defined under section 1725(f)(2), title 38, United States Code. Further, "caregiver services" and "family caregiver" would be defined similar to the manner they would be defined in other bills before the Subcommittee today, specifically including parents, spouses, children, siblings, step-family members and extended family members.

The DAV applauds this worthwhile bill since family caregivers who provide 36 or more hours of care per week are more likely than non-caregivers to experience mental health issues, including symptoms of depression or anxiety—for spouses the symptom rate is six times as high.[8] Studies also demonstrate that family caregivers report having a chronic health condition at more than twice the rate of non-caregivers.[9] In addition, studies indicate that when family caregivers experience ex-

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[7] The Independent Budget for the Department of Veterans Affairs Fiscal Year 2010, Medical Care Section, *Family and Caregiver Support Issues Affecting Severely Injured Veterans* Subsection, pp 157–162. (2009). *http://www.independentbudget.org/pdf/IB__10medcare.pdf*.

[8] C.C. Cannuscio, C. Jones, et al., *Reverberation of Family Illness: A Longitudinal Assessment of Informal Caregiver and Mental Health Status in the Nurses' Health Study*, Am Jrnl of Pub. Health 92: 305–11. (2002).

[9] Dept of Health and Human Services (DHHS), *Informal Caregiving: Compassion in Action*, Washington, D.C. (1998). *http://aspe.hhs.gov/daltcp/Reports/carebro2.pdf*.

treme stress, they age prematurely and this level of stress can take as much as 10 years off a family caregiver's life.[10]

Family caregivers of severely disabled veterans with long-term care needs are able to divert those at risk from nursing home placement and in the absence of family caregivers, an even greater burden of direct care would fall to VA at significantly higher cost to the government and reduced quality of life for these veterans who have sacrificed so much. This bill is fully consistent with DAV resolution number 165 supporting the needs of family caregivers of disabled veterans. Therefore, DAV fully supports its intent and urges this bill to be enacted.

However, we believe under this proposal that only a minority of severely disabled veterans who require a high level of care from their family caregiver would meet the special monthly disability compensation rates (r) or (s), potentially leaving a majority of family caregivers in need of medical care without access to such care. We ask the Subcommittee to give due consideration to this high threshold for eligibility, which also lacks the appropriate clinical determination based on need for medical care due to a family member's role as caregiver of a severely disabled veteran. We recommend the Subcommittee consider lowering the threshold by adopting the eligibility standard that currently exists in section 1781(a)(1) of title 38, United States Code, for a veteran who has a total disability permanent and total in nature resulting from a service-connected disability.

H.R. 2738—To Amend Title 38, United States Code, To Provide Travel Expenses for Family Caregivers Accompanying Veterans to Medical Treatment Facilities

This bill would amend section 111(e), title 38, United States Code, to authorize family caregivers of certain sick and disabled veterans to receive beneficiary travel reimbursement, including lodging and subsistence, during the periods these caregivers accompany such veterans to and from VA health care facilities, and during the duration of treatment episodes, with certain limitations.

The bill would also amend section 1701, title 38, United States Code, to define "caregiver services" as one form of non-institutional care including homemaker and home health aide services, and it would define "family caregiver" as a member of a disabled veteran's family including parents, spouses, children, siblings, step-family members and extended family members of a disabled veteran, who provide caregiver services to a veteran.

Mr. Chairman, VA currently provides beneficiary travel payments to a member of a veteran's immediate family, legal guardian, or person in whose household the veteran certifies an intention to live if such person is traveling for consultation, professional counseling, training, or mental health services concerning a veteran who is receiving care for a service-connected disability or is traveling for bereavement counseling.

The DAV appreciates the intent of this bill since the availability of transportation is a key concern and barrier for many family caregivers of disabled veterans to access VA medical care. In order for veterans and their family caregivers to receive beneficiary travel payment, the veteran must meet certain eligibility criteria for VA's travel beneficiary program.[11] This measure would define the term "family caregiver" and include them in being able to receive mileage reimbursement, lodging, and subsistence under this program.

DAV resolution number 165, as discussed above, calls for legislation that would provide comprehensive support services to family caregivers of severely disabled veterans. Therefore, DAV endorses this legislation and urges its enactment.

Draft Bill—To Direct the Secretary of Veterans Affairs to Annually Conduct a Survey of Family Caregivers of Disabled Veterans, and for Other Purposes

This bill would require the VA Secretary to annually conduct a survey of family caregivers, to determine the number of family caregivers in the United States; the range of caregiver services provided by family caregivers, including the average schedule of such services and the average amount of time a caregiver has spent providing such services; the support services needed by family caregivers; and other information the Secretary considers appropriate. The bill would also require the Secretary to consider the findings of the survey when carrying out programs regarding

[10] Peter S. Arno, *Economic Value of Informal Caregiving*, presented at the VA Care Coordination and Caregiving Forum, Bethesda, MD (January 25–27, 2006).

[11] 38 CFR § 70.10(7) and (8). See also: Beneficiary Travel Handbook 1601B.05 (July 29, 2008).

family caregivers, and provide these reports to the House and Senate Committees on Veterans' Affairs. The bill would also define "caregiver services" and "family caregiver" in ways similar to the provisions of the other draft bills before the Subcommittee today.

Mr. Chairman, we agree with your opening statement for this Subcommittee's June 4, 2009, hearing on meeting the needs of family caregivers of disabled veterans, specifically that the VA does not collect data on this population and therefore, the number of family members who provide care for veterans is unknown. Moreover, in our testimony for that hearing we indicated a need for VA to conduct a longitudinal survey to obtain information and develop a nationally representative profile on the health and functional status of people who take care of severely disabled veterans.

At that hearing, we cited in our testimony the National Long Term Care Survey (NLTCS) and Informal Caregiver Survey (ICS) that can be used to examine such things as how many hours of help caregivers provide with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for chronically disabled elders, and what number and percentage of those hours are provided by informal caregivers. It can also be further broken down by primary and secondary caregivers and by relationship, (e.g., spouse, son, daughter, friend, etc.) as compared to paid workers. This enables policy researchers to measure the time burden on caregivers of providing informal care (especially primary caregivers) in relation to the severity of disability and other care recipient characteristics. The relationship between weekly time burden of informal care and self-reported indicators of caregiver stress can then be analyzed. Further analyses could be carried out with respect to relationships among time burden of informal care, self-reported caregiver stress, use/nonuse of formal services, and funding sources for formal services (public/private). Finally, the NLTCS/ICS contains numerous questions regarding the primary informal caregiver's perception of the need or lack of formal services and the reason why these services are not being used if they are perceived as needed (e.g., lack of affordability, lack of local availability, etc.). This enables policymakers to estimate (using various criteria) the potential size and characteristics of the target population for public policy interventions to assist caregivers.

As part of the IB, the DAV recommends VA should conduct a baseline national survey of caregivers of veterans to address the needs of informal caregivers as a public health concern by looking at population-based public health outcomes of caregivers. Because health outcomes and quality of life of family caregivers affect the lives of disabled veterans, data on family caregivers is needed to capture the influence of their roles and responsibilities as caregivers on their lives, including influence on work, social, psychological, and physical burden. Considering the demographics of the enrolled and user population of the VA health care system, attention to caregivers has with reason been drawn to the needs of the aging veteran, but that group represents only one segment—although a large one—of those who receive and provide care; however, the survey should include a special emphasis on caregivers of OEF/OIF veterans. In addition, since caregiving is a lifespan experience, this survey should be conducted at regular intervals.

In concert with a longitudinal survey, the DAV believes that caregiver assessments are equally important. In programs where caregivers are assessed, they can be acknowledged and valued by practitioners as part of the health care team. While requiring VA to perform caregiver assessments is not considered in this draft proposal, we urge VA to ensure this type of health care tool is utilized throughout the VA health care system. The DAV believes that unlike a longitudinal population survey, caregiver assessments can identify those family members most at risk for health and mental health effects and determine if they are eligible for additional support.

This bill is fully consistent with DAV resolution number 165 and the IB recommendation that VA conduct annual surveys of family caregivers as well as periodic assessments to determine their unmet needs. Therefore, DAV fully endorses this bill and urges its enactment.

Mr. Chairman, again, DAV appreciates the Subcommittee's interest in these issues, and we appreciate the opportunity to share our views on these important bills. I would be pleased to respond to questions from you or other Members of the Subcommittee on these matters.

Prepared Statement of Hon. Jerry Moran, a Representative in Congress From the State of Kansas

I want to thank Congressman Hare for his leadership on reintroducing this bill. I join Congressman Hare as an original co-sponsor of H.R. 1302. This bill creates a full time Director of PA Services within the Department of Veterans Affairs. This legislation is beneficial in improving patient care for our Nation's veterans, ensuring that the more than 1,800 PAs employed by the VA are fully utilized to provide veterans medical care.

As a Member of Congress who represents one of the most rural districts in the country, I know that physician assistants are a key to providing medical care in underserved areas. Often, they are the only health care professional available. PAs help ensure those who live in our communities receive timely access to quality health care.

I want to be certain that PAs are appropriately utilized by the VA to serve our veterans. Like our armed forces that have full-time directors of PA services, this legislation will establish a dedicated expert in the VA Central Office. This PA Director will work to fully integrate the profession into VA health care, ensuring PAs have a stronger voice in the VA so they can better serve our veterans and their patients.

In May of last year, the House approved this bill. I am hopeful this Committee will continue its support and this year we can enact H.R. 1302 into law.

Prepared Statement of National Association of Veterans' Research and Education Foundations

The National Association of Veterans' Research and Education Foundations (NAVREF) thanks Veterans Affairs Committee Chairman Bob Filner for introducing H.R. 2770, the *Veterans Research and Education Corporations Enhancement Act of 2009*, on June 9. We also thank Ranking Member Steve Buyer for collaborating with Mr. Filner to finalize and co-sponsor this legislation. We are grateful to Chairman Mike Michaud, Ranking Member Henry Brown and the Members and staff of the Health Subcommittee for holding a hearing on this and other important health-related legislation.

Upon enactment, H.R. 2770 will update and clarify provisions of the law authorizing the VA-affiliated nonprofit research and education corporations. The Senate counterpart of H.R. 2770 is title VI of S. 252 which was introduced by Chairman Daniel Akaka on January 15, 2009. Subsequently, it was the subject of a Senate Committee on Veterans' Affairs hearing on April 22 and was marked up by the Senate Committee on Veterans' Affairs on May 21. The substantive provisions of S. 252 and H.R. 2770 are identical. The only differences between the two bills are in the clause numbering and in a few provisions, the lead-in phrasing.

NAVREF is the membership organization of the 82 VA-affiliated nonprofit research and education corporations (NPCs) originally authorized by Congress under Public Law 100–322, and currently codified at sections 7361 through 7366 of the United States Code. NAVREF's mission is to promote high quality management of the NPCs and to pursue issues at the Federal level that are of interest to its members. NAVREF accomplishes this mission through educational activities for its members as well as interactions and advocacy with agency and congressional officials. Additional information about NAVREF is available on its Web site at www.navref.org.

Background About the NPCs

In 1988, Congress allowed the Secretary of the Department of Veterans Affairs to authorize "the establishment at any Department medical center of a nonprofit corporation to provide a flexible funding mechanism for the conduct of approved research and education at the medical center" [38 U.S.C. §7361(a)]. Currently, 82 NPCs provide their affiliated VA health care systems and medical centers with a highly valued means of administering non-VA Federal research grants and private sector funds in support of VA research and education.

The fundamental purpose of the nonprofits is to serve veterans by supporting VA research and medical education to improve the quality of care that veterans receive. For example, a seed grant provided by the Palo Alto Institute for Research and Education (PAIRE) to a gastroenterology clinician-investigator resulted in his finding that an easily overlooked type of abnormality in the colon is the most likely type to turn cancerous, and is more common in this country than previously thought. This finding, reported on the front page of the March 5, 2008,

New York Times and in the *Journal of the American Medical Association*, is changing colonoscopy practices and may well lead to widespread earlier detection of a cancer that is preventable or curable through surgery. During 2008 PAIRE made nine similar awards to VA Palo Alto investigators in the hope of equally significant research success down the road. Similarly, a few years ago funds administered by the Seattle Institute for Biomedical and Clinical Research (SIBCR) allowed a psychiatry clinician-investigator to test use of Prazosin, an inexpensive, already approved drug, for treatment of veterans with debilitating post-traumatic stress-related nightmares. The SIBCR funding allowed the investigator to accumulate positive preliminary data that then led to DoD and NIH awards to further test this promising treatment.

Last year, the NPCs collectively administered more than $250 million with expenditures that supported approximately 4,000 VA-approved research and education programs. **These nonprofits are dedicated solely to supporting VA and veterans.** This includes providing VA with the services of nearly 2,500 without compensation (WOC) research employees who work side-by-side with VA-salaried employees, all in conformance with the VA background, security and training requirements such appointments entail.

Beyond administering VA-approved research projects and education activities, these nonprofits support a variety of VA research infrastructure and administrative expenses. As described above, they have provided seed and bridge funding for investigators; staffed animal care facilities; funded recruitment of clinician researchers; paid for research administrative and compliance personnel; supported staff and training for institutional review boards (IRBs); and much more.

Legislation Would Enhance and Clarify NPC Authorities

The purpose of H.R. 2770 is to modernize and clarify the 1988 statute after 20 years of experience under its current terms. The NPCs have already proven themselves to be valued and effective "flexible funding mechanisms for the conduct of approved research" [38 U.S.C. § 7361(a)]. VA's most recent annual report to Congress regarding the NPCs stated, "The VA-affiliated NPCs continue to make a substantial contribution to the VA research and education missions." This legislation will further enhance their value to VA.

The objectives of this legislation are consistent with the findings in the May 2008 VA Office of Inspector General (OIG) review of five NPCs and VHA's oversight of them. VHA is working hard to address the shortcomings in oversight that the OIG identified. NAVREF and the NPCs are working equally hard to ensure that NPCs have appropriate controls over funds and equipment (including strengthening the documentation for all transactions), and that all NPC officers, directors and employees are certifying their awareness of the applicable Federal conflict of interest regulations. While NAVREF firmly believes that NPC boards and administrative employees strive to be conscientious stewards of NPC funds, NAVREF thanks the OIG for its thorough review of those five NPCs and for bringing to light these areas in need of improvement.

It is noteworthy that the OIG report cited no misuse of funds or instances of conflicts of interest, no dual compensation of Federal employees and no fraud. However, we take very seriously the OIG finding that these NPCs nonetheless may not have had adequate controls over some of the funds they manage. Two major provisions in H.R. 2770 directly address this finding:

First, section 2(a) allows voluntary formation of "multi-medical center research corporations." That is, two or more VA medical centers may share one NPC, subject to board and VA approval, while preserving their fundamental nature as medical center-based organizations. This provision—the centerpiece of the legislation—will allow interested VA facilities with small research programs to join voluntarily with larger ones. Or several smaller facilities may pool their resources to support management of one NPC with funds and staffing adequate to ensure an appropriate level of internal controls, including segregation of financial duties.

Second, the last item in section 5(a)—"(f) Policies and Procedures"—addresses the OIG criticism by broadening VA's ability to guide NPC expenditures. The only constraint on VA is that such guidance must be consistent with other Federal and State requirements as specified in laws, regulations, Executive orders, circulars and directives—of which there are many—applicable to other 501(c)(3) organizations. The purpose of this limitation is to prevent the possibility of imposing on NPCs conflicting requirements and to ensure that they remain independent "flexible funding mechanisms."

H.R. 2770 provides a number of other welcome enhancements to the NPC authorizing statute.

- Section 4(b) of the bill broadens the qualifications for the two mandatory non-VA board members beyond familiarity with medical research and education.

This will allow NPCs to use these board positions to acquire the legal and financial expertise needed to ensure sound governance and financial management.

- Section 4(c) deletes the overly broad stipulation in the current statute that these non-VA board members may not have "any financial relationship" with any for-profit entity that is a source of funding for VA research or education. This absolute prohibition conflicts with regulations applicable to Federal employees with respect to conflicts of interest, which are invoked for all NPC directors and employees in section 7366(c)(1) of title 38, United States Code. Unlike the standard currently applied to NPC board members, Federal conflict of interest regulations provide means of recusal as well as *de minimus* exceptions. Additionally, the current prohibition may be applied to any individual who has accepted compensation or reimbursement from a for-profit sponsor of VA research for purposes unrelated to VA research, thereby eliminating many otherwise desirable and qualified individuals from serving on NPC boards.
- Section 5(a) "(b) "(1) "(C) increases the efficiency of NPC administration of funds generated by educational activities. This clause allows NPCs to charge registration fees for the education and training programs they administer, and to retain such funds to offset program expenses or for future educational purposes. However, it also explicitly sustains the existing prohibition against NPCs accepting fees derived from VA appropriations.
- Section 5(a) "(b) "(1) "(D) provides NPCs with authority to reimburse the Office of General Counsel (OGC) for legal services related to review and approval of Cooperative Research and Development Agreements (CRADAs), the form of agreement used to establish terms and conditions for industry-funded studies performed at VA medical centers and administered by NPCs. Although OGC is already obligated to review these agreements without reimbursement, the funds generated under this provision would help OGC to staff Regional Counsel offices to accommodate the substantial workload these agreements entail and to provide training for VA attorneys in CRADA requirements and related VA policies. The NPCs support making these reimbursements.
- Section 5(a) "(b) "(2) of the legislation provides VA with authority to reimburse NPCs for the salary and benefits of NPC employees loaned to VA under Intergovernmental Personnel Act (IPA) assignments conducted in accordance with section 3371 of title 5, United States Code. This provision responds to recent OIG questions asking whether such reimbursements are allowable and permits VA to continue to benefit from this efficient and cost-effective mechanism to acquire the temporary services of skilled research personnel.
- Section 5(a) "(c) "(3) establishes explicit authority for VAMCs to accept funds provided by NPCs that may fall outside of VA's gift acceptance authority. It also allows VAMCs to retain such funds locally and to deposit them in the appropriate VA account without having to route them through the Treasury, necessitating cumbersome steps to get the funds to the right VA account. Finally, this provision makes these reimbursements "no year" money to give VAMCs needed flexibility in timing for use of the funds.

  Although VA has broad authority to accept gifts (38 U.S.C. § 8301), many NPC payments to VAMCs are more accurately described as reimbursements to the VAMC or payments for services and may not be consistent with VA's gift acceptance authority. For example, NPCs typically reimburse VAMCs for the cost of clinical services provided exclusively for research purposes; VA employees' time spent on NPC-administered programs; and animal per diems. This clause also will allow VA to resolve longstanding VAMC uncertainty about how to treat such reimbursements and will let the VAMC that incurred the cost retain the amounts reimbursed. Currently, VAMCs must send such reimbursements to the Treasury and then the Fiscal Office must use a cumbersome process to bring the funds back to the VAMC.

H.R. 2770 also contains a number of useful clarifications of NPC status and purposes.

- Sections 2(b), (c) and (d) codify—without changing—the legal status of the NPCs as State-chartered, independent organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Service (IRS) code and subject to VA oversight and regulation. Clause (c) of this section codifies the congressional intent, previously expressed in the House report that accompanied the original NPC authorizing statute (H. Rept. 100–373), that nonprofits established under this authority would not be corporations controlled or owned by the government. As a result, this legislation resolves longstanding differences of opinion among stakeholders, overseers and funding sources about the legal status of NPCs.

- Section 3(a)(1) of the legislation establishes that in addition to administering research projects and education activities, NPCs may support "functions related to the conduct of research and education." This resolves differences of opinion about the appropriateness of NPC expenditures that support VA research and education generally, such as purchase of core research equipment used by many researchers for multiple projects, and enhances the value of NPCs to VA facilities.
- Section 5(a) "(d) ascertains that all NPC-administered research projects must undergo "scientific" rather than "peer" review. This change recognizes that peer review is not necessary or appropriate for all research projects administered by NPCs. However, the legislation leaves in place the overarching requirement for VA approval and the medical center's Research and Development Committee remains in a position to determine on a case-by-case basis whether a project also requires peer review as a condition of VA approval.

In addition to these enhancements and clarifications, H.R. 2770 reorganizes the NPC authorizing statute to put all provisions regarding their establishment and status in one section; describes their purposes in another; and gathers in one section the clauses enumerating their powers. Other revisions are largely technical and conforming amendments.

Proposed Legislation Preserves Measures Providing Oversight of NPCs

H.R. 2770 makes no changes in VA's power to regulate and oversee the NPCs. Further, NPC records remain fully available to the Secretary and his designees; to the Inspector General; and to the Government Accountability Office (GAO). Likewise, NPCs are still required to undergo an annual audit by an independent auditor in accordance with the sources—Federal or private—and the amount of their prior year revenues, and they must submit to VA an annual report that includes the resulting audit report along with detailed financial information and descriptions of accomplishments.

In the wake of the Sarbanes-Oxley Act and changing Federal Accounting Standards Board (FASB) auditing standards, even the most basic form of nonprofit audit has become an effective means for assessing an organization's financial controls. Additionally, the percentage of NPC funds subject to audits conducted in accordance with OMB Circular A–133, the most rigorous level of applicable auditing standards, will continue to increase as more NPCs assume responsibility for non-VA Federal grants. According to reports submitted to VA in June 2008, nearly 80 percent of prior year NPC expenditures were subject to an A–133 audit and overall, 99.7 percent of NPC expenditures were subject to an audit of one type or another. These audits are comprehensive and provide a sound framework for examining an organization's controls over funds as well as compliance with program requirements.

Conclusion

In conclusion, NAVREF urges the Congress to pass H.R. 2770 at the earliest possible opportunity. The NPCs are already a highly efficient means to maximize the benefits to VA of externally funded research conducted in VA facilities, ably serving to facilitate research and education that benefit veterans. Additionally, they foster vibrant research environments at VA medical centers, enhancing VA's ability to recruit and retain clinician-investigators and other talented staff who in turn apply their knowledge to state-of-the-art care for veterans.

Twenty years after the VA–NPC public-private partnership was first authorized by Congress, this is a timely opportunity to update and clarify the NPCs' enabling legislation. This legislation will accomplish those objectives. Experience working within the current statute has brought to light its many strengths, but also areas that will benefit from modification, enhancement and updating, particularly in light of the increasing complexity of both research and nonprofit compliance. We believe enactment of H.R. 2770 will allow NPCs to better achieve their potential to support VA research and education while ensuring VA and congressional confidence in their management.

NAVREF thanks the Health Subcommittee of the House Committee on Veterans Affairs and its staff members, as well as the Full Committee staff, for their work on H.R. 2770. We look forward to working with the Members of the Committee toward enactment of this bill. Please direct any questions you may have to NAVREF Executive Director Barbara West at 301–656–5005 or bwest@navref.org.

Prepared Statement of Barbara Cohoon,
Government Relations Deputy Director, National Military Family Association

The National Military Family Association is the leading nonprofit organization committed to improving the lives of military families. Our 40 years of accomplishments have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality of life for active duty, National Guard, Reserve members, retired servicemembers, their families, and survivors from the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.

Association Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive Federal grants or contracts.

Our Web site is: ***www.MilitaryFamily.org***.

Chairman Michaud and Distinguished Members of the Subcommittee on Health of the U.S. House of Representatives Committee on Veterans' Affairs, the National Military Family Association would like to thank you for the opportunity to submit for the record for your legislative hearing. The National Military Family Association will take the opportunity to discuss our views on pending legislation to this Subcommittee.

Wounded servicemembers and veterans have wounded families. The system should provide coordination of care; VA and DoD need to work together to create a seamless transition. Our Association recommends there be a comprehensive approach to caregiver support services to ensure everything is covered and there are no gaps in the support system. We need one overall approach rather than having DoD, VA, and Members of Congress making ad hoc fixes as they arise. We cannot continue to approach the problem in a vacuum. We ask this Subcommittee to assist in meeting that responsibility.

'Veterans Nonprofit Research and Education Corporations Enhancement Act of 2009'

The National Military Family Association supports this proposed legislation that will modify and update provisions of the law that relate to nonprofit research and education corporations. We appreciate the amended section that will now include "education and training for patients and families." The provision allowing the established corporation to accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities would create an environment of flexibility allowing the corporation to receive and spend funds in the most efficient and beneficial manner.

Our Association would like to see a provision added creating an overview by the Under Secretary for Health to ensure there is a coordination of research projects done across the multi-medical center research corporations. This provision would prevent the potential for the duplication of research projects and allow for the opportunity for projects to be expansions of existing research projects.

'Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009'

The National Military Family Association supports this proposed legislation increasing the funds available to disabled veterans for improvements and structural alterations as part of home health services. We appreciate the monetary increase; however, our Association recommends the amount in this provision not be tied to a flat fee. The amount should be flexible and allow for regional differences in costs across the United States for improvements and alterations. There are variations on how much $6,800 can provide in services depending on where the veteran lives. We believe this benefit should be equal in purchase power regardless of where the veteran resides.

'Medal of Honor Health Care Equity Act of 2009'

The National Military Family Association supports this proposed legislation assigning a higher priority status for hospital care and medical services provided

through the Department of Veterans Affairs (VA) for veteran recipients of the Medal of Honor. This provision recognizes the distinguished service these veterans provided for our Nation.

Establishes the Position of Director of Physician Assistant Services

The National Military Family Association has no position on this proposed legislation.

Prohibits the Collection of Certain Co-payments from Catastrophically Disabled Veterans

The National Military Family Association supports this proposed legislation to prevent the VA from collecting certain co-payments from catastrophically disabled veterans. This provision recognizes the severity of injury and its potential financial impact on these veterans when receiving hospital or nursing home care. However, this provision prevents the collection for only in-patient care. Our Association would like to see this provision expanded to include out-patient services for catastrophically disabled veterans.

'Caring for Veterans with Traumatic Brain Injury Act of 2009'

The National Military Family Association supports the intent of this proposed legislation directing the Secretary of Veterans Affairs to establish the Committee on Care of Veterans with Traumatic Brain Injury (TBI). Traumatic Brain Injury has been referred to as the signature wound of this current conflict. Many of our servicemembers and now veterans have sustained this type of wound. However, we have some concerns. Currently, there exists a joint Center to address TBI in both active duty servicemembers and veterans. This Center is called the Defense Center of Excellence (DCoE). There is also a state-of-art health care facility being built in the National Capitol Region called the National Intrepid Center of Excellence (NICoE) that will provide evidence-based health care for servicemembers and veterans with TBI and post-traumatic stress disorder (PTSD). We are wondering how this newly established committee will interface with these two already established entities.

Another concern is that many of our wounded are affected by more than one injury. Who will ensure there is a system or committee in place to oversee continuity of care for those veterans with polytrauma? Seamless care will be difficult to obtain if we continue to create one-injury focused committees. We must be cognizant of our resources and acknowledge our injured veterans begin as active duty servicemembers. Members of Congress and the VA must work closely with the Department of Defense (DoD) to ensure there is coordination of services and that we are not creating duplicate services. We recommend these concerns be considered as Congress and the VA move forward in the creation of additional committees to address injuries affecting our veterans.

'Health Care for Family Caregivers Act of 2009'

The National Military Family Association supports the intent of this proposed legislation to provide medical care to family members of disabled veterans who serve in the role as caregiver. Our Association recommends caregivers of our veterans be recognized for the important role they play in maintaining the wellbeing of the disabled veteran, often resulting in personal financial sacrifices. Providing access to medical care for caregivers would go a long way in recognizing their important contribution. However, the bill's language needs further clarification.

We appreciate the inclusion of "family members" in the definition of caregiver. Most individuals and government agencies recognize and understand the blood and marriage connection. However, the definition of caregiver needs to be expanded to include those who are normally not considered a "member of the family," such as a girlfriend, fiancée or fiancé, and significant other. We frequently hear they are part of the caregiver structure. The difference between DoD and VA in regards to a caregiver definition and eligibility is important because the choice or self selection of the caregiver begins while the wounded, ill, and injured servicemember is still on active duty. According to the VA, "'informal' caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously gives their time and energy to provide whatever assistance is needed to the veteran." We would like to make sure DoD and VA have the same definition of caregiver and the eligibility is broad enough to capture additional individuals.

We believe we also need to know what constitutes a "caregiver." We need to have a better understanding of their roles and the scope of responsibilities that would

allow them to be considered a caregiver? This proposal as written would allow for a wide range of caregivers to qualify for this benefit and receive medical care.

Another area of concern involves the provision for the family caregiver to not be subject to "deductibles, premiums, co-payments, cost sharing, or other fees for medical care." Given the broad definition of caregiver, this provision could be very costly for the VA. Is the VA adequately funded to provide these services for free? We recognize the potential financial strain the caregiver may be under; however, we ask about the widow whose husband made the ultimate sacrifice. They too have experienced tremendous financial impact following the loss of their loved one, but are subject to these fees. According to this proposal's language, they would not be eligible for this generous benefit.

Our Association feels we need further clarification on what is currently being offered as a medical care benefit for caregivers. For example, the National Defense Authorization Act for Fiscal Year 2008 (NDAA FY08) section 1672 provides for medical care at DoD Military Treatment Facilities (MTFs) or VA facilities on a space-available basis authorized for certain family members, not otherwise eligible for medical care, caring for a recovering servicemember. According to a briefing by General Elder Granger, Deputy Director and Program Executive Officer for TRICARE Management Activity, on April 13, 2009, DoD has implemented this section of the NDAA FY08. This law allows for non-emergent care. How has the VA complied with this provision in allowing access to care for caregivers? We need to have a better understanding of the eligibility and availability of medical care for our caregivers before we can identify areas of quality care and where gaps still exist.

Provides Travel Expenses for Family Caregivers Accompanying Veterans to MTFs

The National Military Family Association supports this proposed legislation to provide travel expenses for family caregivers accompanying veterans to MTFs. This proposed legislation recognizes the important services the caregiver provides in assisting our servicemembers and veterans by acknowledging the fact that the caregiver often accompanies the wounded, ill, or injured servicemember and veteran to their medical appointments at the various MTFs. Often caregivers find themselves having to pay out of their own pockets for lodging and other unintended expenses, such as for meals. There are many benefits being created by DoD, VA, and Members of Congress to help address many of the issues arising from care of our wounded, ill, and injured servicemembers and veterans. Our Association appreciates everyone's commitment to do the right thing; however, we must be aware that these solutions need to be seamless when addressing these problems. For example, a benefit created by the DoD to address travel expenses should be equal to the one offered by the VA. Our military and veteran families do not understand that there are two different agencies caring for them. The families, along with the servicemember and veterans, should only feel as though there is one system of care. On June 17th the House Armed Service Committee approved the NDAA FY10. This legislation would provide for travel and transportation assistance for three designated persons, including non-family members and enable seriously injured servicemembers to use a non-medical attendant for help with travel for medical treatment. Our Association recommends there be coordination of caregiver travel benefits, making it work seamlessly for our wounded, ill, and injured servicemembers, veterans, their families, and caregivers.

Provides Continued Health Care for Certain Vietnam-era Veterans

The National Military Family Association supports this proposed legislation to direct the Secretary of Veterans Affairs to provide, without expiration, hospital care, medical services, and nursing home care for certain Vietnam-era veterans exposed to herbicide and veterans of the Persian Gulf War. This provision recognizes the need for uninterrupted medical care for veterans who were exposed to herbicides. This legislation also acknowledges the important service these veterans provided for our Nation at a time of war.

Provides Support Services for Family Caregivers of Disabled Veterans

The National Military Family Association supports the intent of this proposed legislation to provide support services for family caregivers of disabled veterans. However, our Association would like to make a few comments. First of all, we should not be duplicating services. Currently, the National Resource Directory established by DoD and the Department of Labor provides a Web-based service for obtaining, tracking, and maintaining important support services for the caregiver and the

wounded, ill, and injured servicemember and veteran. This service is already being provided and this proposal will be a duplication of service.

We understand the intent to limit the availability for training to the current wounded, ill, and injured population. However, we would recommend this program be expanded to capture all caregivers of veterans regardless of where or when the wound, injury, or illness took effect.

A caregiver curriculum is currently being developed for family caregivers of servicemembers and veterans with TBI. This curriculum is being created by a panel of experts, per guidance in the NDAA FY07 section 744. Our Association recommends this caregiver curriculum be expanded to cover all types of wounds, illness, and injuries of servicemembers and veterans.

Conduct a Survey of Family Caregivers

The National Military Family Association supports this proposed legislation to annually conduct a survey of family caregivers of disabled veterans. Our Association believes this survey will help the VA gain a better understanding of this population. This information can then be used to develop and implement better benefits to assist the caregivers in performing their duties. However, we recommend the survey should capture a wider range of information than what is currently included in this proposal. We suggest the survey start with caregiver demographics, and include additional items, such as the financial impact, identify gaps and successes in the support system, and the disruption to the family unit, especially children. Also, the survey should capture data on caregivers' experiences with both the VA and DoD support programs and benefits. We would also encourage the establishment of a panel of experts to help with the survey's design and implementation. This panel would consist of, but not be limited to, members representing: Veteran Service Organizations; Military Service Organizations; caregivers of our wounded, ill, and injured servicemembers and veterans; staff from the VA and DoD who work on caregiver issues; and members from each of the Services' wounded warrior programs.

The National Military Family Association would like to thank you again for the opportunity to provide testimony on proposed legislation. We look forward to working with you to improve the quality of life for veterans, their families, and caregivers.

Prepared Statement of Christopher Needham,
Senior Legislative Associate, National Legislative Service,
Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would like to thank you for the opportunity to testify at today's legislative hearing. Before us is a wide range of health care related bills, all of which would make improvements to the system that benefits America's veterans.

H.R. 1197

This legislation would change the VA health care enrollment status of veterans who were awarded the Medal of Honor. It would put them in Category 3, putting them on par with veterans who are former POWs and those who were awarded the Purple Heart.

There is no doubt about the sacrifice and bravery of the recipients of the Medal of Honor. They clearly have given everything they could for this country and for their fellow service men and women. Changing their enrollment status—which would also exempt them from having to pay hospital care co-payments—is an acknowledgement of the deep debt we as a Nation owe them, and it is a small price to pay for these true heroes.

H.R. 1293

The Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act would increase the amounts payable under VA's Home Improvement and Structural Alteration (HISA) program. The VFW strongly supports this legislation.

HISA was created to provide funding for home adaptations to allow veterans to receive care at home. These grants help make houses more accessible through small, but necessary improvements. With the number of severely disabled servicemembers returning from Iraq and Afghanistan, it is a program that will continue to grow in importance and relevance.

Despite this, Congress has not raised the amount of the grants—$4,100 for service-connected veterans and $1,200 for those without service connections—since 1992. It is time to change that. The increases in this bill—to $6,800 and $2,000—reflect an annual 3-percent increase since the last adjustment and are a step in the right direction for what we need to do for these severely injured men and women. This small improvement would make a meaningful impact in the lives of hundreds of veterans.

H.R. 1302

This legislation would create 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 Health Care 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 appointing a part-time advisor who serves in the role in addition to his or her regularly scheduled duties while working in the field, far from where VA makes its decisions.

The current PA Advisor role is likely not what Congress envisioned when it created the role, and the PA Advisor has had little voice in the VA planning process; VA has not 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.

H.R. 1335

The VFW strongly supports this legislation, which would exempt catastrophically disabled veterans from paying certain co-payments. The VFW has had a long-standing resolution in support of this concept.

Veterans who are deemed catastrophically disabled—typically those with severe spinal cord injuries—are placed in VA enrollment Category 4. Despite this enhanced enrollment status, they still must pay a co-payment for hospital and nursing home care. These men and women require complex, specialized health care. The nature of their injuries requires frequent, intensive uses of VA services throughout their lifetime as VA is typically better positioned to provide care to them than other health care facilities and insurance programs.

Enacting this legislation would reduce the heavy financial burden these men and women face. Since we already acknowledge their special circumstances by providing them an enhanced health care enrollment status, we should exempt them from hospital and nursing home co-payments as well.

H.R. 1546

The VFW supports this bill, which would create a Committee on Care of Veterans with Traumatic Brain Injury within VA. This committee would be a part of the Veterans Health Administration and would be comprised of VA employees with expertise in TBI. It would evaluate the care, services, gaps in care, and treatment options for veterans suffering from TBI, making recommendations to VHA leadership.

With TBI being described as the signature wound of the war, this is the right thing to do. Emphasizing the treatment and study of TBI—especially in its milder forms—should be a high priority, especially because there is much we still do not know about its effects, and these men and women are likely to be in the VA system for many years. Getting on top of the problem will better allow VA to manage their care and improve outcomes.

H.R. 2734

This legislation would provide medical care to family members who serve as caregivers to disabled veterans. The VFW supports this measure.

This bill would give the same level of access to care to these family caregivers as is provided to surviving spouses and children of disabled servicemembers who die from service-connected conditions. It would apply only to those who lack private health insurance. Since most private health insurance is provided through a per-

son's employer, and being a family caregiver is the family member's full-time job, it ensures that they have access to the basic care and services they need to lead healthy lives.

Numerous studies of other caregiver programs have shown that caregivers often have more severe health problems than others in their peer group. Providing this level of care is a stressful experience that affects their mental and physical health, as documented by the 1996 National Caregiver Survey.

Giving them access to care and services helps them deal with these difficulties, which, in turn, improves the level of care they are providing to the disabled veteran.

H.R. 2738

The VFW is pleased to support this bill, which would provide a lodging and subsistence allowance to family caregivers who accompany disabled veterans to medical facilities.

The disabled veterans eligible for the family caregiver program are likely to require lifelong care, and many trips to VA. They are unlikely to be able to travel alone, and will need their caregiver to accompany them. This is a compassionate change in policy that recognizes the unique circumstances faced by these veterans and their caregivers, and we urge its passage.

H.R. 2770

The VFW endorses the *Veterans Nonprofit Research and Education Corporations Enhancement Act*. This legislation would make several changes, which would strengthen and improve the nonprofit research corporations affiliated with VA. These NPCs help VA to conduct research and education and assist in the raising of funds for VA's essential projects from sources VA otherwise might not have access to, including private and public funding sources.

Included in the legislation is a section that would reaffirm that these NPCs are 501(c)(3) organizations that are not owned or controlled by the Federal Government. This is important to ensure that they are able to receive funding from all intended sources and to clarify their purpose in accordance with various State laws or private foundation regulations.

It would also allow for the creation of multi-medical center NPCs to streamline and make the administration of these important organizations more efficient. Ultimately, this should make more funds available for critical research purposes. Additionally, it would improve the accountability and oversight of these corporations, requiring more information in their annual reports and periodic audits of their activities. As these corporations continue to expand, we urge continued oversight of their actions to ensure that they continue to serve the best interest of America's veterans.

The legislation would address some of the concerns laid out in the recent VAOIG report, "Audit of Veterans Health Administration's Oversight Nonprofit Research and Education Corporations."

Draft Bill, Family Caregivers Support

The VFW is pleased to support the draft bill on family caregivers.

Section 1 of the bill would expand support services for family caregivers by providing Internet-based training on caregiver techniques, strategies and skills. It would also require the Secretary to give access to information from public, private and nonprofit agencies that offer support for caregivers, as well as requiring VA to perform more outreach so that families are aware of the range of services available to them.

These resources would be of great use to the loved ones of disabled servicemembers, and they would provide them with information, resources, and personal connections with others dealing with the challenges of being a caregivers.

Section 2 would expand the counseling and mental health services VA already provides to immediate family members to any family member who provides caregiver services, to include step- and extended-family members. This is clearly the right thing to do.

Section 3 would require VA to provide respite care to assist family caregivers. This would help to alleviate the burden on family caregivers, giving them a much-deserved break when they need it. It also would serve as another incentive for a loved one to provide these necessary services to their disabled veteran family member, since they know they could receive the occasional break.

Draft Bill, Family Caregivers Survey

VFW supports the draft bill that would require the VA Secretary to conduct an annual survey of family caregivers. The information from the survey could be useful to help shape the critical program, allowing VA and Congress to make adjustments to better meet the demands of critically wounded servicemembers and their families.

Draft Bill, Health Care for Gulf War and Herbicide Exposures

The VFW supports the draft bill that would indefinitely offer hospital care, medical services and nursing home care to certain Vietnam-era veterans exposed to herbicides and veterans of the Persian Gulf War.

Both groups have unique health needs that often manifest over a lifetime. And there is still much we do not know about the condition of these men and women. By eliminating the sunset dates for their eligibility for care, we can ensure that these former servicemembers will continue to have access to the health care and services they need because of the exposures and illnesses they may have encountered during their service to this country.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions that you or the Members of this Subcommittee may have.

Prepared Statement of Bernard Edelman,
Deputy Director for Policy and Government Affairs,
Vietnam Veterans of America

Good morning, Chairman Michaud, Ranking Member Miller, and other Members of this distinguished Subcommittee. We appreciate your giving Vietnam Veterans of America (VVA) the opportunity to testify today on legislation that relates to improving the health care of veterans and issues involving their caregivers. And on behalf of the members and families of VVA, we thank you for the stellar work this Subcommittee has been doing.

We would like first to comment on **H.R. 1197, the "Medal of Honor Health Care Equity Act of 2009."** VVA supports enactment of this bill unequivocally. We would like to offer a bit of commentary as to why.

Americans are hungry for heroes. We confer this status on people who lead their sports teams to championships to the adoration of their fans: guys who can throw for 50 touchdowns or run for 2,000 yards in a season; guys who can rocket baseballs into the stands 50 times a season; guys who score 30 points a game; guys who drive race cars really fast. We tend, too, to overuse this term when we honor men and women in uniform.

In reality, all who serve are not heroes. Yes, they don the uniform and, during times of war or conflict, put themselves in harm's way. Some are killed. Others are wounded, some grievously. Mostly, though, they are men and women doing the jobs for which they've been trained (and oftentimes doing jobs for which they haven't been trained).

While this gesture—dubbing them heroes—may be understandable, and even commendable, it in some ways diminishes what a hero really is: one who puts his (and as more women serve in the military, her) life in danger, and sometimes loses it, attempting to protect or save the lives of his comrades.

We have heroes—true heroes—who have met this standard. Their heroism, their selfless acts of valor and bravery in the chaos of combat, has been acknowledged with the awarding of the Medal of Honor. Others who have committed heroic acts have been honored with the Silver Star, the Navy Cross, the Distinguished Service Cross.

These heroes are deserving of our enduring appreciation and honor. This is what, in one small way, H.R. 1197 seeks to do. To accord all of these men, and women, who obtain their health care from VA facilities higher priority status is warranted. We are willing to bet, however, that most will not take advantage of this. Humble as most tend to be, they will not flaunt a medal to "get to the head of the line." They will stand in line, with the rest of their comrades, awaiting their turn.

H.R. 2770, the "Veterans Nonprofit Research and Education Corporations Enhancement Act of 2009." This bill, introduced by Chairman Filner and Ranking Member Buyer in what we wish was a permanent display of bipartisanship, seeks to modify and update provisions of law relating to nonprofit research and education corporations by facilitating the conduct of research, education or both at more than one VA medical center. If enacted, this bill should help facilitate research projects, the fruits of which can help not only veterans and their families but so many others as well.

VVA supports passage of H.R. 2770.

H.R. 1293, introduced by Mr. Buyer and designated the **"Disabled Veterans Home Improvement and Structural Alteration Grant Increase Act of 2009,"** in effect acknowledges the realities of inflation by increasing the amount available to disabled veterans for improvements and structural alterations furnished as part of home health services.

VVA supports the enactment of H.R. 1293.

As physician assistants have come to play increasingly important roles in the Veterans Health Administration, it seems to us a logical if somewhat belated effort with **H.R. 1302 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 persons to occupy the position of Under Secretary of 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.

Whomever President Obama ultimately selects as the next Under Secretary of Health must be an individual who will be open, transparent, respectful of the clear will of the Congress (as in the case of the status of Physician Assistants within the Veterans Health Administration), and above all truthful and honest. It is frankly 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.

VVA applauds Congressman Hare for having introduced this legislation, thanks him for his leadership on this and so many other issues, and supports its enactment without reservation.

It is a stark reality that as the military is able to save more and more troops who have received catastrophic wounds or injuries on the battlefield, more and more veterans will survive who are catastrophically disabled. **H.R. 1335**, introduced by Mrs. Halvorson, would prohibit the Secretary of Veterans Affairs from collecting certain co-payments and other fees for hospital or nursing home care from these veterans.

This bill is right-minded and forward-thinking. As such, VVA endorses for enactment H.R. 1335.

While we are not thrilled about creating yet another committee to focus on yet another facet of combat injury, **H.R. 1546, the "Caring for Veterans with Traumatic Brain Injury Act of 2009,"** would meet a growing and highly visible need if enacted. As TBI has become the "signature wound" of the fighting in Iraq and increasingly in Afghanistan, it has garnered a great deal of attention in the media as well as in the medical and veterans' communities. Millions of dollars have been appropriated to learn more about it. Is this money being spent wisely and well? Which treatment modalities are working? Which aren't? What ought to be the role of community-based organizations in caring for veterans with such wounds?

Establishment of a Committee on Care of Veterans with TBI does make sense and we commend Congressmen McNerney and Boozman for introducing it. However, such a committee should be comprised not only of VA employees "with expertise in the care of veterans with" TBI. It should integrate outside experts with perhaps differing expertise who might offer other and perhaps better ideas, along with representatives of veteran consumers and their families, who should be appointed by the Secretary of Veterans Affairs. Further, VVA recommends that we ensure that the operations of this committee are transparent, and that all deliberations and notes of this committee be open for public scrutiny.

As a general comment, the secrecy of the last 8 years, and the unwarranted arrogance that has taken hold in the culture of the VA, particularly within the VHA, needs to be reversed and transparency, full public disclosure, consultation with veterans and veterans' advocacy groups, and meaningful measures of accountability must be written into all areas. Frankly, it will take the Congress working closely in a bi-partisan manner with the new leadership team to undo the considerable damage that has been done, and to begin to resurrect significant gains and progress that could have been achieved in so many areas.

With these caveats, VVA endorses H.R. 1546.

H.R. 2734, the "Health Care for Family Caregivers Act of 2009," would provide medical care to family members of disabled veterans who serve as caregivers to such veterans. As noted above, more and more troops who survive catastrophic wounds face life with extraordinary needs for medical services and home care. Home care is provided by a parent, or a spouse, in some cases a child, in others some other family relation, significant other, or other companion. To make life easier for these individuals, Mr. Perriello's bill would inure such caregivers from "deductibles, premiums, co-payments, cost sharing, or other fees for medical care provided to such caregiver."

Even though a family member will take on the burden of caring for these veterans out of love and familial obligation, H.R. 2734 would provide a small measure of assistance to them. As such, VVA endorses this bill.

H.R. 2738, introduced by Congressman Teague, would also assist family caregivers accompanying veterans to medical treatment facilities, in this case by paying for "lodging and subsistence" as well as "expenses of travel" to and from such facilities.

As this seems eminently fair, VVA supports enactment of this bill.

Two of the three Draft Bills relate to family caregivers. The bill that would direct the Secretary of Veterans Affairs to conduct annual surveys of such caregivers makes eminently good sense. If properly conducted with well-thought-out questionnaires, it can help provide the VA with information that will better help caregivers assist the veterans for whom they are caring.

The bill that would "provide support services for family caregivers" contains some important and viable clauses. One potentially valuable clause is (b)(2), which would provide caregivers with an Internet-based service containing "a directory of services available at the county level; message boards and other tools that provide family caregivers with the ability to interact with each other and disabled veterans for the purpose of fostering peer support and creating support networks; and comprehensive information explaining health-related topics and issues relevant to the needs of disabled veterans and family caregivers."

We do not, however, agree that to accomplish this, the VA must "contract with a private entity." This ought to be done in-house, by folks with the necessary expertise and technical savvy. To do so will eliminate an unnecessary layer of bureaucracy, and a potentially costly one at that.

Similarly, in the "Information and Outreach" clause, which would direct the Secretary to mount what is in effect a multi-faceted media campaign, ought to be done in-house. However, we would advocate that such a campaign be coordinated with other VA health care outreach efforts. In this realm, we have advocated a major effort by the VA to use various media and methods to communicate with veterans and their families about health conditions that may have derived from their service while in the military and the care and other benefits to which veterans are entitled to by virtue of their service. In the past, the VA's attempts at outreach have been, to be generous, an embarrassment. The VA needs budget lines for its outreach activities, which must go a lot further than booklets and brochures in kiosks in VA health care facilities, and in-house media productions that are rarely, if ever, actually viewed by patients at these facilities.

We also would encourage this Subcommittee to meld the bills relating to family caregivers into a single "Disabled Veterans Family Caregivers Support Act of 2009."

It is our understanding that the Draft Bill that would direct the VA Secretary "to provide, without expiration, hospital care, medical services, and nursing home care for certain Vietnam-era veterans exposed to herbicide and veterans of the Persian Gulf War" would codify in statute what the VA already is doing. The bill would basically grant permanent authorization for the VA to provide this care for herbicide-exposed Vietnam-era veterans and Gulf War-era veterans who have insufficient medical evidence to establish a service-connected disability by placing them in Priority Group 6.

VVA will support this legislation.

Mr. Chairman, we again thank you for the opportunity to present our thoughts before this Subcommittee, and we welcome the opportunity to respond to any questions you might have.

Prepared Statement of Wounded Warrior Project

Chairman Michaud, Ranking Member Brown and Members of the Subcommittee:

Thank you for inviting the Wounded Warrior Project (WWP) to provide views regarding proposals before the Subcommittee today, and for including measures of concern to family caregivers, WWP's highest legislative priority. In candor, we are disappointed that H.R. 2342, the Wounded Warrior Project Family Caregiver Act, is not among the measures under consideration today, as it provides comprehensively for the needs of family caregivers. In our view, the Subcommittee's hearing of June 4th underscored the importance of family caregiving to the well-being and rehabilitation of wounded warriors, and the compelling need for comprehensive caregiver assistance, as provided for in H.R. 2342.

The Department of Veterans Affairs' Veterans Health Administration can have no higher obligation than providing for the treatment, rehabilitation, and long-term

care needs of veterans who have been severely injured in war, including providing these warriors' the fullest opportunity for meaningful, productive lives in the community. The experience of this war, however, has been unique in exposing gaps in the services VA provides. Among the most profound of those gaps is the absence of a comprehensive VA program to ensure that family members who have given up jobs, lost health insurance, and otherwise sacrificed to care for wounded warriors at home have the supports needed to sustain that lonely vigil.

Needs of Family Caregivers of Wounded Warriors

Each warrior's situation and each family's experience is unique. But all face the very real danger that without solid supports caregiving will become unsustainable—whether due to utter exhaustion, severe interpersonal strain, incapacitating illness, personal bankruptcy, or nervous breakdown. And when family caregiving cannot be sustained, there may be no other alternative for the veteran than institutional care. Such an outcome would not only be tragic for wounded warriors and their families, but could become enormously costly to the VA health care system which will likely be called upon to care for them.

More Comprehensive Support through Medicaid than VA

Congress provides for generous programs of support for low-income caregivers through Medicaid, notably through what is generally known as its Cash and Counseling program. (See Public Law 109–171, section 6087.) Surely the Department of Veterans Affairs should provide no less for family caregivers of severely wounded warriors. These families need comprehensive supports, and should not have to impoverish themselves to become eligible for a caregiver program.

We did note VA's June 4th testimony before this Subcommittee that it has begun to purchase home care services for family caregivers through a partnership with the Administration on Aging (AoA). While a positive step in that this may be a helpful option for some families, the initiative is being mounted in only a limited number of States. Moreover, it offers no assurance that those in greatest need would even be accepted into the "program," given that the VA/AoA program standards explicitly state that "Aging Network Agencies can refuse to accept veteran participants and their family caregivers when it is anticipated that the services required would exceed the scope of the Agency's ability to meet the veteran's needs." In short, despite this initiative, VA has no comprehensive solution to offer wounded warriors' family caregivers.

That program gap is critical given that certain fundamental needs must be met to sustain family caregiving. These include basic support services:

- an ongoing source of assistance to meet routine, specialized, and emergency needs;
- access to needed mental health services;
- provision for age- and medically-appropriate respite care;
- provision of needed medical care; and
- some modest level of economic support.

WWP strongly supports H.R. 2342, the Wounded Warrior Project Family Caregiver Act, because it would meet those needs.

Proposed Legislation

We appreciate that several of the proposals under consideration today address aspects of caregiving. However, none of those measures, individually or collectively, provide the level of support required to sustain caregiving for veterans with the kinds of needs identified in H.R. 2342.

Family caregivers from around the country, taking a few precious days away from their caregiving roles, will share their experiences with legislators next month as they come to the Nation's Capital to attend a WWP-sponsored caregiver summit. Most have been caring for wounded warriors for years, and would not need the training and informational services provided for in the discussion draft bill before the Subcommittee. Caregivers already have access to informational services addressed in the draft bill, but what they need are comprehensive support services that are rarely available in the community, and not provided for through VA. Most caregivers would get little benefit from other provisions of the draft bill, which (in amending relatively limited provisions of law) fall short of providing the extent of respite or mental-health support many families need. Moreover, the measure would not provide the comprehensive supports so critical to sustaining caregiving. In short,

while we appreciate the effort to help family caregivers, this well-intentioned proposal is not a solution.

VA is certainly remiss in not having systematically compiled information on the needs of veterans' caregivers and on the services they provide. But while we see no objection to the draft bill that proposes an annual survey on family caregiving, we believe enough is known about the burdens wounded warriors' caregivers are shouldering—often full time and with only the most limited respite—that Congress can and must move beyond piecemeal measures immediately.

To illustrate, we appreciate the recognition in H.R. 2734 that family caregivers are at increased health risk, and that health coverage under the CHAMPVA program is an important, needed support. But health coverage, important as it is, is but one of the core needs experienced by caregivers of severely wounded veterans. Moreover, the bill does not fully answer that need as it would limit this benefit to family caregivers of veterans who receive compensation under subsections (r) or (s) of section 1114 of title 38, U.S. Code. Yet many OIF/OEF veterans with profound service-incurred wounds who require full-time personal care receive, or would be entitled to, special monthly compensation, but not under those particular provisions of section 1114.

There can be no question that severely wounded veterans continue to depend on loved ones for round-the-clock care. While the numbers of those veterans is not large, their needs are great—as is the debt we owe them. That debt is not discharged simply because the veteran has left a hospital and returned to the community and home. We must support their rehabilitation and long-term care needs. Surely we best serve those veterans—and honor their service—by enabling their families to care for them at home.

We call on the Committee to fill this critical gap by taking up and moving H.R. 2342 at the earliest possible date.

Finally, we welcome the opportunity to supplement this statement in the days ahead with additional views on other measures under consideration today.

POST–HEARING QUESTIONS FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shinseki:

Thank you for the testimony prepared by Dr. Robert A. Petzel, Acting Principal Deputy Under Secretary for Health, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Dr. Petzel's testimony noted that the cost of H.R. 1197 is insignificant. Does this mean that the cost is estimated to be below $500,000? How many living Medal of Honor recipients are there?
2. H.R. 1302 would establish a full-time Director of Physician Assistant Services, who reports directly to the Under Secretary for Health. Which positions currently report directly to the Under Secretary for Health? In other words, is there a comparable, full-time Central Office position for other health professions? Please provide the Committee with a visual organizational chart outlining the positions that report directly to the Under Secretary for Health.
3. What efforts are being made to recruit and retain physician assistants, presently and in the foreseeable future?
4. If H.R. 1335 eliminated all co-payments for nursing home care, pharmacy, and outpatient care, would VA continue to support this proposal?
5. How many veterans were enrolled in Priority Group 4 in 2008? Of this total, how many were veterans who are catastrophically disabled from nonservice-connected causes and have income levels that would have placed them in Priority Group 7 or Priority Group 8?
6. I have several questions on VA's position on H.R. 2734.
   a. You note that defining this group as veterans who receive special monthly compensation for aid and attendance or homebound care may include veterans who do not need caregiver support. Please explain. Doesn't aid attendant and homebound care only include veterans who are the most severely disabled and cannot function on their own?
   b. Is there a way of targeting the intended beneficiaries of this bill by linking it to the existing disability evaluation system in VBA so that VHA does not have to set up a new system for evaluating the eligibility criteria for this benefit?
   c. How many individuals would newly qualify under the provisions in H.R. 2734?
   d. What is your response to VSO recommendations that the eligible veteran be redefined to capture more individuals?
7. H.R. 2738 authorizes lodging and subsistence payments to family caregivers of veterans. Under current law, what services are available under the VA's beneficiary travel authority? Who is eligible for these services under current law?
8. VA has conducted several demonstration projects to provide supportive services to family caregivers. Please provide the Committee with a brief summary and copies of the detailed reports on what VA found from these projects.
9. Providing some type of relief and services to the caregiver is an issue that every organization on the VSO panel supports. However, how to provide this relief and what the benefits should look like has been an ongoing discussion for years. Congressional hearings have been held on this issue. Despite this intense focus, VA did not provide views on two pieces of caregiver legislation, with the stated rationale that VA is currently undertaking a comprehensive review of existing benefits to determine potential gaps.

a. Besides the demonstration projects underway, what else is VA doing?
b. How is the comprehensive review structured and who is responsible for the final recommendations of this review? When will the review be completed?
c. For the two pieces of caregiver legislation that VA did not comment on, why was VA unable to submit views? The Subcommittee would like VA's views and cost estimates on these two pieces of legislation.

10. VA established the Caregiver Advisory Board in June 2008 to develop caregiver assistance programs that address issues facing caregivers of veterans. Please provide an update on the activities of the Advisory Board, including a summary of the caregiver needs the Board identified and any initial recommendations to expand support services for caregivers. In addition, please share all internal reports and memorandums authorized by this Advisory Board.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman
Subcommittee on Health, House Committee on Veterans' Affairs
June 18, 2009

Legislative Hearing

Question 1: Dr. Petzel's testimony noted that the cost of H.R. 1197 is insignificant. Does this mean that the cost is estimated to be below $500,000? How many living Medal of Honor recipients are there?

Response: The Department of Veterans Affairs (VA) estimates that the fiscal 2010 cost to provide care to the 17 living Medal of Honor recipients currently not already enrolled in or eligible for enrollment in a higher VA health care priority group would be $216,520 if all were placed in Priority Group 1. According to the official Congressional Medal of Honor Society Web site (www.cmohs.org), there were 96 living Medal of Honor recipients as of July 2, 2009.

Question 2: H.R. 1302 would establish a full-time Director of Physician Assistant Services, who reports directly to the Under Secretary for Health. Which positions currently report directly to the Under Secretary for Health? In other words, is there a comparable, full-time Central Office position for other health professions? Please provide the Committee with a visual organizational chart outlining the positions that report directly to the Under Secretary for Health.

Response: Currently, the Associate Deputy Under Secretary for Health for Quality and Safety, the Chief of Staff, the Principal Deputy Under Secretary for Health, the Medical Inspector, and the Chief Officer for Research Oversight report directly to the Under Secretary for Health. The most comparable position to that proposed is the Chief Nursing Officer. Section 7306, of title 38, provides that the Director of Nursing Service shall report directly to the Under Secretary for Health. The Veterans Health Administration's (VHA) Chief Nursing Officer reports to the Under Secretary through the Principal Deputy Under Secretary for Health. Other clinical care providers, such as optometry and podiatry, report to the Chief Officer for Patient Care Services, who reports to the Principal Deputy Under Secretary for Health. VHA has attached an organizational chart of chief officers, current as of June 25, 2009.

VA would like to note an error in the Department's June 18, 2009, testimony on H.R. 1302. The testimony indicated that all clinical leadership positions are aligned within the Office of Patient Care Services. As illustrated by the attached VHA organizational chart, the Chief Nursing Officer reports to the Principal Deputy Under Secretary for Health, not Patient Care Services. However, VA remains opposed to the proposed realignment of the Director of Physician Assistant Services as the position's current placement within Patient Care Services provides the necessary access to the Under Secretary for Health.

Question 3: What efforts are being made to recruit and retain physician assistants presently and in the foreseeable future?

Response: VA continues significant efforts to recruit and retain physician assistants to meet patient care workload demands. Physician assistant recruitment efforts are coordinated by the VA Health Care Recruitment and Retention Office. VA recruitment exhibits at major, national physician assistant events have proved to be a very effective recruitment tool. The Education Debt Reduction Program which assists VA employees in repayment of student loans and the Employee Incentive Scholarship Program, providing tuition assistance to VA employees who wish to obtain advanced degrees are available to physician assistants in difficult to recruit areas. VA facilities also have the option of requesting special pay rates for physician assistants to offset any labor market salary discrepancies. VA continues to explore other recruitment and retention initiatives to ensure sufficient numbers of physician assistants are available to meet VHA's patient care needs.

Question 4: If H.R. 1335 eliminated all co-payments for nursing home care, pharmacy, and outpatient care, would VA continue to support this proposal?

Response: VA has no objection to eliminating all co-payments for those veterans determined to be catastrophically disabled. VA estimates that it would incur lost collections amounting to $7.8 million in fiscal year (FY) 2010, $7.9 million in FY 2011, $40.5 million over 5 years, and $85.2 million over 10 years.

Question 5: How many veterans were enrolled in Priority Group 4 in 2008? Of this total, how many were veterans who are catastrophically disabled from non-service-connected causes and have income levels that would have placed them in Priority Group 7 or Priority Group 8?

Response: In FY 2008, 237,208 veterans were enrolled in Priority Group 4. The number of veterans placed in Priority Group 4 based on a catastrophic determination that would have otherwise been placed in a Priority Group 7 or 8 based on income is 7,978.

Question 6(a): I have several questions on VA's position on H.R. 2734. You note that defining this group of veterans who receive special monthly compensation for aid and attendance or homebound care may include veterans who do not need caregiver support. Please explain. Doesn't aid and attendance and homebound care only include veterans who are the most severely disabled and cannot function on their own?

Response: The statutes regulating entitlement to additional compensation based on the need for aid and attendance or housebound care are found in subsections (r) and (s) of section 1114 of title 38, United States Code. While it is true that subsections (r) and (s) apply to veterans with severe injuries or illnesses, VA believes that the population of veterans who qualifies for one or both of these benefits is not synonymous with the population of veterans that is the focus of H.R. 2734 and other pending caregiver legislation.

The language in subsection (r) concerning aid and attendance benefits supports this view. Clause (r)(1) states that veterans eligible for regular aid and attendance shall be paid a monthly aid and attendance allowance. Clause (r)(2) goes farther and asserts that "*if the veteran, in addition to such need for regular aid and attendance, is in need of a higher level of care, such veteran shall be paid monthly aid and attendance* [at a much higher rate]." *Subsection (r) then states that "for the purposes of clause (2) of this subsection, need for a higher level of care shall be considered to be need for personal health care services provided on a daily basis in the veteran's home. . . ."* Therefore, it is VA's position that a veteran who qualifies for benefits under clause (1) would not be eligible for caregiver benefits, whereas a veteran who qualifies for the higher level benefits under clause (2) most likely would be eligible for caregiver benefits.

Subsection (s) relates to eligibility for additional compensation based on a veteran's status as housebound. For the purposes of this subsection, the requirement of "permanently housebound" is considered to have been met when the veteran is substantially confined to such veteran's house . . . due to a service-connected disability or disabilities which it is reasonably certain will remain throughout such veteran's lifetime." It is VA's view that many veterans who would qualify for caregiver benefits would not qualify for housebound benefits: for example, veterans who have severe mental disabilities resulting from post-traumatic stress disorder (PTSD) or Traumatic Brain Injury (TBI). Indeed, in many cases, the need for a caregiver might be justified precisely because such caregiver would allow the veteran a level of support that would prevent the veteran from having to be housebound.

These examples demonstrate that H.R. 2734 and other caregiver legislation should not define an eligible veteran as being one who would qualify for either aid and attendance benefits or housebound benefits. In the case of subsection (r), eligibility would *include* veterans who should not qualify for a caregiver while restriction to subsection (s) qualifications would *exclude* many veterans who should be entitled to a caregiver.

Question 6(b): Is there a way of targeting the intended beneficiaries of this bill by linking it to the existing disability evaluation system in VBA so that VHA does not have to set up a new system for evaluating the eligibility criteria for this benefit?

Response: VA believes eligibility criteria for the special monthly compensation administered by the Veterans Benefits Administration (VBA) are appropriate for financial support decisions but are inappropriate for clinical decisionmaking. VA would not need to develop new eligibility criteria if factors such as activities of daily living or instrumental activities of daily living were used to determine caregiver benefits. VA already uses these clinical factors to determine eligibility for home maker and home health aide services and other benefits through the Geriatrics and Extended Care program, and consequently would not need to set up a new system for evaluation. Moreover, VA could define severely injured veterans as those in need of a higher level of care, due to injury or illness suffered in the line of duty, and in the absence of such care, would require hospitalization, nursing home level care, or other residential, institutional care. This population would include fewer than 2,500 veterans of all combat eras. The definition suggested above is very similar to those receiving special monthly compensation at the R2 level under section 1114 of title 38, U.S.C.

Question 6(c): How many individuals would newly qualify under the provisions in H.R. 2734?

Response: VA estimates that if the legislation is passed as written, 47,049 additional beneficiaries would receive Civilian Health and Medical Program of VA (CHAMPVA) benefits in FY 2010, increasing to 60,009 by FY 2019.

Question 6(d): What is your response to VSO recommendations that the eligible veteran be redefined to capture more individuals?

Response: VA is sensitive to the growing need of veterans for caregivers as the population of enrolled veterans continues to age. We also understand that, as the population of enrolled veterans increases, the costs of caregiver benefits will continue to grow. VA believes resources appropriated by Congress for the medical care of America's veterans must be used efficiently and effectively to care for those with the greatest need. Therefore, we believe that caregiver benefits should primarily be provided to caregivers of veterans with certain service-connected disabilities.

Question 7: H.R. 2738 authorizes lodging and subsistence payments to family caregivers of veterans. Under current law, what services are available under VA's beneficiary travel authority? Who is eligible for these services under current law?

Response: Current VA beneficiary travel regulations at 38 CFR Part 70 authorize VA to pay for certain travel costs of an attendant when VA medically determined that an attendant is required to assist the veteran during travel. Benefits include the actual cost of travel (unless traveling with the veteran in a shared personal vehicle), and lodging and per diem at 50 percent of the area Federal employee rate during the actual period of travel. Should a veteran be admitted to a VA facility for care following travel and VA determines the veteran no longer needs a non-VA attendant, per diem and incidental costs have usually been at the caregiver's or attendant's expense.

Question 8: VA has conducted several demonstration projects to provide supportive services to family caregivers. Please provide the Committee with a brief summary and copies of the detailed reports on what VA found from these projects.

Response: Section 214 of Public Law 109–461 authorized VA to allocate $5,000,000 for FY 2007 and 2008 to carry out a pilot program on improvement of caregiver assistive services. VA conducted a robust review of 52 applications based on a request for proposals and selected 8 caregiver assistance pilot programs. These pilots represented projects from across the country (including rural areas), different patient populations, different clinical needs and different approaches. VA designed these pilots to assess the feasibility and advisability of various mechanisms to expand and improve caregiver assistance services. The caregiver assistance pilot pro-

grams were launched in October 2007 and will end in September 2009. A 1-year extension of the legislative authority was approved through Public Law 110–329 Appropriations Act of 2009. VA will submit its final report to Congress in the first quarter of FY 2010 and may replicate or expand successful initiatives in other locations. A brief description of each program follows:

1. *Resources for enhancing Alzheimer's caregiver health (REACH) VA.* The coordinating site is Memphis, Tennessee.

   Eligibility for participation and description of services provided: Caregivers of veterans diagnosed with dementia enrolled in home-based primary care. REACH VA is currently piloted in 24 home-based primary care programs across the country in 15 States. This program provides an intervention translated from a similar, evidence-based National Institutes of Health initiative that provides education, support and skills building to help caregivers manage both patient behaviors and their own stress. In October 2008, REACH VA won the Rosalynn Carter Institute Leadership in Caregiving Award.

2. *Transition assistance program.* The coordinating site is Gainesville, Florida, while actual pilots are underway at the Stroke Centers of Excellence in Houston, Texas, and San Juan, Puerto Rico.

   Eligibility for participation and description of services provided: Caregivers of veterans with stroke-related disabilities. Caregivers are taking part in a transition assistance program, which provides skills training, education and supportive problem solving using videophone technology for new stroke patients or patients with stroke-related disabilities and their caregivers.

3. *Use of caregiver advocates to develop, expand and coordinate services for veterans' caregivers.* The pilots are underway in Cincinnati and Dayton, Ohio.

   Eligibility for participation and description of services provided: Caregivers of frail impaired veterans at highest risk for institutionalization, including veterans with multiple chronic conditions such as chronic obstructive pulmonary disease, congestive heart failure, hypertension, diabetes mellitus and dementias. Veterans Integrated Service Network (VISN) 10 has established a 24/7 hotline titled, *Caregiver Advocates*. Caregiver advocates assist caregivers in identifying, accessing and coordinating between VA and existing community providers in home-based primary care programs and augmented caregiver support services and providing therapeutic interventions to the caregiver. This pilot also provides additional hours for adult day health care, in-home respite and inpatient respite care.

4. *VA California Office on Caregiving.* VISNs 21 and 22.

   Eligibility for participation and description of services provided: Caregivers of veterans with Traumatic Brain Injury (TBI), post-traumatic stress disorder (PTSD), or dementia. VA is working with a community coalition to provide interventions that support caregivers for veterans with TBI, PTSD or dementia across the State of California using telehealth, Web, telephone and video teleconferencing. Interventions are provided by VA and the State of California caregiver resource centers, the caregiver training program (*Powerful Tools*), and Stanford University's Internet-based caregiver self management program.

5. *Communicating Effectively with Health Care Professionals.* Albany, New York.

   Eligibility for participation and description of services provided: Caregivers of veterans having a chronic disease and who have received care in a VA facility within a period of 12 months prior to the start of the study. This pilot program converted a 3-hour workshop developed by the National Family Caregivers Association, *Communicating Effectively with Health Care Professionals*, into a DVD and manual. Face-to-face workshops have been implemented to offer an additional delivery method. If this program proves effective, VA may be able to add this content to the My Health*e*Vet Web site to promote further distribution.

6. *Telehealth Technology to Support Family Caregivers.* Atlanta, Georgia.

   Eligibility for participation and description of services provided: Caregivers to veterans 60 years old or older who have at least one chronic illness requiring daily activity of daily living or instrumental activity of daily living assistance. Caregivers must live with the veteran. This pilot uses a model telehealth program adapting *Health Buddy* devices, which are existing technologies used by VA, to provide help and emotional support for caregivers who live in remote areas or cannot leave the veteran by him or herself.

7. *Joint program between the Tampa and Miami medical centers to provide support to caregivers of high-risk veterans.*

   Eligibility for participation and description of services provided: Tampa's existing respite program is being expanded to provide 24-hour in-home respite care for temporary relief to caregivers (up to 14 days per calendar year) and emergency respite in local assisted living or medical foster care facilities. The Miami program provides and coordinates comprehensive community-based care services including respite, home companions, adult day care, and use of an emergency response system for high risk veterans.

8. *Heroes of the heart.* VA Pacific Islands Health Care System.

   Eligibility for participation and description of services provided: Caregivers of veterans who meet the criteria for respite and live on the more rural, less populated islands of Hawaii, Kauai and Maui in the State of Hawaii. The medical foster home concept is used to provide overnight respite for veterans in areas where no other inpatient respite options are available, particularly in remote and rural service areas. Currently, overnight respite care can only be provided at the VA Pacific Islands Health Care System Center for Aging in Honolulu or in contract nursing homes located on Oahu.

Question 9(a): Providing some type of relief and services to the caregiver is an issue that every organization on the VSO panel supports. However, how to provide this relief and what the benefits should look like has been an ongoing discussion for years. Congressional hearings have been held on this issue. Despite this intense focus, VA did not provide views on two pieces of caregiver legislation, with the stated rationale that VA is currently undertaking a comprehensive review of existing benefits to determine potential gaps. Besides the demonstration projects underway, what else is VA doing?

Response: VA is committed to providing clinically appropriate home health care services as an integral component of medical care services. VA provides in-home services to enhance or build a comprehensive array of resources necessary to address the short-term or long-term care needs of enrolled veterans. All enrolled veterans are eligible for a comprehensive array of medically necessary in-home services as identified in VA's medical benefits package (see title 38 CFR 17.38(a)(1)(ix)). These in-home services support the caregiver in meeting the needs of the veteran whose desire is to remain in his or her own home setting. Below is a description of the Veterans Health Administration (VHA) and VBA programs that support caregivers.

Name of Program	**Eligibility for Participation**	**Description of Services Provided**	**Provision of Services**
Respite Care	• Enrolled veteran • Chronic condition • Caregiver who needs respite	• Of limited duration • Inpatient (CLC,* acute or community facility) • Home respite • Adult day health care	• Provided in CLCs and adult day health care • Contract: nursing homes, home health agencies, adult day health care
Volunteer Home Respite Care	• Enrolled veteran	• Volunteer program providing full-time caregivers break to perform required duties outside home or for needed break • Recently expanded to include buddy program matching volunteers with veterans. Provides support system and additional services outside home	• Volunteer base, with training materials provided by Senior Companion Program and American Red Cross. Program is operational in 8 sites, with over 60 service organizations briefed on the program to generate potential volunteers
Home Based Primary Care	• Enrolled veteran	• Education and training on care needs of veterans Caregiver burden assess- • ment annually and follow up with resources as indicated	• Provided by VHA staff at 131 facilities and more than 90 CBOCs *

Name of Program	Eligibility for Participation	Description of Services Provided	Provision of Services
Adult Day Health Care (ADHC)	• Enrolled veteran who would otherwise require nursing home care	• Alternative setting for respite care • Caregiver support and education (e.g., instruction on managing challenging behaviors of veterans with Alzheimer's)	• Currently provided on campus of 21 VAMCs* • VA also contracts with community providers in locations where the VAMC does not have onsite ADHC*
Veteran Directed Home and Community Based Care	• Enrolled veteran	• Budget provided by local area agency on aging (AAA) to veteran to purchase own support services • AAA provides case management and fiscal intermediary to assist with purchase of services	• Local VAMC agreement with local AAA to arrange for home care of veteran
Home-maker/ Home Health	• Eligible veteran who is in need of nursing home care	• Provides personal care and supportive services	• Contracted home health agency (HHA) • Employee of HHA can be family caregiver
Temporary Lodging and Fisher Houses	• Veteran with appointment at VA medical facility to receive health care or compensation & pension (C&P) exam & family member of veteran or person accompanying veteran to provide equivalent of familial support	• Persons accompanying veterans receiving VA medical care or C&P exams are provided temporary lodging and support. Provided in Fisher Houses, non-used beds in medical center or at community hotels/ motels	• VHA with support from service and other volunteer agencies
Home Improvement and Structural Alterations	• Enrolled veterans	• Amount $4,100 for most service-connected veterans, $1,200 for all other enrolled veterans	• VHA benefit
Beneficiary Travel	• Eligible veterans & attendant under certain circumstances	• Mileage reimbursement • Special transportation reimbursement	• VHA travel related reimbursement
Special Adaptive Housing	• Service-connected veterans who meet special criteria	• Can be used 3 times for a lifetime max of $60,000 • Veteran must be on deed for the home	• VBA benefit
Special Housing Adaptation	• Service-connected veterans meeting special criteria • Active Duty	• Provides $12,000 for temporary or permanent housing	• VBA benefit
Servicemembers Group Life Insurance Traumatic Injury Protection (TSGLI)	• Active Duty participating in Servicemembers Group Life Insurance	• Payments of up to $100,000 according to a schedule of traumatic injuries	• VBA benefit
Automobile Grant	• Veteran and servicemembers with certain disabilities	• 1 time benefit automobile grant up to $11,000 paid to seller	• VBA benefit

*Acronyms: CLC, community living center; VAMC, VA medical center; CBOC, community-based outpatient clinic; ADHC, adult day health care

Question 9(b): How is the comprehensive review structured and who is responsible for the final recommendations of this review? When will the review be completed?

Response: A VA caregiver support task force has been chartered by the Office of Patient Care Services to develop a comprehensive model for caregiver support across VHA. VA has implemented multiple programs and services throughout the Department to address the needs of caregivers. VA recognizes there is a need to better orchestrate efforts, to establish a process to identify gaps, and to identify core characteristics of a comprehensive model for caregiver support. The caregiver support task force will develop an integrated approach to caregiver support that encompasses all practice areas. The caregiver support task force review and recommendations will be completed by October 2009 for submission to VA senior leadership. The taskforce, with support from other program offices in VA, has also developed proposals for expanding benefits to caregivers of veterans severely injured in the line of duty who would otherwise require institutional care. VA estimates this population would include fewer than 2,500 veterans of all eras. These benefits would include travel and lodging benefits, support services, and a triennial survey of caregivers. In light of the current Federal efforts regarding comprehensive health care reform, VA believes any proposals in this area may duplicate coverage for individuals who may soon be granted such access without VA incurring responsibility for caregiver medical services.

For the caregiver assistance pilot programs, a comprehensive review is structured through the Caregiver Advisory Board, which is chaired by the Caregiver Support Program Manager. Two subcommittees of the Caregiver Advisory Board have been developed to start preliminary comprehensive reviews of the caregiver assistance pilot programs to assess the feasibility and advisability for nationwide implementation and to review their final fiscal 2009 budgets. The Caregiver Support Program Manager is responsible for the final recommendations, which will be completed by November 30, 2009. A final report of the caregiver assistance pilot programs will be written at this time and sent to Congress by December 31, 2009.

Question 9(c): For the two pieces of caregiver legislation that VA did not comment on, why was VA unable to submit views? The Subcommittee would like VA's views and cost estimates on these two pieces of legislation.

Response: VA was unable to provide views on the two draft pieces of legislation because they were received later than the initial docket of bills included in the Subcommittee's invitation letter and the Administration was unable to fully analyze these issues in time. Below is VA views and cost estimates on the two caregiver bills.

Views on Two Caregiver Bills (H.R. 2898 Supportive Services and Annual Survey)

H.R. 2898: Supportive Services for Family Caregivers. H.R. 2898 would add a new section 1786 to title 38 to provide support services for family caregivers. The term "family caregiver" is defined as a member of the disabled veteran's family (including parents, spouses, children, siblings, step-family members, and extended family members) who provide caregiver services to the disabled veteran. Section 1 of the bill would require the Secretary to make interactive training sessions available for family caregivers and individuals who support such caregivers. Such training must be available both in person and via the Internet and should incorporate telehealth technologies to the extent practicable. The bill provides that it should also teach techniques, strategies and skills for caring for a disabled veteran including effective methods for caring for veterans with PTSD, TBI, or who deployed in support of Operation Enduring Freedom or Operation Iraqi Freedom.

In addition, section 1 would require the Secretary to provide family caregivers with information concerning public, private, and nonprofit agencies that support caregivers. In providing this information, the Secretary would be required to collaborate with the Assistant Secretary for Aging for the Department of Health and Human Services and contract with a private entity to provide family caregivers an Internet-based directory of services at the county level, message boards and other tools to allow caregivers to interact with each other and disabled veterans, as well as comprehensive information explaining health-related topics and issues relevant to the caregivers' needs.

Pursuant to the bill, the Secretary would also be required to conduct outreach to inform disabled veterans and their families about these caregiver support services.

The outreach must include public service announcements, brochures, social networking sites, the VA Web site and methods which target rural families.

Section 2 of the bill would also amend 38 U.S.C. 1782 to make family caregivers eligible for counseling and mental health services. Section 3 would amend 38 U.S.C. 1720B to allow the Secretary to provide respite care to veterans who receive care from a family caregiver.

Before discussing our views on each of the sections, we must again note our concern with the narrow definition of "family caregiver." This definition applies to all three sections of the bill.

VA supports the concepts outlined in section 1 of the legislation but does not support this provision as written because it is too prescriptive. Section 1 requires VA to conduct outreach and information sharing in specific means and through defined media, while an alternate draft bill would require VA to conduct an annual survey of caregivers to determine their needs. The results of this survey may provide evidence that VA should adopt methods of outreach different than those identified in this legislation. We agree that VA must do more to use technologies and existing networks, but the agency should not become committed in law and restricted to only specific approaches. We believe an adaptive and responsive campaign will be the most effective way to reach the changing demographics and needs of veterans and their caregivers. We estimate the cost of section 1 to be $64.5 million in FY 2010, $68.5 million in FY 2011, $364.9 million over 5 years and $854.7 million over 10 years.

VA supports the concept behind section 2. This section would extend counseling and mental health services to family caregivers. We recognize that last year Congress expanded VA's authority to provide mental health care as well as marriage and family counseling to the members of the immediate family, the legal guardian of a veteran, and the individual in whose household such veteran certifies an intention to live. Care may only be provided under this authority as necessary in connection with the treatment of the veteran. Section 2 would expand this principle to include family caregivers as potentially eligible participants. VA estimates that there would be no significant additional costs associated with section 2 or H.R. 2898. We note that H.R. 2734 would allow VA to satisfy both the mental and physical health care needs of primary family caregivers through CHAMPVA.

VA supports section 3, which would extend eligibility for respite care to veterans receiving services from a family caregiver. VA believes this authority would largely duplicate existing authorities, as any veteran with another caregiver would already receive these services. As such, VA anticipates there would be no significant costs associated with this proposal.

Discussion Draft: Annual Survey of Caregivers. This discussion draft would require the Secretary to conduct an annual survey of family caregivers to determine the number of family caregivers, the range of caregiver services provided by family members, the amount of time spent providing such services and the support services needed by family caregivers. The draft would also require the Secretary to report to Congress the findings of the survey as well as a summary of the services available to family caregivers, the number of family caregivers receiving such services, and the cost of each service. The term "family caregiver" in this draft is limited to members of the disabled veteran's family (including parents, spouses, children, siblings, step-family members, and extended family members) who provide caregiver services to the veteran for their disability.

VA supports this bill in concept but recommends the survey be required less frequently. VA has previously testified that the exact number of caregivers is currently unknown, but that caregivers fill an important role. Receiving such feedback from family caregivers would provide important insights into their needs and help us better care for severely injured or ill veterans. This legislation would ensure VA monitors and identifies caregiver needs and would provide valuable data to help VA better develop, enhance, or implement programs benefiting caregivers and veterans. However, we would like to note that the definition of "family caregiver" is quite narrow and will exclude veterans who may not have family members available to serve as appropriate caregivers. VA would prefer a broader definition that would allow a veteran to select the appropriate caregiver of his or her choice, including non-family members. We estimate the cost of this provision to be $930,000 for FY 2010, $1.4 million for FY 2011, $9.8 million over 5 years, and $21.56 million over 10 years.

Question 10: VA established the Caregiver Advisory Board in June 2008 to develop caregiver assistance programs that address issues facing caregivers of veterans. Please provide an update on the activities of the Advisory Board, including a summary of the caregiver needs the Board identified and any initial recommenda-

tions to expand support services for caregivers. In addition, please share all internal reports and memoranda authorized by this Advisory Board.

Response: The Caregiver Advisory Board has been focusing much of its time on reviewing the caregiver assistance pilot programs, determining program needs including infrastructure, and building relationships with partners internal to VA with other Federal agencies and national caregiver advocacy and support organizations. Legislative proposals by Congress will also play a key role in how programs and support services for caregivers are shaped.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 24, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

On Thursday, June 18, 2009, the Subcommittee on Health held a legislative hearing and received testimony from Dr. Robert Petzel, Acting Principal Deputy Under Secretary for Health. As a followup to the hearing, I request that you respond to the following questions in written form for the record:

1. Already in existence are the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (TBI) and the Defense and Veterans Brain Injury Center (DVBIC). DVBIC devotes significant resources to its mission of providing education on the prevention, treatment and rehabilitation of TBI. A DoD/VA workgroup recently released clinical practice guidelines for the management of concussive and mild TBI. Specifically, what advice and recommendations would a TBI Committee, as required in H.R. 1546, provide that is not currently being provided through existing resources?
2. One of the concerns with TBI is that it has co-morbidities, including post-traumatic stress disorder (PTSD) and visual impairments. Would the responsibilities of the committee that would be established in H.R. 1546 include assessing care for co-morbid conditions?
3. The Vietnam Veterans of America (VVA) testified that the organization is "not thrilled about creating yet another committee to focus on yet another facet of combat injury." Please respond to this concern.
4. H.R. 2734 would establish a new health care benefit under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for "primary" family caregivers. Would it make sense to carry out a study to have a better understanding of the eligibility, availability, and health care service gaps of family caregivers before enacting this legislation?
5. The average length of time that an eligible veteran may need a primary caregiver can vary and a family caregiver could change throughout the course of a veteran's life. Would H.R. 2734 obligate VA to continue CHAMPVA coverage for a family caregiver that may no longer be the veteran's family caregiver?
6. H.R. 2734 would exempt family caregivers from co-payments and cost sharing as other CHAMPVA beneficiaries are required to pay, resulting in family caregivers having a greater benefit than the current CHAMPVA beneficiaries. What administrative, equity and other challenges would this create for CHAMPVA?
7. H.R. 2734 would allow a broad array of family caregivers to qualify for this benefit. Please describe in detail the obligations and implementation challenges this legislation would create for the Department.
8. Does H.R. 2734, in your view, provide an appropriate definition of "primary family caregiver?" If not, how would you recommend defining this term?
9. In your view, would it be prudent to require that a family caregiver also have a "medical power of attorney" to be eligible for benefits under H.R. 2734? If so, why? If not, why not?

10. H.R. 2734 limits eligibility to caregivers of veterans receiving aid and attendance (38 U.S.C. 1114 (r)), or entitled to the highest rate of Special Monthly Compensation (38 U.S.C. 1114 (s)), and have no other health care coverage. What is the purpose of providing aid and attendance and the special monthly compensation?

11. What challenges would VA face in implementing H.R. 2734?

12. Section 1672 of Public Law 110–181, provides for medical care for certain family members caring for a wounded warrior that are not otherwise eligible for medical care on a space-available basis in military treatment and VA facilities. What and how much care has VA provided in compliance with the law?

13. What are the current beneficiary travel benefits for a veteran traveling to a medical center for care and benefits for an attendant traveling with the veteran?

14. H.R. 2738 would allow VA to prescribe regulations to limit the number of attendants and require that certain travel services be used. However, it does not allow VA the authority to prescribe eligibility regulations based on the need for a caregiver to accompany a veteran. Would H.R. 2738 allow a veteran to travel to a VA medical center with both an attendant and a family caregiver? Should there be limits on the length of time a family caregiver could receive this benefit?

15. H.R. 2738 would require VA to provide "lodging and subsistence" to eligible family caregivers. How would VA implement the subsistence requirement—would VA pay a per diem similar to that which is provided to Federal employees on official travel?

16. In your view, would H.R. 2738 require VA to provide an eligible family caregiver lodging and subsistence if the veteran is receiving inpatient treatment?

17. Section 744 of Public Law 109–364 required VA and DoD to work together to develop a training curricula for family caregivers of veterans with TBI. What is the status of this curriculum? When should Congress expect to receive the report this law also requires? What challenges did you face in developing this training?

18. H.R. 2898 would require VA to provide family caregivers such consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with that treatment. Please describe in detail the type and extent of services VA would be providing under this requirement.

19. The National Resource Directory was created in collaboration with DoD, VA, and the Department of Labor. The Directory is a Web-based center of resources for wounded warriors and veterans and includes maintaining important support and training services for family caregivers. Would certain requirements under section 1 of H.R. 2898 duplicate the purpose of the National Resource Directory? Should certain requirements under section 1 of the bill be changed to enable servicemembers and veterans to have a centralized resource to further our goal of achieving a true seamless transition?

20. H.R. 2898 would require VA to make available interactive training sessions for family caregivers. Is it your view that the bill would allow VA to meet this requirement using an independent entity with expertise in training to meet this requirement?

21. A draft bill would require VA to conduct a survey of family caregivers. Would this proposal capture the information that you believe would be beneficial to developing better policies for family caregivers?

22. Regarding the draft bill to conduct a survey of family caregivers, please respond to the following recommendations included in the National Military Family Association Statement for the Record of June 18, 2009: "However, we recommend the survey should capture a wider range of information than what is currently included in this proposal. We suggest the survey start with caregiver demographics, and include additional items, such as the financial impact, identify gaps and successes in the support system, and the disruption to the family unit, especially children. Also, the survey should capture data on caregivers' experiences with both the VA and DoD support programs and benefits. We would also encourage the establishment of a panel of experts to

help with the survey's design and implementation. This panel would consist of, but not be limited to, members representing: Veteran Service Organizations; Military Service Organizations; caregivers of our wounded, ill, and injured servicemembers and veterans; staff from the VA and DoD who work on caregiver issues; and members from each of the Services' wounded warrior programs."

The attention to these questions is much appreciated, and I request that they be returned to the Subcommittee on Health no later than close of business, 5:00 p.m., Friday, July 3, 2009. If you or your staff have any questions, please contact Dolores Dunn, Republican Staff Director for the Subcommittee on Health, at 202–226–1293.

Sincerely,

Henry Brown
Ranking Republican Member

Questions for the Record
The Honorable Henry Brown, Ranking Member
Subcommittee on Health, House Committee on Veterans' Affairs
June 18, 2009

Legislative Hearing

Question 1: Already in existence are the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (TBI) and the Defense and Veterans Brain Injury Center (DVBIC). DVBIC devotes significant resources to its mission of providing education on the prevention, treatment and rehabilitation of TBI. A DoD/VA workgroup recently released clinical practice guidelines for the management of concussive and mild TBI. Specifically, what advice and recommendations would a TBI Committee, as required in H.R. 1546, provide that is not currently being provided through existing resources?

Response: The Department of Veterans Affairs (VA) Committee on Care of Veterans with Traumatic Brain Injury (TBI) to be established by H.R. 1546 would specifically advise the Secretary of up-to-date information on optimizing the quality of clinical care, maintaining superior training programs in TBI-specific specialties, providing contemporary education to the field in TBI rehabilitation advances, and recommending research priorities for the Department. The Committee would be comprised of VA employees from multiple specialty areas of care with expertise in TBI, including: physical medicine and rehabilitation, neurology, mental health, care management and social work, telehealth, readjustment counseling, public health, research and development, and academic affiliations. This interdisciplinary structure would facilitate support for veterans across the entire VA health care system and would serve as a consultative body with specific and direct knowledge of VA's benefits and services. Representatives from Department of Defense (DoD) and the civilian sector, who represent a broad national perspective on the care needs and are recognized as experts in TBI rehabilitation, could also be used to provide input to VA as requested.

The Defense and Veterans Brain Injury Center and the Defense Center of Excellence for Psychological Health and TBI fulfill important but complementing roles. The DVBIC's mission is to serve active duty military, their dependents and veterans with TBI through state-of-the-art medical care, innovative clinical research initiatives and educational programs. The Defense Center of Excellence for Psychological Health and TBI's mission is to assess, validate, oversee and facilitate prevention, resilience, identification, treatment, outreach, rehabilitation and reintegration for psychological health and TBI to ensure DoD meets the needs of the Nation's military communities, warriors and families.

Question 2: One of the concerns with TBI is that it has co-morbidities, including post-traumatic stress disorder (PTSD) and visual impairments. Would the responsibilities of the committee that would be established in H.R. 1546 include assessing the care for co-morbid conditions?

Response: Yes. The VA TBI/polytrauma system of care (PSC) represents the largest system of treatment and management for TBI in the United States. VA is currently using the knowledge and experience of interdisciplinary TBI experts within this system of care to evaluate and stratify the assessment, treatment, and investigation of co-occurring symptoms with TBI, such as post-traumatic stress disorder

(PTSD), depression, chronic pain, and other symptoms. This committee can readily assume responsibility for overseeing this effort.

Question 3: The Vietnam Veterans of America (VVA) testified that the organization is "not thrilled about creating yet another committee to focus on yet another facet of combat injury." Please respond to this concern.

Response: VA greatly values the opinion of Vietnam Veterans of America (VVA) and is pleased to respond to the concerns. TBI is a high priority program for VA, Congress, and the American public. TBI-related impairments and disability significantly impact a large number of veterans, and the previous Vietnam Head Injury Study represents one of the largest medical investigations conducted for that cohort of veterans. Improved trauma care and an aging population are resulting in increasing numbers of veterans who sustain TBI and have long-term survival. Other conditions and problems that frequently co-occur with TBI (such as PTSD and chronic pain) can readily lead to increased probability for secondary problems, such as depression, substance abuse, coping problems, and social integration problems. Also, the science of TBI management is a rapidly growing field that requires rigorous clinical, research and academic collaboration. As previously explained, the multi-disciplinary VA Committee on Care of Veterans with TBI not only would facilitate better understanding of the complexities and medical effects of TBI, but also focus efforts on addressing these secondary and co-occurring issues.

Question 4: H.R. 2734 would establish a new health care benefit under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for "primary" family caregivers. Would it make sense to carry out a study to have a better understanding of the eligibility, availability, and health care service gaps of family caregivers before enacting this legislation?

Response: VA acknowledges there are many issues related to family caregivers, including their access to available health care coverage, where more information is needed. VA agrees that a study to have a better understanding of the eligibility, availability, and health care service gaps of family caregivers before enacting this legislation would be helpful to determine the impact of increased access and scope of eligibility for family caregivers.

Question 5: The average length of time that an eligible veteran may need a primary caregiver can vary and a family caregiver could change throughout the course of a veterans' life. Would H.R. 2734 obligate VA to continue CHAMPVA coverage for a family caregiver that may no longer be the veteran's family caregiver?

Response: It is unclear to VA if the intent of H.R. 2734 would require VA to continue CHAMPVA coverage for a family caregiver that may no longer be the veteran's family caregiver, or how many family caregivers a severely injured veteran could elect at one time or over a period of time. It is similarly unclear if CHAMPVA benefits would continue if a veteran died or no longer needed caregiver services. VA believes these issues would require further study, and either need to be resolved through regulations or through amendment to the legislation to properly define and limit the scope of this benefit to those with genuine need.

Question 6: H.R. 2734 would exempt family caregivers from co-payments and cost sharing as other CHAMPVA beneficiaries are required to pay, resulting in family caregivers having a greater benefit than the current CHAMPVA beneficiaries. What administrative, equity and other challenges would this create for CHAMPVA?

Response: VA is concerned that H.R. 2734 would result in equity and administrative challenges. CHAMPVA is a cost-sharing program. H.R. 2734 specifies family caregivers would not be subject to the same deductibles, premiums, co-payments, cost-sharing and other fees for medical care that are available to the existing population. The language in the legislation provides the family caregiver a benefit that the dependent children, spouse, or surviving spouse of permanently and totally disabled veterans or those veterans who died as a result of their service-connected disability do not have. VA recommends there be parity of benefits for the family caregivers and the existing program beneficiaries, rather than preferential benefits for family caregivers.

VA is also concerned about the lack of clarity concerning whether or not benefits expire if a veteran identifies a new caregiver or if a veteran no longer requires caregiver services. If only one family caregiver is eligible for benefits at a time, there would be some administrative burden to VA in designating a new beneficiary if the veteran switches caregivers. The legislation as written does not limit the veteran's

ability to change caregivers. VA believes that for such a mechanism to work properly, veterans should be provided a periodic opportunity to identify a new caregiver, except for cases of patient safety or well-being, when a veteran should be allowed to immediately identify a different caregiver. Additionally, when a new caregiver is identified, CHAMPVA benefits should end for the previous caregiver and begin for the newly appointed caregiver. This approach would balance the interests of the veteran, the caregiver and VA.

Question 7: H.R. 2734 would allow a broad array of family caregivers to qualify for this benefit. Please describe in detail the obligations and implementation challenges this legislation would create for the Department.

Response: As noted above, VA is concerned with an open-ended commitment to an identified caregiver, even if the veteran later selects another person to perform as his or her caregiver. VA believes a system that allows veterans a periodic opportunity to select a new caregiver, much like an open season for selecting new health insurance benefits available to employers, would facilitate the administration of this program and allow veterans and caregivers sufficient flexibility. This would also not be as administratively burdensome as an at-will assignment of caregivers where a veteran could change caregivers whenever and as often as he or she pleased. VA believes that veterans who qualify should have equal latitude in determining their appropriate caregiver, be it a family member or non-family member. This latitude would not be unduly burdensome to VA.

Question 8: Does H.R. 2734, in your view, provide an appropriate definition of "primary family caregiver?" If not, how would you recommend defining this term?

Response: VA is concerned the definition of "family caregiver" included in H.R. 2734 is too narrow as it limits the scope of possible caregivers to a veteran's family. VA is concerned such a limitation would unfairly disadvantage veterans who do not have available or appropriate family members for their day-to-day care, but are in need of caregiver services, or veterans whose family members are unable or unwilling to participate as the veteran's primary caregiver. Caregiver services sometimes involve intimate care that a veteran may be unwilling to have a family member perform.

VA recommends defining eligible caregivers as the spouse, dependent child of a veteran, parent, legal guardian, or other as determined by the veteran (including an individual in whose household a veteran certifies an intention to live).

Question 9: In your view, would it be prudent to require that a family caregiver also have a "medical power of attorney" to be eligible for benefits under H.R. 2734? If so, why? If not, why not?

Response: VA does not believe requiring a family caregiver to have medical power of attorney is appropriate. We understand the Committee is interested in ensuring caregivers are invested in the treatment and well-being of the veteran, but this recommendation is unnecessary for that purpose. A medical power of attorney is often given to a family member in a position to make the hard health care decisions required for health care providers to care for a family member. However, this family member is not always the individual taking care of the veteran on a daily basis. A veteran could prefer a situation where one family member provides caregiver services and another holds medical power of attorney. VA believes it is not prudent to require a family caregiver to also have a medical power of attorney to be eligible for benefits under H.R. 2734. To do so would place a veteran in the position of choosing a benefit for his family caregiver over another family member who, in the veteran's opinion, would best represent his or her medical interests.

Question 10: H.R. 2734 limits eligibility to caregivers of veterans receiving aid and attendance (38 United States Code 1114(r)), or entitled to the highest rate of Special Monthly Compensation (38 U.S.C. 1114(s)), and have no other health care coverage.

What is the purpose of providing aid and attendance and the special monthly compensation?

Response: Initially, we want to point out that the highest rate of special monthly compensation (SMC) is provided at 38 U.S.C. 1114(r)(2). Compensation under section 1114(s) is lower than under many of the other subsections in section 1114.

Many of the current eligibility criteria for SMC date back to 1933, including compensation provided under subsection (l) based on need for aid and attendance. SMC differs from disability compensation in that the rates provided take into account

other factors in addition to loss of earning capacity. For example, the lowest level of SMC, which provided under subsection (k), includes as eligibility criteria anatomical loss or loss of use of a creative organ and certain losses of breast tissue. These disabilities may not result in significant earnings loss. SMC based on need for aid and attendance is based on the veteran's need for the personal assistance of another individual in performing the basic activities of daily living, such as bathing, eating, attending to the needs of nature, and protecting him or herself from the hazards of daily living. Congress has recognized the additional expense of securing the personal care needed by veterans who require such assistance by authorizing increased compensation benefits.

Question 11: What challenges would VA face in implementing H.R. 2734?

Response: H.R. 2734 does not define the scope or limitation of these benefits. As noted above, VA is concerned with an open-ended commitment to an identified caregiver, even if the veteran later selects another person to perform as his or her caregiver. VA believes a system that allows veterans a periodic opportunity to select a new caregiver, much like an open season for selecting new health insurance benefits available to employers, would facilitate the administration of this program and allow veterans and caregivers sufficient flexibility. This would also not be as administratively burdensome as an at-will assignment of caregivers where a veteran could change caregivers whenever and as often as he or she pleased. VA believes veterans should have equal latitude in identifying an appropriate caregiver, be it a family member or non-family member. This latitude would not be unduly burdensome to VA. These limits would need to be defined through regulation if the legislation as written became law. Additionally, the legislation needs to define whether family caregiver eligibility and benefits would extend to those severely injured veterans and their caregivers living abroad. VA is also concerned about the technology required to support this initiative across multiple agencies and business lines for real-time eligibility management. This level of technology may be difficult to achieve within the timeframe defined in the legislation for program implementation.

Question 12: Section 1672 of Public Law 110–181 provides for medical care for certain family members caring for a wounded warrior that are not otherwise eligible for medical care on a space-available basis in military treatment and VA facilities. What and how much care has VA provided in compliance with the law?

Response: This provision is currently in the regulatory process; however, VA already has authority to provide care on a humanitarian and emergency basis. At this point, VA does not track care provided to such specificity.

Question 13: What are the current beneficiary travel benefits for a veteran traveling to a medical center for care and benefits for an attendant traveling with the veteran?

Response: Current VA beneficiary travel regulations at 38 CFR Part 70 authorize VA to pay for certain travel costs of an attendant when VA had medically determined that an attendant is required to assist the veteran during travel. Benefits include the actual cost of travel (unless traveling with the veteran in a shared personal vehicle), and lodging and per diem at 50 percent of the area Federal employee rate during the actual period of travel. Should a veteran be admitted to a VA facility for care following travel and VA determines the veteran no longer needs a non-VA attendant, per diem and incidental costs have usually been at the caregiver's or attendant's expense.

Question 14: H.R. 2738 would allow VA to prescribe regulations to limit the number of attendants and require that certain travel services be used. However, it does not allow VA the authority to prescribe eligibility regulations based on the need for a caregiver to accompany a veteran. Would H.R. 2738 allow a veteran to travel to a VA medical center with both an attendant and a family caregiver? Should there be limits on the length of time a family caregiver could receive this benefit?

Response: VA would not require new regulations to limit the scope of H.R. 2738 because the bill would modify VA's existing statutory authority to provide travel benefits to someone accompanying a veteran. Essentially, this legislation would only authorize benefits to caregivers comparable to what attendants who would otherwise be eligible under VA's beneficiary travel authority would receive. If a veteran is not eligible for attendant benefits under VA's existing beneficiary travel authority, his or her caregiver would not be eligible to receive benefits under this legislation.

It is unlikely that a family caregiver would not also be the appropriate attendant during the majority of veteran travel where an attendant is medically required. In such situations where a more skilled attendant is required, it is likely that special mode transport (e.g., ambulance, wheelchair van, air medical evacuation, etc.) would be used, and in such cases, the scope of H.R. 2738 would provide for caregiver travel.

Question 15: H.R. 2738 would require VA to provide "lodging and subsistence" to eligible family caregivers. How would VA implement the subsistence requirement—would VA pay a per diem similar to that which is provided to Federal employees on official travel?

Response: Current VA beneficiary travel regulations at 38 CFR Part 70 authorizes VA to reimburse eligible attendants during a period of travel up to 50 percent of the area Federal employee lodging and subsistence rates. If H.R. 2738 became law, it would provide a per diem to caregivers accompanying a veteran for care. It is unclear whether a per diem rate similar to DoD per diem benefits for family members accompanying an injured servicemember on special travel orders, the same per diem benefit provided to Federal employees, or the current regulated 50 percent of Federal employee per diem rate would be appropriate. VA notes an exception that would waive any applicable monetary payments if available facilities such as a Fisher House or VA lodging are available.

Question 16: In your view, would H.R. 2738 require VA to provide an eligible family caregiver lodging and subsistence if the veteran is receiving inpatient treatment?

Response: VA believes H.R. 2738 would require VA to provide an eligible family caregiver lodging and subsistence benefits if the veteran is receiving inpatient treatment. VA notes that DoD's authority for providing benefits in these situations is capped to a specific number of days per year.

Question 17: Section 744 of Public Law 109–364 required VA and DoD to work together to develop a training curricula for family caregivers of veterans with TBI. What is the status of this curricula? When should Congress expect to receive the report this law also requires? What challenges did you face in developing this training?

Response: The DoD/VA TBI family caregiver project panel, with oversight by the Defense and Veterans Brain Injury Center (DVBIC), has developed a four-module written curriculum entitled, *A Caregiver's Guide to Traumatic Brain Injury: Roadmap to Recovery*. A Web version of the curriculum is also under development with the Center of Excellence for Medical Multimedia (CEMM). Focus groups to evaluate the curriculum are scheduled to be completed July 31, 2009, with a full report to the panel due August 31, 2009. Feedback from the focus groups must be evaluated and subsequent revisions completed before the vendor can format the curriculum into the various modalities for distribution. The complete curricula package is due to Congress with a full report by December 31, 2009. DVBIC has requested an extension to meet the standards recommended by the panel to effectively evaluate the curriculum. The panel faced challenges in determining the scope of the curriculum, identifying family preferences for the content, depth and modality of the curriculum, identifying qualified medical writers to assist in the editing and compilation of the curriculum, and in the development of a contract to conduct the focus groups.

Question 18: H.R. 2898 would require VA to provide family caregivers such consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with that treatment. Please describe in detail the type and extent of services VA would be providing under this requirement.

Response: Public Law 110–387, the Veteran's Mental Health and Other Care Improvement Acts of 2008 (enacted October 10, 2008), added marriage and family counseling to the list of suggested services available for veterans. Such services include consultation, professional counseling, and other mental health services considered necessary in connection with treatment of the veteran. This law also removed the contingency that the non-service connected veteran needed to be hospitalized before their family members would be eligible for these services. Immediate family members, guardians, or individuals in whose home the veteran intends to reside are eligible for this benefit. Examples of these services include behavioral family therapy, multiple family group therapy, the support and family education program, the National Alliance on Mental Illness family-to-family education program and family consultation.

In developing treatment plans and providing care, clinicians consider whether there are problems or conditions experienced by a member of the veteran's family that could result in health or mental health problems for the veteran. VA clinicians also consider whether relational problems for the veteran with a spouse or other family member could exist or manifest. For example, being a caregiver for a parent who has Alzheimer's disease could lead to high levels of stress and negative health and mental health problems. Alternatively, a veteran's spousal caregiver could experience stress that, in turn, could affect the veteran and the veteran's marital relationship. With the changes implemented by P.L. 110–387, VA clinicians can provide marital or family counseling services for the veteran's benefit.

H.R. 2898 would not broadly extend services available for the family. The only impact of this legislation would be to make available these benefits to extended family members who do not provide housing to the veteran or to a designated family caregiver.

Every veteran and their caregiver has access to a VA social worker who provides an assessment of individualized needs of the family caregiver with respect to the family caregiver's role, assistance with the development of a plan for long-term care of the veteran, and implementation of a treatment plan. Social workers also provide ongoing counseling and education to veterans and family caregivers.

Question 19: The National Resource Directory was created in collaboration with DoD, VA, and the Department of Labor. The Directory is a Web-based center of resources for wounded warriors and veterans and includes maintaining important support and training services for family caregivers. Would certain requirements under section 1 of H.R. 2898 duplicate the purpose of the National Resource Directory? Should certain requirements under section 1 of the bill be changed to enable service members and veterans to have a centralized resource to further our goal of achieving a true seamless transition?

Response: DoD, VA, and Department of Labor developed and maintain the National Resource Directory (www.nationalresourcedirectory.org, NRD), an online portal that provides access to information from over 11,000 services and resources from Federal, State, and local governmental agencies; veteran service and benefit organizations; non-profit community-based and faith-based organizations; academic institutions, professional associations and philanthropic organizations. The mission of the NRD is to provide a one-stop online resource for up-to-date, easily accessible, information about services and resources for servicemembers, veterans, their families and all who support them. Available information is organized into six categories: benefits and compensation; education, training & employment; family and caregiver support; health, housing and transportation; services; and resources.

The specific requirement of H.R. 2898 for the Secretary to contract with a private entity could be interpreted to require a new and separate effort apart from the current collaborative NRD structure. Many of the specific elements required by H.R. 2898 have been discussed by the NRD governance group and are in various stages of development as future requirements.

The NRD is part of a larger effort to improve wounded warrior care coordination and access to information, and provides a foundation for the ongoing development of Web portals that will tailor resources upon login. Additional improvements to the NRD site are under development and include Web feeds, *E-mail-A-Friend* capability, and a *Link to Us* page. All resources added to the NRD are evaluated and edited using a 25-point content management style guide, as well as guidance provided by the site's partner agencies. To ensure the quality and acceptability of posted content, as well as consistency and clarity of language, all links uploaded to the NRD undergo a series of reviews and cross-reviews. NRD content has recently been leveraged in other Web portal development efforts including ebenefits.gov and the Wounded Warrior resource center Web site.

Question 20: H.R. 2898 would require VA to make available interactive training sessions for family caregivers. Is it your view the bill would allow VA to meet this requirement using an independent entity with expertise in training to meet this requirement?

Response: VA would likely need to contract with at least one independent entity to fulfill the requirements of H.R. 2898 section 1. Section 1 would require the Secretary to make interactive training sessions available for family caregivers and individuals who support such caregivers. Such training must be available both in person and via the Internet and should incorporate telehealth technologies to the extent practicable. VA provides training to family members or caregivers related to the clinical needs of the veteran prior to his or her discharge from a VA facility. How-

ever, VA would probably contract with an independent entity to provide interactive training sessions online.

The bill also provides that VA should teach techniques, strategies and skills for caring for a disabled veteran including effective methods for caring for veterans with PTSD, TBI, or who deployed in support of Operation Enduring Freedom/Operation Iraqi Freedom. Again, VA social workers and clinicians regularly work with family members to identify concerns and treatment plans while the veteran is still receiving care in VA. Our staff remains available to veterans and their family members after their release to provide additional support as needed.

In addition, section 1 would require the Secretary to provide family caregivers with information concerning public, private, and nonprofit agencies that support caregivers. In providing this information, the Secretary would be required to collaborate with the Assistant Secretary for Aging for the Department of Health and Human Services and contract with a private entity to provide family caregivers an Internet-based directory of services at the county level, message boards and other tools to allow caregivers to interact with each other and disabled veterans, as well as comprehensive information explaining health-related topics and issues relevant to the caregivers' needs. This requirement within the legislation specifically states VA would contract with an independent entity, and VA would do so in compliance with the law.

Pursuant to H.R. 2898, the Secretary would also be required to conduct outreach to inform disabled veterans and their families about these caregiver support services. The outreach must include public service announcements, brochures, social networking sites, the VA Web site and methods which target rural families. VA may be required to contract for these services, specifically concerning public service announcements.

VA recommends adopting less prescriptive language in section 1 to allow VA the flexibility to adapt new methods of outreach as they become available and as they are appropriate to different generations of veterans. Communication technology changes rapidly and VA would prefer to change outreach methods as necessary to best meet the varied demographics and needs of family caregivers.

Question 21: A draft bill would require VA to conduct a survey of family caregivers. Would this proposal capture the information that you believe would be beneficial to developing better policies for family caregivers?

Response: VA believes the survey required by the draft bill would provide needed information to develop and tailor programs to the specific needs of veterans and their caregivers. VA has previously testified that the exact number of caregivers is currently unknown, but that caregivers fill an important role. Receiving feedback from family caregivers would provide important insights into their needs and help us better care for severely injured or ill veterans. This legislation would ensure VA monitors and identifies caregiver needs and would provide valuable data to help VA better develop, enhance, or implement programs benefiting caregivers and veterans. VA anticipates it would conduct focus groups in the first year following enactment of this law to develop appropriate questions and to refine the survey to best gather the necessary data. This process would improve the quality of the survey instrument and the quality of VA benefits and services.

Question 22: Regarding the draft bill to conduct a survey of family caregivers, please respond to the following recommendations included in the National Military Family Association's Statement for the Record of June 18, 2009: "However, we recommend the survey should capture a wider range of information than what is currently included in this proposal. We suggest the survey start with caregiver demographics, and include additional items, such as the financial impact, identify gaps and successes in the support system, and the disruption to the family unit, especially children. Also, the survey should capture data on caregivers' experiences with both VA and DoD support programs and benefits. We would also encourage the establishment of a panel of experts to help with the survey's design and implementation. This panel would consist of, but not be limited to, members representing: Veterans Service Organizations; Military Service Organizations; caregivers of our wounded, ill and injured servicemembers and veterans; staff from VA and DoD who work on caregiver issues; and members from each of the Services' wounded warrior programs."

Response: VA anticipates it would conduct focus groups in the first year following enactment of this law to develop appropriate questions and to refine the survey to best gather the necessary data. VA agrees that the organizations identified by the National Military Family Association could provide important insight and it

anticipates working with these groups and others to craft a survey that will be effective and provide meaningful data.

VA would recommend modifying the legislation to specifically limit the scope of this survey to only family caregivers of enrolled veterans, rather than the entire population of family caregivers within the United States. VA also notes the legislation could benefit from providing flexibility to determine if annual surveys are necessary and to modify the survey as needed from year to year, since new issues, concerns or programs could warrant client feedback.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Mr. Joseph L. Wilson
Deputy Director, Veterans Affairs and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, D.C. 20006

Dear Mr. Wilson:

Thank you for the testimony you prepared on behalf of The American Legion for the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. What other health care legislation does your organization recommend for this Subcommittee?
2. In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.
   a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
   b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Joseph L. Wilson, Deputy Director,
Veterans Affairs and Rehabilitation Commission
The American Legion

Questions and Responses from:
Health Legislative Hearing on June 18, 2009

Question 1: What other health care legislation does your organization recommend for this Subcommittee?

Response: The American Legion supports legislation to expand and improve VA health care services for the 1.8 million women who have served our country. We also ask that proper oversight be reimplemented and/or maintained on issues such as increasing access to veterans health care, especially in rural areas; to revisit efforts to address the issues of an aging veteran population as well as veterans suffering the effects of Gulf War illness, Traumatic Brain Injury, post-traumatic stress disorder and exposure to toxic substances such as Agent Orange. We must keep the woman veteran in mind when addressing the above-mentioned pertinent issues and ensure all receive comprehensive care when visiting VA Medical Centers.

Question 2: In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey in not needed.

Question 2(a): What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?

Response: It is The American Legion's position that a stronger piece of legislation is required to ensure the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veteran Caregiver Program includes but is not limited to, a comprehensive package, including, respite care, to minimize complacency while caring for severely wounded veterans, mental health counseling, health care coverage, and adequate financial support.

Question 2(b): Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Response: The American Legion believes the absence of a recordkeeping system for those who care for this Nations' wounded veterans contributes to the lack of oversight required to ensure veterans are receiving adequate specialty and comprehensive care. Therefore, it is essential an accountability system be in place to ensure veterans' care remains adequate and seamless within their respective communities as well. Adequacy and seamless care can be maintained through the Department of Veterans Affairs continuous communication with and education of the caregiver on caring for the wounded veteran.

Please feel free to contact me @ 202–861–2700 ext. 2998 or jwilson@legion.org if you have questions.

Thank you,

Joseph L. Wilson

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Ms. Joy J. Ilem
Deputy National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, D.C. 20024

Dear Ms. Ilem:

Thank you for the testimony you prepared on behalf of Disabled American Veterans for the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. What other health care legislation does your organization recommend for this Subcommittee?
2. In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.
   a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
   b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Post-Hearing Questions for Joy J. Ilem,
Deputy National Legislative Director of the Disabled American Veterans
From the Subcommittee on Health Hearing
Committee on Veterans' Affairs
United States House of Representatives

June 18, 2009

Question 1: What other health care legislation does your organization recommend for this Subcommittee?

Answer: As a partner organization in producing the *Independent Budget* (IB) for fiscal year (FY) 2010, we have offered many new (and some recurring) health care legislative and policy ideas to Congress and the Administration. Some of them, such as improvements in caregiver support, mental health services, women veterans health care, Department of Veterans Affairs (VA) health care funding reform, Traumatic Brain Injury services and related research, VA capital infrastructure, medical and prosthetic research and its infrastructure, long term care for veterans in VA and State sponsored facilities, and other relevant topics, are being addressed in the regular order. We appreciate the Subcommittee's attention to these critical issues and its efforts in trying to address gaps in services for sick and disabled veterans and their families.

We remain hopeful that Congress will enact, and that the President will approve, the majority of bills addressing these issues hopefully before Congress adjourns this year. With that prospect in mind, Disabled American Veterans (DAV) proposes no additional bills for the Subcommittee's consideration at this time however, we anticipate that the IB for FY 2011, and our DAV Legislative Program for 2010 emerging from DAV's upcoming National Convention, will include new ideas and proposed legislation. We look forward to continuing to work with you and your staff to enact these proposals to help sick and disabled veterans and their caregivers.

Question 2: In a statement for the record, The Wounded Warrior Project (WWP) notes that the caregiver measures we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.

a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Answer: At the June 18th hearing, the Subcommittee considered four bills aimed at enhancing services for caregivers of disabled veterans. These measures included provisions to: provide Internet-based training for caregivers; travel expenses for family caregivers accompanying veterans to medical care appointments; expand outreach and ensure access to mental health and respite services; extend eligibility for CHAMPVA services; and to conduct an annual survey of family caregivers of disabled veterans.

Collectively, if enacted, these measures would begin to form a package of services to support caregivers of disabled veterans. However, we concur with WWP and would have preferred that H.R. 2342, the Wounded Warrior Project Family Caregiver Act, be considered during the legislative hearing since this measure would provide a more comprehensive caregiver support program. In addition, we urge the Subcommittee to consider amending H.R. 2342 to expand the eligible population beyond those who were injured in Operations Enduring and Iraqi Freedom.

A more comprehensive package would be in line with DAV's position that caregivers of severely disabled veterans should be seen as a resource and fully supported in their role. During our most recent National Convention, delegates approved resolution number 165, calling for legislation that would provide comprehensive sup-

portive services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to family caregivers of veterans severely injured, wounded or ill from military service. Likewise, the IB includes similar recommendations.

Additionally, Mr. Chairman, we believe the survey and reporting features included in the draft measure are critically important and should be included in the final caregiver legislation. The DAV believes that in crafting a new program for veterans' caregiver support services, it is important from a health policy standpoint, among other factors, to clearly define the population to be served, and properly assess that population. We believe it prudent to ensure that a new caregiver support program, one that DAV strongly advocates, should be evaluated to determine whether it is achieving its intended purposes of addressing the impact of the imposition into their lives and on their obligations and responsibilities as caregivers, including influences or barriers on their ability to work or pursue other activities, and to assess the social, psychological, physical and medical burdens that caregiving places upon them.

Although the combined National Long-Term Care Survey (NLTCS) and Informal Caregiver Survey (ICS) are not the only tools used to assess caregivers, we included these surveys in our testimony as examples in which data are being gathered. Information from NLTCS and ICS has served the needs of the Department of Health and Human Services, Congress, policymakers and researchers, to help produce and improve successful programs and public policy interventions that have benefited informal caregivers and their care recipients in other publicly-funded programs.

The lack of information on this caregiver population within the VA is a prime reason why the DAV recommends VA conduct a statistically significant longitudinal survey. Accordingly, we recommend the draft legislation be amended to require VA to conduct a longitudinal survey that would allow VA to obtain information and develop a nationally representative profile on the demographics, quality of life, available social support services, health status and outcomes of people who care for severely disabled veterans. With subsequent surveys, VA could look at population-based public health outcomes of caregivers as one way to ensure the support services it provides are effective. Also, with statistically valid survey data, VA would be in a position to compare and contrast its caregiver programs with those outside VA—something that today VA cannot do.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Mr. Fred Cowell
Senior Health Policy Analyst
Paralyzed Veterans of America
801 18th St., N.W.
Washington, D.C. 20006

Dear Mr. Cowell:

Thank you for the testimony you prepared on behalf of Paralyzed Veterans of America for the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. What other health care legislation does your organization recommend for this Subcommittee?
2. In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.
   a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
   b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Paralyzed Veterans of America
Washington, DC.
July 28, 2009

Honorable Michael H. Michaud
Chairman, Subcommittee on Health
House Committee on Veterans' Affairs
Room 335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

Thank you for the opportunity to respond to questions from Paralyzed Veterans of America's (PVA) June 18, 2009 testimony on pending legislation before the Committee.

Regarding your questions:

Question 1: What other health care legislation does your organization recommend for this Subcommittee?

Response: PVA recommends several pieces of legislation for the Subcommittee to consider. The best source for this is *The Independent Budget* coauthored annually by AMVETS, Disabled American Veterans (DAV), PVA and the Veterans of Foreign Wars (VFW). This document provides a comprehensive overview of our concerns and recommendations for legislation and policy changes and is endorsed by many Veterans Service Organization supporters of the *IB*.

Question 2: In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.

Question 2(a): What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?

Response: PVA agrees with the concerns of WWP that the legislation may need modifications to make it more comprehensive, points clearly identified in their statement for the record. PVA would also support the passage of H.R. 2342, the Wounded Warrior Project Family Caregiver Act. However, we see the legislation the Subcommittee is currently working on as an important first step. We agree that more can always be done and we encourage the Subcommittee to reach for a more comprehensive goal.

Specifically, PVA agrees with WWP's position that the current VA program in partnership with the Administration on Aging (AoA) is of limited value by allowing the Aging Network Agencies to refuse to accept veteran participants. This program can not be expected to meet the needs of veterans if there is the option to exclude veterans.

PVA wants to work with the Subcommittee and other Veterans Service Organizations to create the most comprehensive and complete legislation possible that provides for support to veteran caregivers.

Question 2(b): Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Response: Unfortunately, the VA collection of data on caregivers is limited at best and as noted in our testimony, "... VA can only estimate how many of these [44 million] caregivers serve veterans."

PVA supports the annual survey for two reasons. First, it is critical that VA develop detailed information on the situation of caregivers. Legislation can not be built on anecdotal background. As VA understands the scope of the problem and the benefits provided to veterans by family caregivers, it builds a stronger and more sustainable case for legislation. Second, if the population of caregivers is not surveyed, it is impossible to know if the programs are working and what programmatic changes may be needed and "Without this information, it will be difficult for VA to honestly provide recommendations on funding caregiver programs to the White House and Congress." [PVA 18 June 09 testimony]

Sincerely,

Fred Cowell
Senior Health Policy Analyst

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Mr. Christopher Needham
Senior Legislative Associate, National Legislative Service
Veterans of Foreign Wars
200 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Needham:

Thank you for the testimony you prepared on behalf of the Veterans of Foreign Wars for the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. What other health care legislation does your organization recommend for this Subcommittee?
2. In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.
   a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
   b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

VFW Responses to Questions for the Record of the Subcommittee on Health With Respect to the June 18, 2009 Legislative Hearing

Question 1: What other health care legislation does your organization recommend for this Subcommittee?

Response: We thank the Subcommittee for their actions this year. The Subcommittee has taken action on a significant number of VFW priorities, such as the Women Veterans' Health Care Improvement Act and the exemption of catastrophically disabled veterans from having to pay medical care co-payments. The Sub-

committee has had an aggressive agenda, which has addressed many of our highest priorities.

One issue that we feel could improve the consistency of the delivery of health care is a consolidation of contracts within Community-Based Outpatient Clinics (CBOCs), as we outlined on pages 81–82 of the FY 2010 *Independent Budget*.

We are strongly supportive of CBOCs and their role in expanding the availability of care to veterans throughout the country, especially to those who are not located near a large VA Medical Center. CBOCs serve as extensions of each Medical Center, and each VAMC establishes its own requirements based upon local needs.

As they have expanded, the growth in these clinics has involved multiple contracts with different entities to provide care. Along with this, each contract can have different measurements of quality care, pricing models and administration structure. Accordingly, there may not be consistency within a VAMC's area, nor on the VISN level. There is almost certainly no uniform standard throughout the health care system.

Consolidating contracts could offer VA many administrative benefits, and it could improve the quality of care provided to veterans. Benefits include: greater continuity of care and uniformity of the benefits; simplified contract administration and oversight; efficiency within contracts; improvements to access; efficiencies of procurement; standardized reporting and assessments, etc.

Question 2: In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.

Question 2(a): What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?

Response: We agree that veterans and their families need a more comprehensive program for caregiving. P.L. 109–461 created a pilot program for family caregivers, and we understand that VA has begun programs at eight locations throughout the country.

We all understand the need for this type of program. With the number of severely wounded servicemembers returning from Iraq and Afghanistan continuing to grow, its importance will increase. As these veterans stabilize in VA's polytrauma centers, most of these veterans will be able to return home, at least on a part-time basis. Many others will find comfort in therapeutic residential care settings. In all these cases, family members of veterans often will be the key link to providing care, helping their loved one deal with the challenges their health care needs create.

The VFW strongly believes that we should implement a systemwide program as soon as possible, implementing whatever lessons have been learned from those pilot programs, combined with information from caregiving programs run by other Federal and State agencies and lessons learned from private-sector implementation. We feel that we have enough information and data to implement a successful program, and that we must not let the search for a perfect program become the enemy of the good. We have laid out our vision of what a successful program looks like in the *Independent Budget*. I would refer you to pages 157–163 of the FY 2010 version for details.

In short, a family caregiver program must have several key components, all of which stress quality of life issues for both the veteran and the caregiver.

1. VA must provide training for family members to serve as the caregiver, as well as certifying that they are able to provide care. VA should provide regular training and provide information and resources for caregivers so that they can understand the veterans' demands for care. The Department must also ensure that the family member is capable of meeting the intense demands for care. Caregiving has been shown to provide immense physical, emotional, and psychological challenges, and it is critical for these veterans that their caregivers are up to the challenge.
2. VA must provide compensation to these certified family caregivers. They often have to put their lives on hold to provide care. It is not enough, as VA has sometimes suggested, for these family members to work for providers who already contract care, especially with the limitations VA provides on the contract care it provides.
3. VA must provide respite care services. Caregivers need a break from time to time for their physical, emotional and psychological health. Respite services help to alleviate caregiver burden and are critical for the quality of care veterans receive.

4. VA must provide family caregivers access to mental health care services and help provide other medical care services. Studies have shown that caregivers experience increased likelihoods of stress, depression, and other physical problems when compared to their peer group who do not provide care. It is a difficult, stressful job. These family members are serving on behalf of disabled veterans, to provide services the veteran is entitled to through the VA system. Accordingly, their well-being should be taken care of by the Department, if only to ensure the quality of care for the veteran remains first rate.

These are just some of the principles of a comprehensive national caregiver program that the VFW would like to see become law.

The VFW believes that H.R. 3155, which recently passed, is a step in the right direction. Although we have concerns over who ultimately is covered by this legislation, the overall program it would create is in line with our recommendations.

Question 2(b): It is my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Response: We disagree with their position. We feel that collecting information and input from caregivers and their families is going to be critical to understanding and adapting the program in the future. It is certainly true that we know many of the burdens and problems with caregiving programs through numerous studies of other agencies and organizations with caregiving programs. But it is likely that any VA program will have unique challenges, and any information we can get to improve and tailor the program in the future is beneficial.

What we do not want to see, however, is the demands for a study and the calls for more information and data about caregiving programs being used as a roadblock to implementing a program this session of Congress. This study should look to the future with whatever program is ultimately implemented for adaptation in the years to come. Congress must not use this study to prevent passage of these critical improvements.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 22, 2009

Mr. Bernard Edelman
Deputy Director for Policy and Government Affairs
Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Mr. Edelman:

Thank you for the testimony you prepared on behalf of Vietnam Veterans of America for the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Legislative Hearing that took place on June 18, 2009.

Please provide answers to the following questions by August 3, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. What other health care legislation does your organization recommend for this Subcommittee?
2. In a statement for the record, The Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.
   a. What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?
   b. Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

3. For H.R. 1546, the "Caring for Veterans with Traumatic Brain Injury Act of 2009," you state that you are not "thrilled" about creating another committee to focus on another facet of combat injury. By this comment, do you mean that you believe that there are too many committees focusing on combat veterans' issues? If so, do you have an alternative recommendation regarding the care and treatment of veterans with TBI?
4. In your testimony on H.R. 1546, you recommend that we must ensure that the operations of the TBI Committee are transparent and that all deliberations and notes of the Committee be open to public scrutiny. Please elaborate and explain what you mean by this statement.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by August 3, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Vietnam Veterans of America
Silver Spring, MD.
July 23, 2009

The Honorable Mike Michaud
Chairman
Subcommittee on Health
House Veterans' Affairs Committee
335 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Michaud:

In reply to your June 22nd letter following up on our written testimony for the hearing on health care legislation conducted by your Subcommittee on June 18th, let me respectfully submit to you the following:

Question 1: What other health care legislation does your organization recommend for this Subcommittee?

Response: Concerning other health care legislation, VVA would suggest that the Subcommittee hold a hearing on the intergenerational, or multigenerational, effects of a veteran's exposure to Agent Orange/dioxin while serving in Vietnam and the cancers, birth defects, and learning disabilities that have afflicted not only his/her children but *their* children as well. We hear far too many stories from the daughters (mostly) of veterans who wonder if the health conditions that they were born with, and that now their children have as well, could derive from their father's service in Vietnam. The results of such a hearing might, we would hope, suggest specific legislation concerning research into the association between exposures to dioxin and other toxic substances with reproduction.

In this realm, your Subcommittee might also consider looking into the studies on groundwater contamination at Camp Lejeune, North Carolina, from which birth defects and childhood cancers may derive.

We also would suggest your Subcommittee, perhaps in concert with Oversight and Investigations, look into Project HERO, a pilot program in four VISNs, that is supposed to get a handle on fee-basis health care expenditures. We have serious concerns about this program, particularly with regard to its ability to effectively enlist clinicians in rural/remote areas. (Currently, all of the health care contracts have been "won" by Humana, and the dental contracts by Delta Dental.) Is HERO part of the answer in getting a handle on the 1 in 10 health care dollars expended by the VA out of the VA system?

Question 2: In a statement for the record, the Wounded Warrior Project notes that the caregiver legislation we are considering today are not as comprehensive as they should be. Additionally, they note that we already know enough about the burdens of caregivers and that an annual survey is not needed.

Question 2(a): What are your thoughts on WWP's position? Do you believe that modifications to the caregiver legislation are necessary?

Response: Concerning caregiver legislation, certainly a comprehensive approach is needed, one that might incorporate the various initiatives of the draft legislation as well as H.R. 2378 and 2734.

Question 2(b): Is it my understanding that VA does not currently collect any data on family caregivers, such that we don't even know how many family caregivers there are or the types of services they are receiving. While I agree that we have many anecdotes to understand the burden of caregiving, more information is needed to better help this population. Do you believe that the annual survey and reporting requirements are not necessary?

Response: Yes, we do believe that the annual survey and reporting requirements concerning caregivers are both warranted and potentially valuable. To argue that we know all we need to know because we know it, doesn't hold up. Anecdotal evidence is fine. Having a database of solid information can assist the VA in adapting to the needs of caregivers, and in tracing how dollars are expended in this admirable effort.

Question 3: For H.R. 1546, the "Caring for Veterans with Traumatic Brain Injury Act of 2009," you state that you are not "thrilled" about creating another committee to focus on another facet of combat injury. By this comment, do you mean that you believe that there are too many committees focusing on combat veterans' issues? If so, do you have an alternative recommendation regarding the care and treatment of veterans with TBI?

Response: Perhaps my original testimony was a bit unclear as to what I attempted to say concerning the creation of a committee to focus on assisting troops who return home with Traumatic Brain Injury. Often, committees and commissions are created when legislators and Governors and Presidents don't want to make a hard decision on a particular issue. In this case, however, such a committee is needed, to help coordinate and get a handle on the multitude of efforts both public and private aimed at helping troops/veterans afflicted with TBI.

As we wrote: "Millions of dollars have been appropriated to learn more about [TBI]. Is this money being spent wisely and well? Which treatment modalities are working? Which aren't? What ought to be the role of community-based organizations in caring for veterans with such wounds?"

Question 4: In your testimony on H.R. 1546, you recommend that we must ensure that the operations of the TBI Committee are transparent and that all deliberations and notes of the Committee be open to public scrutiny. Please elaborate and explain what you mean by this statement.

Response: The discussions and deliberations during meetings should be open to the public, and to public scrutiny, just as hearings are for (most) Committees and Subcommittees in Congress. I think the "and notes" may be a bit misleading. We do not mean that all notes and e-mails from one Committee Member to another should be laid out to be examined by anyone. Certainly, we recognize the necessity for private communications between Committee Members and staff if such a Committee is to function properly.

We hope that these responses to your questions, Mr. Chairman, offer some illumination as to what we said in our written testimony. And we appreciate your efforts, and that of your colleagues and staff, in a most important undertaking.

Sincerely,

Bernard Edelman
Deputy Director for Policy and Government Affairs