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CAREGIVER AND VETERANS HEALTH SERVICES ACT OF 2009

SEPTEMBER 25, 2009.—Ordered to be printed

Mr. AKAKA, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany S. 801]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 801), to amend title 38, United States Code, to waive charges for humanitarian care provided by the Department of Veterans Affairs (hereinafter, "VA" or "the Department") to family members accompanying veterans severely injured after September 11, 2001, as they receive medical care from the Department, and to provide assistance to family caregivers, and for other purposes, reports favorably thereon with an amendment, and recommends that the bill, (as amended) do pass.

INTRODUCTION

On April 2, 2009, Chairman Akaka introduced S. 801, the proposed "Family Caregiver Program Act of 2009." S. 801, as introduced, would create a national program for the caregivers of seriously injured veterans to provide them with education, grants, counseling, and other support.

Earlier, on February 10, 2009, Senator Akaka introduced S. 404, the proposed "Veterans" Emergency Care Fairness Act of 2009." S. 404 would expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility.

On March 6, 2009, Senator Durbin introduced S. 543, the proposed "Veteran and Servicemember Caregiver Support Act of 2009." S. 543 would require a pilot program on training, certification, and support for family caregivers of seriously disabled veterans.

On March 19, 2009, Senator Tester introduced S. 658, the proposed "Rural Veterans Improvement Act of 2009." S. 658 would, among other things, improve health care for veterans who live in rural areas.

On March 30, 2009, Senator Akaka introduced S. 734, the proposed "Rural Veterans Health Care Access and Quality Act of 2009." This bill would improve the capacity of the Department of Veterans Affairs to recruit and retain physicians in underserved areas known as Health Professional Shortage Areas (hereinafter, "HPSAs") and improve the provision of health care to veterans in rural areas.

On April 2, 2009, Senator Brown introduced S. 793, the proposed "Department of Veterans Affairs Vision Scholars Act of 2009." S. 793 would direct the Secretary of Veterans Affairs to establish a scholarship program for students seeking a degree or certificate in the areas of visual impairment and orientation and mobility.

On February 26, 2009, the Committee held a hearing on caring for veterans in rural areas. Testimony was offered by: Kara Hawthorne, Director, Office of Rural Health, Veterans Health Administration; Adam W. Darkins, M.D., Chief Consultant for Care Coordination, Veterans Health Administration; Reverend Ricardo Flippin, Project Coordinator, West Virginia Council of Churches, CARENET: Caring Beyond the Yellow Ribbon; H. Alan Watson, Chief Executive Officer, St. Mary's Medical Center of Campbell County, Lafollette, Tennessee; Tom Loftus, Commander, The American Legion, Post 45, Clarksville, Virginia; and Matt Kuntz, Executive Director, National Alliance for the Mentally Ill, Montana Chapter.

On April 22, 2009, the Committee held a hearing on pending health care legislation. Testimony was offered by: Gerald M. Cross, M.D., Principal Deputy Under Secretary for Health, Department of Veterans Affairs, accompanied by Walter A. Hall, Assistant General Counsel, and Joleen Clark, Chief Officer for Workforce Management and Consulting, Veterans Health Administration; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Ammie Hilsabeck, R.N., Oscar G. Johnson VA Medical Center, representing the American Federation of Government Employees; and Blake Ortner, Senior Associate Legislative Director, Paralyzed Veterans of America.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on May 21, 2009, to consider, among other legislation, an amended version of S. 801, consisting of provisions from S. 801 as introduced, and other legislation noted above, as well as several freestanding provisions. The Committee voted unanimously to report favorably S. 801, as amended.

SUMMARY OF S. 801 AS REPORTED

S. 801, as reported, would amend the title of the original bill (hereinafter, "the Committee bill" or "this Act"), and would provide for a program of support for caregivers of seriously injured veterans, improve health care provided to veterans residing in rural

areas, and make other enhancements and expansions to VA health care.

TITLE I—CAREGIVER SUPPORT

Section 101 would authorize VA to waive the cost of furnishing hospital care or medical services for caregivers of veterans in emergency cases.

Section 102 would create a comprehensive program to provide assistance to the caregivers of severely injured veterans.

Section 103 would authorize the Secretary to pay for the caregivers' lodging and subsistence as well as the expenses of travel for the period consisting of travel to and from a treatment facility and the duration of a treatment episode at that facility.

Section 104 would require VA to collaborate with the Department of Defense (hereinafter, "DOD") to conduct, and thereafter submit to Congress, a national survey of family caregivers.

TITLE II—RURAL HEALTH IMPROVEMENTS

Section 201 would authorize the Secretary to include education loan repayment in offers of employment in an amount equal to the potential employee's total indebtedness.

Section 202 would create a new visual impairment, orientation and mobility professionals' education assistance program.

Section 203 would require VA to transfer funds to the Department of Health and Human Services for the purpose of listing VA facilities on the National Health Service Corps list.

Section 204 would mandate the expansion of telehealth services, promote the training of health care personnel in telemedicine technologies, and require appropriate reimbursement to facilities offering those services.

Section 205 would authorize rural health demonstration projects which may include partnering with other agencies or community entities.

Section 206 would authorize VA to contract-out mental health services for Operation Iraqi Freedom (hereinafter, "OIF") and Operation Enduring Freedom (hereinafter, "OEF") veterans in rural areas.

Section 207 would promote improved partnership and collaboration between VA and the Indian Health Service (hereinafter, "IHS") to enhance care for Indian veterans.

Section 208 would require VA to reimburse certain veterans requiring air travel transportation for treatment at VA facilities.

Section 209 would require the VA Office of Rural Health to develop a 5-year strategic plan for improving access to quality health care for veterans who live in rural areas.

Section 210 would provide incentives for providers paid by VA through contracts or on a fee-for-service basis to implement certain quality improvement measures.

Section 211 would authorize VA to use volunteers and other individuals to provide readjustment counseling, and to expedite the credentialing and privileging of licensed independent health care providers working on a volunteer basis in readjustment counseling centers.

Section 212 would require VA to establish rural health Centers of Excellence.

Section 213 would authorize a pilot program that incentivizes physicians to assume inpatient responsibilities at community hospitals in health professional shortage areas.

Section 214 would require reports on the implementation of sections 209 through 213 of the Committee bill and a report on VA fee-basis health care and outreach programs.

Section 215 would authorize grants to veterans service organizations for the purposes of providing certain transportation services to veterans.

TITLE III—OTHER HEALTH CARE MATTERS

Section 301 would authorize VA to reimburse certain veterans for emergency treatment received at a non-VA medical facility, without regard to insurance coverage.

Section 302 would exempt veterans who are catastrophically disabled from copayment requirements for the receipt of hospital care or medical services.

TITLE IV—CONSTRUCTION AND NAMING MATTERS

Section 401 would authorize funds for design and construction at the VA Medical Center, Walla Walla, Washington.

Section 402 would designate the VA outpatient clinic in Havre, Montana as the "Merril Lundman Department of Veterans Affairs Outpatient Clinic."

BACKGROUND AND DISCUSSION

TITLE I—CAREGIVER SUPPORT

Title I of the Committee bill contains a number of provisions that are designed to help caregivers of veterans.

Many veterans returning from the conflicts in Iraq and Afghanistan sustained severe injuries and need substantial care. According to VA, as of January 2009, 981,834 OEF/OIF servicemembers had left active duty, and 425,538 (or 43 percent) had accessed VA health care.

Congress has recognized the need for VA to provide assistance to caregivers of severely injured veterans. Public Law 109–461, Section 214 authorized $5,000,000 for each of the fiscal years (FY) 2007 and 2008 for VA to carry out pilot caregiver assistance programs. VA began eight caregiver assistance pilot programs in October 2007. A 1-year extension of the authority for these pilot programs was approved in Public Law 110–329, the "Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009."

These pilot programs offer such services as caregiver education, training, improved care coordination, and peer networking. They do not provide health care, mental health counseling, or financial assistance to caregivers. Based on the comprehensive needs of caregivers, Ralph Ibson, Health Policy Senior Fellow of the Wounded Warrior Project (hereinafter, "WWP") testified before the Committee at its April 22, 2009, health legislation hearing that "the time for pilot programs is past."

Fully supporting caregiving activities is also cost effective, as the cost of providing care in an institutional setting can be much greater than the cost of providing care in the home. According to a sur-

vey conducted in 2005 by MetLife's Mature Market Institute, the average cost of a private room in a nursing home in the United States was $74,095 per year. VA is obligated to provide nursing home care for veterans who need such care, and who meet one of the following criteria: a service-connected disability rating of 70 percent or more; a need for nursing home care for a service-connected disability; or a rating of 60 percent when a veteran is either unemployable or permanently and totally disabled. In its 2009 budget submission, VA projected that the average daily census in its institutional care settings, including community living centers, community nursing homes, and state veterans homes, would reach 90,654 in 2010, an increase of 25.3 percent over 2009 levels.

Many veterans, however, prefer care in the home, especially younger veterans such as those now returning from the conflicts in Afghanistan and Iraq. As the WWP witness, Ralph Ibson, testified before the Committee at its April 22, 2009, health legislation hearing:

> These individuals usually want to return to, or remain in, their homes, and strongly resist being institutionalized * * *. Most warriors want to be cared for by their loved ones, if possible, rather than agency personnel. Most families want the same for their wounded warrior. But the extraordinary demands of caregiving invariably takes a toll on family caregivers—physically, psychologically, emotionally, and financially.

At the same hearing, the witness representing the American Federation of Government Employees (hereinafter, "AFGE"), Ammie Hilsabeck, also called the contributions of today's caregivers "invaluable economically as they obviate the rising costs of traditional institutional care."

The financial toll on caregivers can be substantial, however. The 2006 MetLife Caregiving Cost Study estimated that 15 to 20 percent of the nation's workforce as a whole is engaged in caregiving at any one time. According to CNA's April 2009 report *Economic Impact on Caregivers of the Seriously Wounded, Ill, and Injured*, 84 percent of veteran caregivers were either working or in school prior to becoming a caregiver. MetLife's cost study estimated that employer costs for working caregivers totaled up to $33.6 billion in lost productivity. In addition, an employed caregiver lost an average of about $659,000 in wages, pension, and Social Security benefits over a "career" of caregiving.

These financial burdens may impact the ability of caregivers to obtain health insurance. According to a 2001 Kaiser Family Foundation study, half of all caregivers have an annual household income of less than $35,000. In the Family Caregiver Alliance's September 2003 policy brief, authors reported that 25 percent of women caregivers had difficulty obtaining medical insurance compared to 16 percent of non-caregiving women.

Mental health concerns are often prevalent in this population as well. Caregivers report unmet needs in the areas of finding time for themselves (35 percent) and of managing emotional and/or physical stress (29 percent). In one study, 30 to 59 percent of care-

givers reported depressive disorders or symptoms.[1] Testifying before the Committee at its April 22, 2009, health legislation hearing, the WWP witness said:

> Highlighting the need for access to counseling and other health care services, the studies also show that family caregivers experience an increased likelihood of stress, depression, and mortality compared to their non-caregiving peers * * *. Caregivers report poorer levels of perceived health, more chronic illnesses, and poorer immune responses to viral challenges.

Sec. 101. Waiver of Charges for Humanitarian Care.

Section 101, which is derived from S. 801 as introduced, would modify VA's authority to furnish humanitarian care so that caregivers who accompany veterans would be exempt from charges for emergency medical services.

Background. Non-veterans may receive medical care from VA in emergency cases under current law, but VA charges them for such services. Charging caregivers who accompany veterans to VA facilities, and subsequently need emergency care, adds to the economic impact of caregiving on veterans' families.

Committee Bill. Section 101 of the Committee bill would revise section 1784 of title 38, to amend existing law which authorizes VA to furnish and charge for hospital care or medical services in emergencies, so as to authorize VA to furnish such services, without charge, in emergency cases to attendants accompanying certain veterans when the veterans are receiving care from or through VA.

Subsections (a) and (b) of revised section 1784 are a restatement of current law which authorizes VA to furnish and charge for care in emergencies. New subsection (c) of section 1784 would require VA to waive charges for such services if those services are provided to an "attendant of a covered veteran" while the attendant is accompanying such a veteran receiving care at a VA facility, or at a non-VA facility that is under contract with the Department or which is providing care on a fee-for-service basis to the veteran. For purposes of this section, an attendant is defined as a family member of the veteran; an individual eligible to receive ongoing family caregiver assistance under other provisions of this title; or any other individual the Secretary determines to have a relationship with the veteran sufficient to demonstrate a close affinity with the veteran and who provides a significant portion of the veteran's care.

This new subsection would also authorize VA to bill third parties for health care provided should an attendant be entitled to care or services under a health plan contract or have other legal recourse against a third party that would extinguish some or all liability associated with the charges.

New subsection (d) of section 1784 would define a covered veteran as any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval or air service on or after September 11, 2001. "Severe injury" would be defined as any

[1] Cohen, D., Luchins, D., Eisdorfer, C., Paveza, G., Ashford, J., Gorelick, P., et al. (1990). Caring for relatives with Alzheimer's Disease: The mental health risks to spouses, adult children, and other family caregivers. Behavior, Health and Aging, 1, 171–182.

physiological, psychological or neurological condition that renders a veteran unable to live independently.

The WWP testified in support of these provisions before the Committee at its April 22, 2009, health legislation hearing, noting the economic impact of caregiving on the family.

Sec. 102. Family Caregiver Assistance.

Section 102 of the Committee bill, which is derived from S. 801 as introduced, contains a number of provisions that would require VA to provide training, medical care, a financial stipend and other support for caregivers of veterans sustaining or aggravating a severe injury after September 11, 2001, while on active duty.

Background. While family caregivers may currently receive certification and training through home health agencies, and become employees of those agencies, according to a recent survey conducted by VHA, only 233 family caregivers received such training and certification through existing home health agencies in FY 2008. The study also found that in FY 2009, VA referred only 168 family caregivers to home care agencies for training and certification. This suggests that the population of caregivers who would be eligible for stipends under this section would be very small.

A report from the Principal Deputy Assistant Secretary of the Air Force for Manpower and Reserve Affairs found that there was a greater need for caregiving services. The Assistant Secretary was tasked by the Joint Department of Defense and Department of Veterans Affairs Wounded, Ill, and Injured Senior Oversight Committee (hereinafter, "SOC") to evaluate issues of personnel, pay, and financial support, including the economic impact borne by caregivers of the seriously wounded, ill, and injured. This review, conducted by the Center for Naval Analyses (hereinafter, "CNA"), a non-partisan non-profit research organization, found that 37 percent of caregivers had unmet financial obligations, and that three out of every four caregivers had quit, or taken time off from work or school. CNA estimated that approximately 720 seriously wounded, ill, or injured veterans annually would need the services of a caregiver. Further, these servicemembers were expected to require the services of a caregiver for an average of 19 months.

The WWP witness testified before the Committee at its April 22, 2009, hearing on health legislation that proper caregiver training and health care reduces the chances of injury to both the caregiver and the recipient of the care. Current law limits VA's ability to provide those services. Under section 1782 of title 38, VA is authorized to provide counseling, training, and mental health services to members of the veteran's immediate family, the veteran's legal guardian, and to the individual in whose household the veteran certifies an intention to live. These services, however, are only available for: (1) veterans receiving treatment for a service-connected disability if the services are necessary in connection with that treatment; and (2) veterans receiving treatment for other than a service-connected disability if the services are necessary in connection with the treatment, the services were initiated during the veteran's hospitalization, and the continued provision of the services on an outpatient basis is essential to permit the discharge of the veteran from the hospital. There is no requirement to provide these services if care

can be provided by individuals other than the family caregiver, or if the caregiver does not live with the veteran.

In a letter to the Committee, Shawn Moon, General Manager for Government and Education Services of Franklin Covey, a national organization with specific expertise in the design of training programs, said the following:

> A family caregiver assistance program that emphasizes awareness; prevention and wellness; early intervention and treatment; and proactive health risk, condition or disease management is a prudent federal investment. Over the long term, the benefits of this approach will be realized in improved care and outcomes for wounded warriors, better health and quality of life for family caregivers, reduced health care utilization, and increased cost savings.

Committee Bill. Section 102 of the Committee bill would create a comprehensive program to provide assistance to the caregivers of severely injured veterans.

Subsection (a)(1) of this section of the Committee bill would amend subchapter II of chapter 17 by adding a new section, section 1717A, entitled "Family caregiver assistance."

New section 1717A would consist of eleven subsections, (a) through (k), as follows:

Subsection (a) of new section 1717A would require the Secretary to provide caregiver assistance as part of home health services authorized by Section 1717, so as to reduce the number of veterans who are receiving, or in need of, institutional care. Such assistance would be furnished upon the joint application of an eligible veteran and a family member or other individual designated by the veteran. The Secretary would be permitted to furnish such assistance only if it is in the best interest of the veteran to furnish this assistance.

Subsection (b) of new section 1717A would define which veterans would be eligible to receive caregiver assistance. An eligible veteran would be either a veteran or a member of the Armed Forces undergoing medical discharge who has a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, and who is determined to be in need of personal care services because of being unable to perform one or more independent activities of daily living; or of needing supervision or protection as a result of neurological or other impairment; or because of other matters specified by VA. The Secretary would have discretion to extend the program to other veterans after the first 2 years.

Subsection (c) of new section 1717A would require the Secretary to evaluate each eligible veteran applying for caregiver services to identify the personal care services required by the veteran, and to determine whether the requirements could be significantly or substantially satisfied by the individual designated by the veteran. This evaluation would be carried out at a VA facility or a non-VA facility determined appropriate by VA. The Secretary would also be required to evaluate each family member or other designee of an eligible veteran who makes a joint application to determine the amount of basic instruction, preparation, and training necessary for the individual to provide the personal care services required by the

veteran, as well as additional instruction, preparation, and training required to be the primary personal care attendant for the veteran.

Subsection (d) of new section 1717A would provide for the training and approval of personal care attendants. The Secretary would be required to provide the basic instruction, preparation and training determined necessary to enable the individual to provide personal care services. The Secretary would be authorized to provide additional instruction, preparation, and training determined to be required if the caregiver is approved as the personal care attendant of the veteran, and requests, with concurrence of the veteran, such additional instruction.

Subsection (d) would require the Secretary to approve the caregiver as a personal care attendant for the veteran following completion of basic instruction, preparation and training. If the Secretary determines that a personal care attendant, once designated, is in need of additional training, VA must provide that training.

Subsection (d) would require VA to provide for necessary travel, lodging and per diem expenses incurred by the caregiver of an eligible veteran in undergoing training under this section.

Subsection (d) would require VA to provide respite care to veterans whose caregivers are undergoing training if the participation of the caregiver in this training would interfere with the provision of personal care services to the veteran.

Subsection (e) of new section 1717A would provide for the designation of one family member or designee as the primary personal care attendant for such eligible veteran with at least one eligible caregiver. Eligible caregivers would have to be approved, would have to have completed all instruction, preparation and training, would have to elect to provide personal care services to the veteran, would have to have the veteran's consent to be the primary provider, and would have to be considered competent to provide such services to the veteran.

Subsection (e) would allow a veteran to revoke consent with respect to a caregiver at any time and would require the Secretary to immediately revoke an individual's designation as the primary personal care attendant if the individual fails to meet the specified requirements. In such a case, the Secretary, in consultation with the veteran or the veteran's surrogate, would be authorized to designate a new primary personal care attendant. In the case of a revocation, the Secretary would be required to ensure that the revocation would not interfere with the provision of personal care services required by a veteran.

Subsection (f) of new section 1717A would provide for any ongoing family caregiver assistance including direct technical support, counseling, and access to an interactive Web site on caregiver services to all individuals meeting the qualifications for personal care attendant. In addition, the primary personal care attendant of each veteran would be provided with that same assistance, as well as mental health services, respite care of not less than 30 days annually, medical care unless the individual is entitled to care or services under a health plan contract U.S.C. 1725(f), and a monthly caregiver stipend.

Respite care would be provided either through appropriate VA facilities or through existing respite care contracts or, if neither ap-

proach is appropriate, through other facilities or arrangements that are medically and age appropriate.

Subsection (f) would allow VA to contract for insurance, medical services, or health plans if VA determines that the Department lacks the capacity to furnish medical care to primary personal care attendants.

Subsection (f) would require VA to provide monthly personal caregiver stipends in accordance with a schedule determined by the Secretary and based on the amount and degree of personal care services provided. To the extent practicable, the amount of the personal caregiver stipend would not be less than the amount a commercial home health entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services. If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary would be allowed to consider the costs of commercial providers of personal care services in other geographic areas with similar costs of living.

Subsection (f) would require termination of caregiver assistance if the veteran no longer requires personal care services.

Subsection (g) of new section 1717A would grant the Secretary the authority to appoint a surrogate for the veteran if an eligible veteran lacks the capacity to submit applications, provide consent, make a request, or concur with a request under section 1717A.

Subsection (h) of new section 1717A would provide oversight of the caregiver assistance program through contracts with appropriate entities. Each veteran receiving personal care services from a personal care attendant would be visited in his or her home by such oversight entity no less often than once every 6 months. An oversight entity visiting an eligible veteran would be required to submit findings for each visit, including whether the veteran is receiving the care the veteran requires.

If an oversight entity finds that a veteran has not received required care, the Secretary would be authorized to take appropriate actions, including revoking a caregiver's approval and designation as a primary personal care attendant.

If the Secretary were to terminate ongoing family caregiver assistance under subsection (f) because of the findings of an oversight entity, the Secretary would not be authorized to provide compensation to such entity for the provision of personal care services to such veteran, unless the Secretary determines that it is in the best interests of the veteran to do so.

Subsection (i) of new 1717A would provide for a program of outreach to inform eligible veterans and their family members of the availability and nature of family caregiver assistance under section 1717A.

Subsection (j) of new section 1717A would specify that a decision by the Secretary affecting the furnishing of caregiver assistance shall be considered a medical determination, and that nothing in section 1717A shall be construed to create either an employment relationship between VA and someone receiving family caregiver assistance, or any entitlements to any service or stipend.

Subsection (k) of new section 1717A would define family caregiver assistance, family member, and personal care services for purposes of section 1717A.

Subsection (a)(2) of this section of the Committee bill would provide for a clerical amendment.

Subsection (a)(3) of this section of the Committee bill would amend section 1781(a) of title 38 so as to authorize health care for primary personal care attendants designated under new section 1717A who are not entitled to care or services under some other health plan contract.

Subsection (a)(4) of this section of the Committee bill would specify, in a freestanding provision, that any family caregiver assistance furnished under new section 1717A would be in addition to any family caregiver assistance furnished under VA programs.

Subsection (a)(5) of this section of the Committee bill provides that the amendments made by subsection (a) would take effect 270 days after the date of the enactment of this Act.

The Disabled Veterans of America, the Paralyzed Veterans of America, and the Wounded Warrior Project testified at the Committee's April 22, 2009, hearing on health care legislation in support of the need for the services that would be provided under new section 1717A. AFGE provided written testimony supporting the bill as a whole.

Subsection (b)(1) of section 102 of the Committee bill would mandate the development of a plan for the implementation of new section 1717A and require VA to submit a report on such plan to the Veterans' Affairs Committees of the House of Representatives and Senate not later than 180 days after the date of the enactment of this Act.

Subsection (b)(2) of this section of the Committee bill would require VA, in developing the plan in the implementation of new section 1717A, to consult with veterans eligible for family caregiver assistance; family members of veterans who provide personal services to such veterans; veterans service organizations; national organizations that specialize in the provision of assistance to individuals with the types of disabilities that personal care attendants will encounter while providing personal care services; such other organizations with an interest in the provision of care to veterans as the Secretary considers appropriate; and the Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who would be eligible to benefit from family caregiver assistance that would be furnished under new section 1717A.

The report would be required to contain the plan; a description of the veterans, caregivers and organizations consulted by the Secretary; a description of such consultations; recommendations of such individuals and organizations that were not incorporated into the plan; and the reasons the Secretary did not incorporate such recommendations into the plan.

Subsection (c)(1) of section 102 of the Committee bill would require VA, no later than 2 years after the effective date of this Act and annually thereafter, to submit a comprehensive report on the implementation of new section 1717A of title 38 to the Veterans' Affairs Committees of the House of Representatives and the Senate. This report would be required to contain the number of individuals that received caregiver assistance under section 1717A; a description of the outreach activities carried out by the Secretary

in accordance with subsection (i) of new section 1717A; information on the resources expended by the Secretary under 1717A; an assessment of the manner in which resources are expended by the Secretary under section 1717A, particularly with respect to the provision of monthly personal caregiver stipends; a description of the outcomes achieved by, and any measurable benefits of, carrying out the requirements of section 1717A; a justification of any determination to extend the time period under which veterans would be eligible for family caregiver assistance; an assessment of the effectiveness and efficiency of the implementation of section 1717A; an assessment of how the provision of family caregiver assistance fits into the continuum of VA home health services and benefits; and such recommendations, including recommendations for legislative or administrative action, as the Secretary considers appropriate in light of carrying out the requirements of section 1717A.

Sec. 103. Lodging and Subsistence for Attendants.

Background. Section 103 of the Committee bill, which is derived from S. 801 as introduced, would modify current authority for beneficiary travel so as to authorize VA to pay certain costs of caregivers who must travel. Under Section 111(e) of title 38, VA is authorized to pay qualifying travel expenses for an attendant traveling with an eligible veteran when the veteran requires an attendant in order to perform such travel. This provision does not provide authority for VA to pay for lodging and subsistence costs associated with this travel. The DOD, on the other hand, is authorized to provide for per diem and travel costs for up to three family members while the servicemember is an inpatient and during the outpatient rehabilitative phase for qualified servicemembers.

Committee Bill. Section 103 of the Committee bill would amend section 111(e) of title 38, which authorizes VA to pay certain expenses of travel to an attendant who is required to accompany a veteran when the veteran is traveling to receive VA care, to add a new paragraph (2) which would authorize the Secretary to also pay lodging and subsistence expenses for the period consisting of travel to and from a treatment facility and the duration of treatment episode at that facility. New paragraph (2) would allow the Secretary to prescribe regulations to carry out this section, including regulations that limit the number of individuals who can receive these travel expenses for a single treatment episode of a veteran, and that require attendants to use certain travel services.

This section of the Committee bill would also add a new paragraph (3) to section 111(e) of title 38 which would define the meaning of attendant for the purposes of this section. An attendant would be defined as a family member of the veteran; an individual eligible to receive ongoing caregiver assistance under other provisions of this title; or any other individual whom the Secretary determines has a preexisting relationship with the veteran and provides a significant portion of the veteran's care.

Sec. 104. Survey of Informal Caregivers.

Background. Section 104 of the Committee bill, which is derived from S. 543, would require VA, working with the DOD, to survey family caregivers of veterans. In April 2009, the Veterans Health Administration conducted a survey to determine how many family

caregivers had been referred by VA to home health agencies to be trained and certified as home health aides and to be hired by the agency as a paid caregiver for the veteran. In FY 2008, only 233 family caregivers were referred for such training and certification. VA was unable to provide the total number of family members serving as caregivers, or to provide additional information regarding this population.

Committee Bill. Section 104 of the Committee bill, in a free-standing provision, would require VA, in collaboration with the DOD, to carry out a national survey of family caregivers of veterans and members of the Armed Forces who are seriously disabled in order to gain a better understanding of the size and characteristics of the population of such caregivers, and of the types of care they provide such veterans and members.

This section would require VA to submit to Congress, in collaboration with DOD, a report containing the findings of the survey, with the results disaggregated by those who are veterans and those who are still members of the Armed Forces; by those who served in Operation Iraqi Freedom or Operation Enduring Freedom; and by those who live in rural areas. This report would be due not later than 540 days after the date of enactment of the Committee Bill.

TITLE II—RURAL HEALTH IMPROVEMENTS

Title II of the Committee bill contains a variety of provisions that are designed to enhance the Department's ability to meet the needs of veterans living in rural areas.

Those living in rural areas are more than twice as likely to serve in the armed services as those living in urban areas. More than one third of veterans currently enrolled with VA live in rural areas. This number can only be expected to grow as it was estimated by 2007 that 44 percent of the active duty military were from rural areas.

Ensuring access to health care for rural veterans remains a challenge for VA. Hilda Heady, past president of the National Rural Health Association (hereinafter, "NRHA"), testified during the Committee's April 22, 2009, health legislation hearing:

> There is a national misconception that all veterans have access to comprehensive care. Unfortunately, this is simply not true. Access to the most basic primary care is often difficult in rural America. Access for rural veterans can be daunting. Combat veterans returning to their rural homes in need of specialized care due to war injuries (both physical and mental) will likely find access to that care extremely limited.

Recognizing the need to improve access to health care for rural veterans, witnesses representing the NRHA, Paralyzed Veterans Association (hereinafter, "PVA"), Disabled American Veterans (hereinafter, "DAV"), and AFGE testified in support of the provisions contained in Title II of the Committee bill during the Committee's April 22, 2009, health legislation hearing.

Sec. 201. Enhancement of Department of Veterans Affairs Education Debt Reduction Program.

Section 201 of the Committee bill, which is derived from S. 734, would expand the authority of VA to provide education debt reduction to eligible employees, and require them to notify those employees of an award in a timely manner.

Background. The Education Debt Reduction Program (hereinafter, "EDRP") was authorized by the Veterans Programs Enhancement Act of 1998 (Public Law 105–368), and amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Public Law 107–135. It provides loan repayment for employees recently appointed to title 38 positions providing direct patient care services or services incident to direct patient care.

Marisa Palkuti, Director of the Health Care Retention and Recruitment Office of the VA testified before the Committee on April 9, 2008, that the top three mission-critical occupations within VHA are registered nurses, physicians, and pharmacists. She also highlighted how VA must compete with the private sector to recruit these individuals. In 2009, Merritt Hawkins and Associates conducted an analysis entitled, "Review of Physician and Certified Registered Nurse Anesthetist Recruiting Incentives." Of the 3,288 Merritt Hawkins assignments reviewed, 31 percent of physician and CRNA positions offered loan forgiveness, and 85 percent offered a signing bonus. The average amount of the signing bonus alone was $24,850.

In VA, physicians providing direct patient care services are eligible for EDRP. Currently, section 7683 of title 38 limits the award to a total of $44,000 over a 5-year period. VA offers no signing bonuses. The EDRP award limit applies regardless of occupation, difficulties in recruitment, or actual costs of education.

The current statutory limit is particularly problematic when used as a recruitment or retention tool for physicians. It does not reflect the fact that, according to the American Association of Medical Colleges, the cost of tuition at medical schools has risen faster than the consumer price index for the last 20 years. In addition, the mean educational debt of 2008 graduates from medical school was $154,607, or more than three times VA's current statutory authority to grant loan repayment. To enable VA to compete effectively with the private sector for physicians and other health care providers, VA must have the authority to provide loan repayment to the maximum extent possible with available funds.

During recent oversight visits, majority Committee staff were told that employees were not made aware of VA's loan repayment program until after acceptance of employment, eliminating any opportunity for the program to serve as a recruitment incentive. Further, in some cases, employees did not learn of the program until after they were employed with VA for more than 6 months, eliminating their eligibility under VA's definition of "recently appointed."

The ability of VA to recruit and retain health care workers will be critical in the near future. According to a March 17, 2009, memorandum from the Congressional Research Service, there were 218,000 Veterans Health Administration employees in FY 2007, and 11.5 percent of them were eligible to retire at the end of that year. The Congressional Research Service also noted that there

were an estimated 1,700 vacancies for registered nurses nationwide. VA does not currently have the personnel to care for all veterans' health care needs. In FY 2008 alone, VA spent more than $244 million on contract care for outpatient services and $1.2 billion on fee-basis care.

EDRP's role in the retention of nurses has been well-documented. From May 2002 to September 2007, registered nurses received 2,704 of the 5,656 awards provided through EDRP, or almost half of all awards. Seventy five percent of nurses and pharmacists receiving those awards were still employed by VA 5 years after the conclusion of their service periods.

VA has the statutory authority to pay individuals through EDRP on a monthly or annual basis. VA has chosen to do so once a year. This means that employees must currently make student loan payments monthly, and then are reimbursed at the end of the year. Also, the statute allows VA to define "recently appointed" but does not specify how a potential recipient is made aware of the program, or when they would be notified of an award.

VA has determined that an employee is recently appointed if the employee has held the position for less than 6 months. Therefore, after 6 months of employment with VA, an employee is no longer eligible to apply for the program. Awards are made for 1 to 5 years. Majority Committee staff have been told during oversight visits that qualifying potential employees do not currently routinely receive offers for loan repayment as part of VA's initial offer for employment.

Committee Bill. Subsection (a) of section 201 of the Committee bill would amend subsection (d) of section 7683 of title 38, so as to remove the statutory limit to loan repayment under the EDRP, thereby allowing VA to pay the full cost of tuition and qualifying costs for a health care worker's education.

Subsection (b) of section 201 of the Committee bill would further amend section 7682 of title 38 by adding a new subsection (d) which would require VA, to the maximum extent possible, to include in any offer of employment to an individual who would be eligible to participate in EDRP, information on their eligibility to participate in the program.

Subsection (c) of section 201 of the Committee bill would further amend section 7683 of title 38 to add a new subsection (e) which would require VA to select for participation in EDRP each individual who was provided notice that he or she would be eligible for and selected to participate in EDRP upon employment. The new subsection would also allow VA to offer participation in EDRP to individuals who did not receive such notice.

The Committee is aware of difficulties in determining award availability based on the variability in annual appropriations. The Committee therefore elected to qualify this provision, requiring the Secretary to meet these notice requirements "to the maximum extent practicable." Nevertheless, it is the Committee's expectation that the Secretary will provide this notice in the vast majority of cases, because, without such notice, EDRP cannot function as a recruitment incentive.

DAV, PVA, and AFGE testified in support of these provisions at the Committee's April 22, 2009, hearing on health legislation.

Sec. 202. Visual Impairment and Orientation and Mobility Professionals Education Assistance Program.

Section 202 of the Committee bill, which is derived from S. 793, would create a scholarship program for qualified individuals pursuing degrees or certificates in blind rehabilitation.

Background. According to Tom Zampieri, Director of Government Relations at the Blinded Veterans Association, there are 163,000 legally blind veterans in the United States, with 47,560 currently enrolled in VA. In addition, VA estimates that there are over 1 million low-vision veterans in the U.S., and incidences of blindness among the total veteran population of 24 million are expected to increase by about 40 percent over the next two decades. This is because the most prevalent causes of legal blindness and low vision are age-related, and the average age of the veteran population is increasing.

In addition to this aging population, DOD data compiled between 1999 and 2007 reported 182,828 eye injuries from all causes over a 10-year period and 4,970 evacuees from OIF and OEF operations with severe penetrating eye injuries. According to Tom Zampieri of the Blinded Veterans Association, with the growing numbers of wounded in both OIF and OEF who are entering the VA health care and benefits system today, 13.9 percent with a history of penetrating eye trauma and over 70 percent of traumatic brain injury (hereinafter, "TBI") patients with post trauma vision syndrome (hereinafter, "PTVS"), more of these highly skilled professionals are necessary and critical for VA. While the number of legally blind OIF and OEF veterans enrolled in the VA Blind Rehabilitative Service is approximately 135, VA has identified 585 with functional visual impairments that benefit from the rehabilitative skills of Blind Rehabilitative Outpatient Specialists (hereinafter, "BROS") and Blind Instructors.

The health care costs of blindness are high. According to the Blinded Veterans Association, research on blind and low vision Americans show they are at high risk of falls or making medication mistakes, which results in costly hospital admissions every year and a loss of their ability to live independently at home. Falls are the sixth leading cause of death in senior citizens and a contributing factor to 40 percent of all nursing home admissions with annual federal costs over $45,000 for each nursing home bed.

Tom Zampieri testified before the House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, on March 4, 2009, that falls are the sixth leading cause of death in senior citizens and a contributing factor to 40 percent of all nursing home admissions with annual federal costs over $45,000 for each nursing home bed. In the Framingham Eye Study, 18 percent of all hip fractures among senior citizens—about 63,000 hip fractures a year—were attributable to vision impairment. The cost of medical-surgical treatment for every hip fracture is over $39,000; if outpatient rehabilitation services prevented even 20 percent of these hip fractures, the annual federal savings in health care costs would be over $441 million. Essential outpatient, cost-effective services that would allow blind veterans to safely live independently at home are vitally important.

Blind rehabilitation training can help give blind veterans the ability to function independently in their surroundings. Tom

Zampieri also testified that, despite the demand for such services, there are only 39 filled BROS with 30 vacant positions. Only 19 U.S. universities in the nation offer training programs for training specialists to provide rehabilitation services and orientation and mobility instruction for blind persons. Six universities offer training in blind rehabilitation and 16 offer both blind instructor training and orientation and mobility education. The program for training Certified Vision Rehabilitation Therapists (hereinafter, "CVRT") and Certified Orientation and Mobility Specialists (hereinafter, "COMS") are located in programs that have academic internship positions at various VA Blind Centers but because of the cost of education and the higher compensation available in the private sector, students often enter private agency jobs after graduation.

Committee Bill. Section 202 of the Committee bill would amend title 38 by adding a new Chapter 75, entitled "Visual Impairment and Orientation and Mobility Professionals Education Assistance Program." This new chapter would consist of five new sections, described below.

New section 7501—entitled, "Establishment of scholarship program; purpose"—would, in subsection (a), subject to the availability of appropriations, establish a scholarship program to provide financial assistance to an individual accepted for enrollment or currently enrolled in a program of study leading to a certificate or degree in visual impairment or orientation and mobility or a dual degree in both such areas, at an accredited educational institution in the United States. Such individual would be required to enter into an agreement with the Secretary to receive such assistance.

Subsection (b) of new section 7501 would provide that the purpose of the scholarship program is to increase the supply of qualified blind rehabilitation specialists for VA and the Nation.

Subsection (c) of new section 7501 would require the Secretary to publicize the scholarship program established under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to institutions with high numbers of Hispanic students and to Historically Black Colleges and Universities.

New section 7502—entitled "Application and acceptance"—would, in subsection (a), require individuals applying and participating in the scholarship program to submit an application together with an agreement described in new section 7504, under which the participant would agree to serve a period of obligated service in the Department in return for payment of educational assistance. This section would define information that must be included with the application and agreement, including a fair summary of the rights and liabilities of an individual whose application is submitted and approved by the Secretary and a full description of the terms and conditions that apply to participation in the scholarship program and service in the Department.

Subsection (b) of new section 7502 would require the Secretary to notify an individual in writing upon the Secretary's approval of the individual's participation in the scholarship program.

New section 7503—entitled "Amount of assistance; duration"—would, in subsection (a), specify that the amount of financial assistance provided will be determined by the Secretary as that necessary to pay the tuition and fees of the individual. For individuals

enrolled in dual degree or certification programs, this provision would specify that the tuition and fees not exceed the amounts necessary for the minimum number of credit hours to achieve such dual certification or degree.

Subsection (b) of new section 7503 would allow funds under this new program to supplement other educational assistance providing that the total amount of assistance does not exceed the total tuition and fees for the academic year.

Subsection (c) of new section 7503 would set a maximum limit of $15,000 on the total amount of assistance provided under this chapter for an academic year to full-time students, and to part-time students at a ratio based on the relationship of the part-time study to full-time study. This section also would cap the total amounts of assistance under this program at $45,000.

Subsection (d) of new section 7503 would place the maximum duration of assistance provided under this chapter at not more than 6 years.

New section 7504—entitled "Agreement"—would require that an agreement between the Secretary and a participant in the scholarship program be in writing and signed by the participant.

Paragraph (1) of new section 7504 would mandate that the agreement contain the Secretary's agreement to provide the participant with financial assistance.

Paragraph (2) would require the participant's agreement to a number of conditions, including to accept the financial assistance, to maintain enrollment and attendance in an approved program of study, to maintain an acceptable level of academic standing, and to serve as a full-time VA employee for 3 years following completion of the program of study, with such service to be within the first 6 years after the participant has completed the program and received a degree or certificate.

Paragraph (3) would permit the Secretary to set any other terms or conditions that the Secretary determined to be appropriate for carrying out this chapter.

New section 7505—entitled "Repayment for failure to satisfy requirements of agreement"—would provide for repayment of the unearned amount of educational assistance when the terms of the agreement are not satisfied and would allow for the Secretary to waive or suspend repayment when noncompliance is due to circumstances beyond the individual participant's control or in the best interest of the United States. A discharge in bankruptcy under title 11 would not discharge an individual from his or her obligation to repay the Secretary if the discharge order were entered less than 5 years after the date of the termination of the agreement or contract on which the debt were based.

New chapter 75 of title 38 would be implemented not later than 6 months after the date of enactment of the Committee bill.

DAV, PVA, and AFGE testified in support of these provisions at the Committee's hearing on health legislation on April 22, 2009.

Sec. 203. Inclusion of Department of Veterans Affairs Facilities in List of Facilities Eligible for Assignment of Participants in National Health Service Corps Scholarship Program.

Section 203 of the Committee bill, which is derived from S. 734, would require VA to transfer funds to the Department of Health

and Human Services for the purpose of making VA facilities eligible for assignment of National Health Service Corps scholars.

Background. The Department of Health and Human Services offers a number of programs designed to improve recruitment and retention in underserved areas known as health professional shortage areas. HPSAs are areas designated to have provider shortages based on geography, population groups or facilities with access barriers to primary care services.

Section 254 of title 42, United States Code permits the Secretary of Health and Human Services to designate any public or nonprofit private medical facility a HPSA if the facility otherwise meets certain criteria. Section 254e(a)(2) expressly defines public or nonprofit private medical facilities to include Federal medical facilities. Section 254e(b) also authorizes the Secretary of Health and Human Services to establish regulations governing the designation of medical facilities as HPSAs.

The Health Care Safety Net Amendments of 2002, Public Law 107–251, granted automatic HPSA designations to all federally qualified health centers. This automatic designation granted to those facilities the right to recruit physicians through the National Health Service Corps (hereinafter, "NHSC"). There is currently no statutory barrier to VA facilities being designated HPSA sites.

The NHSC Scholarship Program, through scholarship and loan repayment programs, helps HPSAs throughout the country attract medical, dental and mental health providers. Since 1972, it is estimated that more than 30,000 clinicians have served in the Corps.

The NHSC is a competitive program that pays tuition and fees and provides a living stipend to students enrolled in accredited medical (Medical Doctor or Doctor of Osteopathy), dental, nurse practitioner, certified nurse midwife and physician assistant training. Upon graduation, scholarship recipients serve as primary care providers between 2 and 4 years in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site.

Currently, psychiatry is a qualifying NHSC occupation, and VA has listed this as its hardest specialty to fill. Also, no VA sites are listed on the NHSC placement list.

Committee Bill. Section 203 of the Committee bill, in a free-standing provision, would mandate that VA transfer $20 million to the Department of Health and Human Services for the purpose of including VA facilities on the list maintained by the Health Resources and Services Administration of facilities eligible for assignments of participants in the National Health Services Corps. This would enable veterans' health care facilities, which would otherwise not be able to apply for the Corps scholar placement, to do so.

In testimony before the Committee on February 26, 2009, Kara Hawthorne, Director of the Office of Rural Health for the Veterans Health Administration, said:

> Every day, almost 60 million Americans in rural and highly rural areas face numerous challenges regarding health care, but one of the most significant in this area is a shortage of providers—particularly specialty providers. Recruitment and retention of health care professionals in rural areas is a national problem, not a VA-specific problem.

Sec. 204. Teleconsultation and Telemedicine.

Section 204 of the Committee bill, which is derived from S. 734, would promote the increased utilization of teleconsultation and telemedicine by requiring all Veterans Integrated Service Networks (hereinafter, "VISNs") to fully implement the existing teleretinal imaging program, to use telehealth technologies for the screening of TBI and post traumatic stress disorder (hereinafter, "PTSD") patients in areas where these services are not otherwise available, and by providing appropriate financial incentives for program development.

Background. For decades, telemedicine has been considered a means of overcoming barriers to providing rural health care. According to Dr. Michael Hatzakis et al., a VA physician writing in the Journal of Rehabilitation Research and Development in May/June 2003, experimental programs in telehealth were funded through existing grants on Indian reservations, in psychiatric hospitals, in the prison systems, and in medical schools between the 1950s and the 1970s. Dr. Hatzakis also noted that none have survived, reflecting in part, a failure to secure financial self-sufficiency. In recent years, technological advances have improved the cost-effectiveness of telemedicine technologies. For example, costs for a telemedicine workstation were $50,000 to $100,000 in the mid–1990s, but less than $10,000 by the year 2000.

Unlike private health care organizations, VA is not limited by interstate licensure limitations. Therefore, there is no concern regarding the practice of medicine across state lines. Yet telehealth services are not widely used, even in VA. In FY 2008, for example, VA provided ambulatory services to a total of 4,901,797 veterans. But a telehealth technology allowing health care workers to monitor veterans' chronic diseases while the veteran was at home was used on only 36,400 patients. This is less than one percent of all veterans treated on an outpatient basis.

In addition, while VA provides telemedicine services utilizing real time conferencing between VA medical centers and community based outpatient clinics (hereinafter, "CBOCs"), it is not universally available. Currently, VA provides these services to some degree at most VA medical centers, but only at 353 out of a possible 679 CBOCs.

Under another program, VA provided general telehealth services using real time conferencing to an estimated 48,000 veterans, 29,000 of which utilized the services for mental health purposes. Adam Darkins, Chief Consultant, Office of Care Coordination, in the Office of Patient Care Services, noted that outcomes data for tele-mental health have demonstrated a 24.6 percent reduction in hospital admissions and a 24.4 percent reduction in bed days of care when these services are utilized.

VA also offers teleretinal imaging at some facilities. This is a method of taking digital images of the retina of the eye and transmitting them to eye specialists remotely who are able to interpret the images and diagnose disorders of the eye from those images. In FY 2008, VA had these services available at only 130 of its CBOCs.

In a March 2007 position statement, the American Telehealth Association said:

> There is a growing consensus that the supply of health care providers across the professions is going to be inadequate to meet the expanding needs for health care of the U.S. population—both in the short term and in the long term. Telehealth, while not the entire solution to the problems presented by the shortage and maldistribution of health care providers, can make important contributions to alleviating those problems.

The ability of CBOCs to offer specialty services is particularly important to the needs of returning OEF/OIF veterans, many of whom return to remote areas with conditions like PTSD or TBI. In RAND's 2008 report, *Invisible Wounds of War: Summary and Recommendations for Addressing Psychological and Cognitive Injuries,* RAND estimated that there were approximately 300,000 servicemembers who had been deployed for OIF/OEF suffering from PTSD or major depression and that 320,000 servicemembers reported experiencing a probable TBI during deployment.

According to the report, among those with PTSD or major depression, only 53 percent had seen a physician or mental health provider for a mental health disorder in the past 12 months and those who received care, just over half had received minimally adequate treatment.

Captain Constance Walker, President of the Southern Maryland Chapter of the National Alliance on Mental Illness, testified before the Committee on October 24, 2007, that:

> * * * the likelihood of obtaining specialized services [for PTSD and serious mental illnesses] on a consistent basis is very small for veterans living in rural and frontier areas beyond a reasonable commute to a VA Medical Center or without access to an appropriately and consistently staffed VA Community Based Outpatient Clinic.

Tom Loftus, an American Legion Post Commander, also testified before the Committee on February 26, 2009, regarding the lack of availability of TBI and PTSD assessments in small communities.

According to the National Rural Health Association, it has been estimated that about 20–23 percent of the U.S. population live in rural areas, but only 9–11 percent of physicians practice in rural areas. Among 1253 communities designated as Mental Health Professional Shortage Areas in 2007, for example, almost 75 percent did not have a psychiatrist. For this reason, VA psychiatrists, writing in the Journal of Academic Psychiatry in November 2007, recommended ensuring competency in telemedicine technologies as part of a curriculum designed to emphasize rural practice in psychiatry residency training.

In addition, there is a need for more eye care services in rural areas. According to Dr. Anthony A. Cavallerano, and Dr. Paul R. Conlin, VA physicians writing in the Journal of Diabetes Science and Technology in January 2008, diabetic retinopathy, a condition of the eye resulting from diabetes, is the most common cause of visual loss in the U.S. These physicians further noted that only 60 percent of persons with diabetes receive timely and appropriate eye examinations. In FY 2000, Congress recognized the importance of making eye care accessible to all veterans when, in Senate Report 106–410 to accompany the 2001 Department of Veterans Affairs

and Housing and Urban Development, and Independent Agencies Appropriations Bill of 2001 (Public Law 106–271), the Appropriations Committee recommended that VA collaborate with the DOD and the Joslin Diabetes Center to implement the Joslin Vision Network. This collaboration created a system allowing specialists at a remote location to detect diabetic retinopathy and other eye conditions by reviewing images transmitted across a telecommunications network. Since that time, the program has expanded to assist in providing eye care to almost 20 percent of VA's diabetic veteran population.

In 2001, VA convened an expert panel to evaluate teleretinal imaging to screen for diabetic retinopathy. In a statement regarding the implementation of VA's teleretinal program, this panel said:

> The VHA envisions developing and deploying a nationwide teleretinal imaging system that will be regionalized by VISN and will build on the VHA's robust information technologies for acquiring, transmitting, interpreting, and storing digital retinal images * * *. A similar system for screening for [diabetic retinopathy] has been established in the United Kingdom.

The Committee is concerned that the VISNs currently have no financial incentive to invest in this important technology. The Veterans Equitable Resource Allocation (hereinafter, "VERA") system is the method VA uses to distribute resources among its 21 VISNs. It distributes funds to each VISN based both on patient workload, as well as on the complexity of care provided. This system allocated $31.8 billion in general purpose funds during FY 2009. Currently, VERA does not factor all telemedicine and telehealth visits into its workload data.

Committee Bill. Section 204 of the Committee bill would amend subchapter I of chapter 17 of title 38 by adding a new section 1709, entitled "Teleconsultation and teleretinal imaging."

Subsection (a) of new section 1709 would require VA to carry out a program of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that would not otherwise be able to provide these assessments without using outside providers. VA would be required to consult with appropriate professional services in the development of technical and clinical care standards for the use of teleconsultation services by VA.

Subsection (b) of new section 1709 would require the Secretary to carry out a program of teleretinal imaging—defined as a health care specialist using telecommunications, digital retinal imaging, and remote image interpretation to provide eye care—in each VISN.

The Committee believes that mandating that VA carry out such a program in each VISN is necessary, particularly in light of a recent decision by VA to halt 45 Information Technology projects, including telehealth projects, that were either over budget or behind schedule. Although the Committee agrees that IT projects should be well-managed and resourceful, appropriate priority and focus need to be given to projects that hold the promise of delivering necessary patient care, including telehealth projects. On a recent over-

sight visit, it became clear that in certain areas, the number of telehealth visits is declining rather than increasing.

Subsection (c) of new section 1709 would require that the Secretary submit a report in each of fiscal years 2010 through 2015 to Congress on the teleconsultation and teleretinal imaging programs. Such report shall include a description of the efforts made by the Secretary to make available and utilize teleconsultation in rural areas, and the rates of utilization of teleconsultation by VISNs.

Subsection (b) of section 204 of the Committee bill would require each VA facility that is involved in the training of medical residents to work with their affiliated universities to develop elective rotations in telemedicine for such residents.

Subsection (c) of section 204 of the Committee bill would require VA to include telemedicine and telehealth visits in calculations of facility workload. It also would require the Secretary to provide incentives through the Department's resource allocation process for networks which utilize telemedicine and telehealth services.

In testimony before the Committee on April 22, 2009, VA supported this section of the Committee bill.

Sec. 205. Demonstration Projects on Alternatives for Expanding Care for Veterans in Rural Areas.

Section 205, which is derived from S. 658, would authorize VA to develop pilot programs using innovative strategies to provide health care to rural areas.

Background. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009, Public Law 110–329, appropriated $250 million to VA to carry-out rural veterans' health care demonstration projects. These funds have been used to expand telehealth initiatives, deploy mobile clinics, open new CBOCs and fund numerous other innovative ways of delivering health care to veterans in rural and highly rural areas. Similar funding is included in the Fiscal Year 2010 version of the bill.

When VA receives funding for demonstration projects without those projects being prescribed by legislative action, VA can solicit ideas from the field and choose the best ideas for implementation. With the $250 million VA received in FY 2009 to fund rural health initiatives, for example, VA implemented projects partnering with the community to improve outreach, developed better ways of monitoring intensive care units and expanded telehealth initiatives.

Committee Bill. Section 205, in a freestanding provision, would authorize the Secretary to carry out demonstration projects on alternatives for expanding rural veterans' health care.

This provision would allow VA to consider innovative strategies for providing health care services to veterans who reside in rural and highly rural areas. These demonstration projects could include VA partnership with the Centers for Medicare and Medicaid Services to coordinate care for veterans in rural areas at critical access hospitals; VA partnership with the Department of Human Services to coordinate care for such veterans in community health centers; and increased coordination between VA and Indian Health Service to expand care for Indian veterans. The Secretary would ensure that the demonstration projects are located at facilities that are geographically distributed throughout the United States.

The Committee expects VA to solicit proposals directly from field facilities so as to encourage local innovation.

Section 205 of the Committee bill also requires VA to report to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the Appropriations Committees of the House of Representatives and the Senate on the implementation of these projects 2 years after the date of enactment of this Act.

Sec. 206. Program on Provision of Readjustment and Mental Health Care Services to Veterans Who Served in Operation Iraqi Freedom and Operation Enduring Freedom.

Section 206, which is derived from S. 658, would mandate that VA provide peer outreach and certain services to family members and of returning veterans and members themselves through Vet Centers.

Background. There is a significant need for mental health providers throughout rural America, and VA and private practice often find themselves competing for the same pool of prospective employees. A recent report by the Inspector General found that, as a result of providing VA with authority to contract-out mental health services, the percentage of veterans within 30 minutes' drive of a mental health therapist or medication management rose from 60 percent to 90 percent.

These services are particularly important, considering the numbers of Guard and Reservists returning to remote areas without the services found on a military base.

Committee Bill. Section 206, in a freestanding provision, would require VA, not later than 180 days after the date of enactment of this Act, to establish a program to provide certain mental health services to veterans of OIF and OEF, especially those who served in the National Guard and Reserves, and to their immediate families.

Under this program, VA would be required to provide peer outreach services, peer support services, readjustment counseling services, and mental health services to veterans.

For immediate family members of such veterans during the 3-year period following a veteran's return from OIF/OEF, VA would be required to provide education, support, counseling and mental health services to assist in the readjustment of such veterans to civilian life; in the recovery of any veteran sustaining an illness or injury during deployment; and in the readjustment of the family following the return of such veteran.

Subsection (b) would require VA to contract with community mental health centers and other qualified entities to furnish services under the program in areas that VA determines are not adequately served by VA facilities. The community entities would be required, to the extent practicable, to use telehealth services and employ veterans trained to provide peer outreach and peer support.

The community entities would be required to provide VA with clinical summary information for each veteran furnished mental health services. The community entities would be required to participate in specified VA training and comply with applicable VA protocols before incurring any liability on behalf of VA for the provision of services under the program.

Subsection (c) would require VA to contract with a national not-for-profit mental health care organization to carry out a national program of training for veterans providing certain mental health services. VA would also be required to provide training programs for clinicians of community entities providing services under this program to ensure that such clinicians can furnish services in a way that recognizes factors unique to OIF/OEF veterans.

VA would be required to submit a report, not later than 45 days after the date of enactment of this Act, to the Committees on Veterans' Affairs of the House of Representatives and Senate which contains VA's plan for implementing this program.

The provisions in this section of the Committee bill are not intended to replace the VA as a mental health provider for veterans, but rather to address a practical need in rural areas by providing a clear authority to contract for mental health services for OIF/OEF veterans in rural areas, when mental health services from VA are not available.

Sec. 207. Improvement of Care of American Indian Veterans.

Section 207 of the Committee bill, which is derived from S. 658, would improve coordination between IHS and VA with respect to the treatment of American Indians, as well as the sharing of information and transfer of surplus equipment.

Background. American Indians have a long history of service in the U.S. military, dating back to the American Indians who served alongside General George Washington. According to the DOD, per capita, American Indians and Alaska Natives are more likely to serve in the military than any other major racial or ethnic group. According to VA, American Indian and Alaska Native veterans are nearly 50 percent more likely than the average veteran to have a confirmed service-connected disability, and studies from the National Center for PTSD have found that American Indian veterans may be at a much-higher risk of PTSD. There is an obvious additional need for primary care and mental health services within this population. Despite a clear and historic participation in the military and current need for medical attention related to their service, American Indian veterans continue to face additional barriers to receiving quality care.

American Indian veterans who reside in rural communities and on reservations often suffer disproportionate adverse health outcomes due to access limitations and under-resourced health care infrastructure. While IHS facilities are often more accessible to American Indian veterans, a lack of resources such as medical equipment and information technology limits the quality of care. Also, existing barriers between VHA and IHS in areas such as record-sharing have a negative impact on veterans who receive care at VHA and IHS. Additionally, there is a clear need to resolve cultural barriers that too often limit the effectiveness of VA care given to American Indian veterans. Improved collaboration and partnership between VA and IHS can improve care. Some VA facilities are making progress addressing these issues through the use of coordinators who address care issues for American Indians in a culturally-competent fashion.

Committee Bill. Section 207 of the Committee bill would amend subchapter II of chapter 73 by adding a new section 7330B—enti-

tled "Indian Veterans Health Care Coordinators"—which would require VA to assign certain VA employees to the position of Indian Health Coordinator in each of the 10 VA Medical Centers that serve communities with the greatest number of Indian veterans per capita. These Coordinators would improve outreach to tribal communities; coordinate the medical needs of Indian veterans; expand the access and participation of the Department, the IHS, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program; act as ombudsmen for Indian veterans enrolled in the health care system of the VHA; and advocate for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

This section of the Committee bill, in a freestanding provision, would require that not later than 1 year after the date of enactment of this Act, VA and the Department of Health and Human Services would enter into a Memorandum of Understanding to ensure that the health records of Indian veterans may be transferred electronically between VA and IHS.

This section of the Committee bill, in a freestanding provision, would authorize VA to transfer surplus medical and information technology equipment to the IHS. VA would be authorized to transport and install medical or information technology equipment in IHS facilities. This section would provide that not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of Health and Human Services shall jointly submit to Congress a report on the feasibility and advisability of the joint establishment and operation by VHA and IHS of health clinics on Indian reservations to serve the populations of such reservations, including Indian veterans.

Sec. 208. Travel Reimbursement for Veterans Receiving Treatment at Facilities of the Department of Veterans Affairs.

Section 208, which is derived from both S. 658 and S. 734, would allow VA to adjust mileage rates and compensate veterans for airfare when that is the only practical way to reach a VA facility.

Background. Under section III of title 38, VA is authorized to pay for an eligible veteran's travel to and from a facility for the purpose of examination, treatment or care. In addition to mileage amounts, VA can reimburse a veteran for the actual cost of ferry fares, and bridge, road and tunnel tolls. The statute does not authorize reimbursement for airfare.

There are occasions when veterans must travel by air to receive health care, either because their physical condition requires it, or because that is the only practical way to reach a facility. States such as Hawaii and Alaska, for example, have unique geography requiring veterans to travel by air in order to obtain certain health care services. The expense of such services is often well beyond the means of the veterans who need these services.

Committee Bill. Subsection (a) of section 208 of the Committee bill would amend section 111 of title 38, relating to VA payment of an allowance for certain travel, in two ways. First, it would amend subsection (a) of section 111 to insert a specific reimbursement rate—41.5 cents per mile. Second, it would amend subsection (g) of section 111 so as to, beginning 1 year after the date of enact-

ment of this Act, permit the Secretary to adjust the newly specified mileage rate for travel reimbursement so that that rate would be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business. If such an adjustment would result in a lower mileage rate than that which would be specified in subsection (a) of section 111, the Secretary would be required to submit to Congress, no later than 60 days before the implementation of the revised mileage rate, a report setting forth the justification for the decision to adjust the rate.

Subsection (b) of section 208 of the Committee bill would further amend subsection (a) to specify that the actual necessary expense of travel would include travel by air if such travel is the only practical way for the person traveling to reach a VA facility.

Subsection (c) of section 208 of the Committee bill would amend subsection (b)(1)(D)(i) to affect the limitation on travel eligibility related to pension rate.

Subsection (d) of section 208 of the Committee bill would amend subsection (b) of section 111 by adding a new paragraph (4) which would require the Secretary to consider the medical condition of the veteran and any other impediments to ground transportation in determining whether travel by air is the only practical way to reach a VA facility.

Subsection (e) of section 208 of the Committee bill would specify that the amendments to section 111 of title 38 made by subsections (b) and (d) of section 208 of the Committee bill, relating to travel by air, cannot be construed as expanding or modifying eligibility for payments or allowances for beneficiary travel.

Subsection (f) of section 208 of the Committee bill would require VA, not later than 30 days after enactment of this legislation, to reverse the VHA handbook to clarify that an allowance for travel based on mileage paid under section 111(a) of title 38 may exceed the cost of such travel by public transportation regardless of medical necessity.

The Committee believes it is an issue of equity to include travel by air. Expenses associated with air travel are generally much greater than those associated with ground transportation. For example, the average cost of travel by air is $60 per hour. Assuming mileage rates of 41.5 cents per mile at an average of 60 miles per hour, a vehicle can be operated for less than half the cost of airfare. Veterans traveling by air deserve special consideration regarding compensation for travel.

Sec. 209. Office of Rural Health Five-Year Strategic Plan.

Section 209 of the Committee bill, which is derived from S. 734, would require VA's Office of Rural Health to develop a 5-year strategic plan.

Background. In 2006, Public Law 109–461 established the VA Office of Rural Health (hereinafter, "ORH"). One of ORH's functions is to improve health care for veterans living in rural areas by developing best practices. In both FY 2008 and FY 2009, VA received $250 million for rural health initiatives.

While VA has spent these funds on a variety of innovative pilot projects, it is important that ORH develop a strategy that will address the needs of veterans living in rural areas for years to come.

Providing health care to veterans in rural areas is a national problem, not just a VA problem, and careful stewardship of available resources is important so as to ensure that VA meets the needs of the greatest number of veterans possible.

Committee Bill. Section 209 of the Committee bill, in a free-standing provision, would require the Director of the Office of Rural Health to develop a 5-year strategic plan for the ORH not later than 180 days after the date of enactment of this Act. This provision would require that the plan contain specific goals for the recruitment and retention of health care personnel in rural areas; it be developed in conjunction with the Director of the Health Care Retention and Recruitment Office of the Department of Veterans Affairs; it include specific goals for ensuring the timeliness and quality of health care delivery in rural communities by contract and fee-basis providers, developed in conjunction with the Director of the Office of Quality and Performance of the Department; it include specific goals for the expansion and implementation of telemedicine services in rural areas, developed in conjunction with the Director of the Office of Care Coordination Services of the Department; and it set incremental milestones describing specific actions to be taken to achieve the goals described above.

The Committee expects that these provisions will ensure that ORH engages in sound fiscal planning with respect to the additional funds appropriated by Congress for rural health care development.

PVA testified in support of this provision at the April 22, 2009, health legislation hearing.

Sec. 210. Oversight of Contract and Fee-Basis Care.

Section 210 of the Committee bill, which is derived from S. 734, would create incentives for providers paid by VA through contracts or on a fee-for-service basis to implement certain quality improvement measures.

Background. In FY 2008, VA spent over $244 million for contracted outpatient care, and over $1.2 billion for outpatient fee-basis care. For providers paid on a fee-for-service basis, VA measures the timeliness of claims processing but does not otherwise monitor the quality of patient care provided in a systematic way.

In February 2007, the NRHA wrote in an issue paper addressing the quality of care provided to rural veterans:

> The NRHA calls on the VA and VHA to extend through these contracts access for rural health providers and facilities to the VA's exemplar[y] health care quality improvements systems.

The NRHA also called on VA to improve coordination between community health providers and VA in rural areas.

VA currently requires some indicators for services purchased by contract under Project Hero related to timeliness and access to care, but does not otherwise have uniform quality measures in place in all contracts for the provision of medical services. In the *FY 2010 Independent Budget*, the Independent Budget Veteran Service Organizations (hereinafter, "IB VSOs") recommended that VA develop a set of quality standards to ensure that contract pro-

viders maintain the same quality of care as VA health care providers.

Committee Bill. Section 210 of the Committee bill would amend subchapter I of chapter 17 by adding a new section, section 1703A—entitled "Oversight of contract and fee-basis care"—so as to provide for increased attention to the management of contract and fee-basis care in rural areas.

Subsection (a) of new section 1703A would require the Secretary to designate a rural outreach coordinator at each CBOC where at least 50 percent of the veterans enrolled reside in a highly rural area. These coordinators would be responsible for coordinating care at and through the CBOC and collaborating with providers in the community who furnish care to enrolled veterans on fee-basis or under a contract.

Subsection (b) of new section 1703A would mandate that the Secretary adjust fee-basis compensation paid to community providers in order to encourage such providers to obtain accreditation from recognized accrediting entities of their medical practice. In making the adjustments in compensation, the Secretary would be required to consider the increased costs of acquiring and maintaining such accreditation.

Subsection (c) of new section 1703A would require the Secretary to adjust the fee-basis compensation of health care providers which are not accredited by a recognized accreditation entity to provide incentives for those providers to participate in a voluntary peer review program. In making the adjustments in compensation, the Secretary would be required to set such amounts as would be reasonably expected to encourage participation in voluntary peer review.

Subsection (d) of new section 1703A would require VA to provide for the voluntary peer review of health care providers which provide health care services to VA on a fee basis and are not accredited by a recognized accrediting entity.

The Chief Quality and Performance Officer (hereinafter, "CQPO") in each VISN would be responsible for the oversight of this effort and would select a sample of patient records from each participating entity to be peer reviewed by a facility designated by the CQPO for such role.

Each Department facility conducting peer review of community providers would be required to review the records in accordance with policies and procedures established by the Secretary, ensure that peer reviews are evaluated by the facility's Peer Review Committee, and develop a mechanism for notifying the Under Secretary for Health of any problems identified through peer review.

The Under Secretary for Health would be required to develop a mechanism to terminate the use of fee-basis providers when quality of care concerns are identified through the peer review process.

At the Committee's April 22, 2009, health legislation hearing, AFGE, DAV, NRHA and PVA testified in support of these provisions. These provisions are also consistent with the recommendations contained in the *Independent Budget*.

Sec. 211. Enhancement of Vet Centers to Meet Needs of Veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

Section 211 of the Committee bill, which is derived from S. 734, would allow VA to use volunteers and other individuals to provide readjustment counseling, and to expedite the credentialing and privileging of licensed independent health care providers working on a volunteer basis in readjustment counseling centers.

Background. In recognition that a significant number of Vietnam-era veterans were experiencing readjustment problems, in 1979, VA established the readjustment counseling service which created readjustment counseling centers, or "Vet Centers." Congress has since made readjustment counseling services available to veterans serving during other periods of armed hostilities.

Section 1712A of title 38 requires the Secretary to furnish readjustment counseling, which may include mental and psychological assessments, upon the request of veterans who served on active duty in a theater of combat operations or in any area in which a period of hostilities occurred. If an assessment completed by a physician or psychologist determines that mental health services are necessary to facilitate the successful readjustment of veterans to civilian life, services will be provided by the Department.

Currently, clinical professionals who work in Vet Centers are required to undergo credentialing and privileging procedures in accordance with policies of VA. There is no distinction between paid and volunteer counselors. As previously noted, there is a national and VA-specific shortage of mental health care providers.

Committee Bill. Section 211 of the Committee bill would amend Subsection (c) of section 1712A of title 38, relating to VA's readjustment counseling authority, to allow VA to use volunteer counselors in the provision of readjustment counseling and related mental health services.

To serve as a volunteer counselor at a Vet Center, an individual would have to be a licensed psychologist or social worker who had never been named in a tort claim arising from professional activities and also had never had or have pending against them, any disciplinary action taken with respect to any license or certification qualifying the individual to provide counseling services.

Eligible volunteer counselors would be issued credentials and privileges for the provision of counseling and related mental health services on an expedited basis, not later than 60 days from the date the application is submitted.

Subsection (b) of section 211 of the Committee bill would amend subsection (e) of section 1712A so as to require each Vet Center to develop an outreach plan to ensure that the community served by the center is made aware of the services offered by the center.

The Committee is committed to ensuring that every attempt is made to add more providers to the VA health care system. Those individuals who provide high quality health care services and who voluntarily give their time and professional talents to care for veterans should not be unduly burdened by cumbersome bureaucratic processes. By streamlining the credentialing and privileging processes for those select providers, the Committee hopes to attract more high quality health care professionals to VA's health care system.

Sec. 212. Centers of Excellence for Rural Health Research, Education, and Clinical Activities.

Section 212, which is derived from S. 658, would create VA Rural Health Centers of Excellence.

Background. Veterans who reside in rural areas often have worse health outcomes than veterans residing in urban areas. For example, in FY 2005 and FY 2006, the rate of suicide for veterans last utilizing a rural VA facility was 39.7/100,000 persons per year compared to 35.0/100,000 persons per year for urban veterans. Research sponsored by VA's Health Services Research and Development division has cited worse health outcomes and health quality of life scores among rural veterans compared to urban veterans, and favorably recommended innovative approaches to improve access to care and quality of care in those areas.

Committee Bill. The Committee bill would amend subchapter II of chapter 73, as amended by section 214, to add a new section 7330C, entitled "Centers of excellence for rural health research, education, and clinical activities."

Under new section 7330C, the Secretary, through the Director of the Office of Rural Health, would be required to establish and operate at least one but not more than five centers of excellence for the conduct of research, education, and clinical activities relating to health services in rural areas.

These centers would be required to develop specific models to be used in furnishing health services to veterans in rural areas, provide education and training for health care professionals on the furnishing of health services to veterans in rural areas, and develop and implement innovative clinical activities and systems of care for VA for the furnishing of health services to veterans in rural areas.

VA would be permitted to designate an existing rural health resource center as a center of excellence. These centers of excellence would be required to be geographically dispersed throughout the United States.

Subsection (d) of new section 7330C would authorize the appropriation of such sums as may be necessary to support the research and education activities of the centers of excellence and would authorize the Under Secretary for Health to allot to the centers funds appropriated to VA's Medical Care and Medical and Prosthetic Research accounts.

This subsection would also specify that clinical and scientific investigation activities at each center would be eligible to compete for awards of funding from the Medical and Prosthetics Research Account, and would receive priority for funds awarded to projects for research in the care of rural veterans.

The Committee believes that creating these centers will significantly enhance VA's ongoing efforts to meet the health care needs of veterans residing in rural areas.

Sec. 213. Pilot Program on Incentives for Physicians Who Assume Inpatient Responsibilities at Community Hospitals in Health Professional Shortage Areas.

Section 213, which is derived from S. 734, would create a pilot program allowing VA physicians to provide care to veterans admit-

ted to community hospitals, and providing financial incentives for them to do so.

Background. The Census Bureau estimates that 8 percent of the population as a whole are veterans. The DOD does not track whether its veterans return to rural or urban areas, and there are no consistent Federal-wide definitions of a "rural" population. VA uses the Census Bureau's definition of rural. Using this definition, about 39 percent of current veterans enrolled in the VA health care system reside in rural areas and 1.6 percent reside in highly rural areas.

The high number of veterans returning to rural areas will likely continue with the newest generation. According to the National Rural Health Association's February 2007 Issue Paper, 44 percent of new military recruits came from rural areas. In contrast, just 25 percent of the U.S. population is considered rural.

As a result, there are far fewer VA inpatient facilities located in rural areas. For example, in FY 2008, VA had 633 mental health beds in facilities operating in rural areas, compared to 4,088 mental health beds in facilities operating in urban areas. Building additional facilities in rural areas is problematic because rural veterans are, by definition, dispersed over a wide area. VA stated in a February 26, 2009, response to questions posed at the Committee's rural health hearing:

> Although the cumulative number of veterans living in rural areas is high, the number living in any specific rural area is relatively low. The need for high intensity, low frequency health care services such as admission to an inpatient mental health unit is likely to be variable.

VA must obtain care for veterans in many of these areas by paying community hospitals on a contractual or fee-for-service basis. This means that veterans treated and monitored by VA doctors in VA community based outpatient clinics must be treated by a non-VA doctor when admitted to a community hospital. This is because VA doctors do not have privileges at community hospitals because such facilities require that a physician occasionally accept responsibility for caring for patients needing hospital admission that do not otherwise have a doctor. Currently, VA doctors are not clearly authorized to see non-veteran patients, even if it is a condition of their ability to treat veterans in community hospitals.

Committee Bill. Section 213 of the Committee bill, in a free-standing provision, would require VA to carry out a pilot program to assess the feasibility and advisability of (1) providing financial incentives to VA physicians who obtain and maintain inpatient privileges at certain community hospitals, and (2) the collection of payments from third parties for care provided by any such physicians to nonveterans while carrying out their responsibilities at the community hospital where they are privileged.

The community hospitals that would be involved in the pilot program would be in health professional shortage areas where the number of physicians willing to assume inpatient responsibilities at the hospital is sufficient for the purposes of the pilot program. Eligible physicians would be primary care or mental health physicians employed by VA on a full-time basis who are in good standing with the Department, and who have primarily clinical responsibilities

with the Department. Participation in the pilot program would be voluntary.

The pilot program would be carried out during the 3-year period beginning on the date of the commencement of the pilot program in not less than five community hospitals in each of not less than two VISNs. The locations would be selected by the Secretary based on the results of a survey of eligible physicians to determine the extent of interest of such physicians in participating in the pilot program.

The survey, which would be conducted not later than 120 days after the date of enactment of this Act, would be required to disclose the type, amount and nature of the financial incentives to be provided to physicians participating in the pilot program.

Physicians selected for the program would be required to assume and maintain inpatient responsibilities at one or more community hospitals selected by the Secretary for participation in the pilot.

Any physician participating in the pilot program who would be required to see non-veteran patients as a condition of obtaining privileges would be deemed to be acting in the scope of the physician's office or employment for purposes of the Federal Torts Claim Act.

The Secretary would be required to compensate eligible physicians participating in the pilot program with additional compensation as the Secretary considers appropriate for the discharge of inpatient responsibilities by such physician at a community hospital. The amount of such compensation would be set forth in a written agreement between VA and the physician.

The Secretary would be required to consult with the Director of the Office of Personnel Management regarding how any additional compensation would be treated for the purposes of retirement and other purposes under the civil service laws.

Subsection (i) of section 213 of the Committee bill would require VA to implement mechanisms to collect from third party payers for services provided by VA physicians to non-veterans as part of the pilot program.

Subsection (j) of section 213 of the Committee bill would define inpatient responsibilities as on-call responsibilities required by a community hospital as a condition of granting privileges to the physician to practice in the hospital.

Beginning not less than 1 year after the date of enactment of the Committee bill and annually thereafter, VA would be required to submit to Congress a report on the pilot program, including the Secretary's findings with regard thereto, the number of veterans and non-veterans provided inpatient care, and the amounts collected and payable.

NRHA, PVA and AFGE testified in support of this specific pilot program at the Committee's April 22, 2009, health legislation hearing.

The Committee's goal for this pilot program is to foster improved coordination between VA and community health organizations, as well as to ensure that veterans receive good continuity of care in the community. By allowing VA doctors to treat their VA patients admitted to community hospitals, the community and VA profit from the wise utilization of available health care resources.

Sec. 214. Annual Report on Matters Related to Care for Veterans Who Live in Rural Areas.

Background. According to VA, in FY 2008, contractual purchasing authority on outpatient care, including emergency room costs and inpatient ancillary costs, totaled $244,330,834. In FY 2008, VA also spent $1.27 billion on care provided on a fee-for-service basis.

Information on how and under what circumstances these expenditures are made is not readily available. As this portion of VA's budget continues to expand, improving oversight becomes very important. In the *FY 2010 Independent Budget*, the IB VSOs expressed concern regarding VA's inability to monitor quality of care provided by contract providers.

Committee Bill. Section 214 of the Committee bill, in a free standing provision, would require VA to submit an annual report on the implementation of the provisions in sections 209 through 213 of the Committee bill and on the establishment and functions of the Office of Rural Health. In the first such report, VA would be required to include assessment of the fee-basis health-care program required by section 212(b) of Public Law 109–461 and the outreach program required by section 213 of that Act.

Sec. 215. Transportation Grants for Rural Veterans Service Organizations.

Section 215, as derived from S. 658, would authorize grants to state veterans' service agencies and veterans' service organizations for the purposes of providing certain transportation services to veterans.

Background. Transportation is often a problem for many veterans when making and keeping health care appointments. Cancellation rates for outpatient appointments have historically been high within VA, and transportation issues are commonly cited as a contributing factor.

Veterans service organizations organize and offer van transportation services to veterans traveling to and from health care appointments. Their ability to offer these services, however, is often limited by the availability of funding. This is particularly true in areas where the distances between veterans' residences and VA facilities are great, such as in highly rural areas.

Committee Bill. Section 215, in a freestanding provision, would require VA to establish a grant program to provide innovative transportation options to veterans in highly rural areas. The recipients of grants under the program would be state veterans' service agencies and veterans' service organizations. Entities receiving a grant would be required to use the funds to assist veterans in highly rural areas with transportation to and from VA medical centers and to otherwise assist in providing medical care to veterans residing in highly rural areas.

The maximum amount of a grant under this program would be $50,000 and a recipient of a grant under this program would not be required to provide matching funds as a condition of receiving the grant.

The provision would authorize the appropriation of $3 million for each of the fiscal years 2010 through 2014 to carry out this grant program.

TITLE III—OTHER HEALTH CARE MATTERS

Sec. 301. Veterans' Emergency Care Fairness Act of 2009.

Section 301, which is derived from S. 404, would allow veterans who meet certain criteria to be reimbursed for the difference between the maximum amount payable for emergency medical services and any amount paid by an existing insurance policy.

Background. Under Public Law 110–387, originally enacted on November 30, 1999, a veteran who is enrolled in VA's health care system can be reimbursed for emergency treatment received at a non-VA hospital. However, the statute only permits such VA reimbursement if the veteran has no other outside health insurance, no matter how limited that other coverage might be. This sole payer provision means that a veteran who has any insurance is not entitled to reimbursement from VA for emergency medical treatment received at a non-VA facility, even if the veteran's insurance policy does not cover the full amount owed.

Committee Bill. Section 301 of the Committee bill would amend Section 1725(b)(3)(C) of title 38, relating to VA reimbursement to veterans enrolled for VA care who receive emergency care from outside providers. Subsection (a) of section 301 of the Committee bill would amend section 1725(b)(3)(C) of title 38 so as to strike the phrase "in whole or in part," in order to authorize VA to provide reimbursement for emergency care when the veteran has some insurance coverage but that coverage is not sufficient to cover the cost of the care. Under this change VA would be authorized to cover the difference between the amount a veteran's insurance will pay for emergency care and the total cost of care, thus becoming the payer of last resort in such cases.

Section 1725 is further amended by adding a new paragraph (4) to subsection (c) to specify that VA is to be a secondary payer, that payment by VA along with any insurance payment shall be payment in full, and that VA may not reimburse a veteran for any copayment the veterans owes a third party. These amendments would take effect on the date of enactment of this Act. In addition to amending current law in a prospective manner, Section 301 of the Committee bill, in a freestanding provision, would authorize VA to reimburse the cost of emergency care dating back to the effective date of the current law if the Secretary determines that it is appropriate to do so.

Sec. 302. Prohibition on Collection of Copayments from Veterans Who Are Catastrophically Disabled.

Section 302 of the Committee bill, derived from S. 821, would waive the collection of copayments from veterans who are catastrophically disabled.

Background. In 1996, when Congress passed legislation establishing the priority for enrolling veterans in VA's health care system, it designated catastrophically disabled veterans as Category 4. If these veterans' income would otherwise place them in Categories 7 or 8, they are required to pay all fees and copayments for the care of their non-service-connected disabilities. The IB VSOs recommend that copayments for catastrophically disabled veterans be eliminated in light of the unique health care needs of this popu-

lation. The veterans who would be affected by this change, such as those with spinal cord injury, require ongoing care and services.

Private insurers often do not cover these kinds of services, and most other health programs do not offer the level of care provided by VA. These veterans should not be required to pay fees and co-payments for their care, as they utilize and rely on VA health care at a much higher rate than many other veterans.

Committee Bill. Section 302 of the Committee bill would amend subchapter III of chapter 17 by adding a new section 1730A. New section 1730A—entitled, "Prohibition on collection of copayments from veterans who are catastrophically disabled"—would prohibit VA from collecting any copayment for the receipt of hospital care or medical services from a veteran who is catastrophically disabled, even if due to a non-service-connected injury.

The Committee intends that this provision eliminate all copayments for medical care, including prescriptions and nursing home care, for catastrophically disabled veterans.

DAV, PVA, and the National Multiple Sclerosis Society support this provision.

In a letter dated April 23, 2009, Blinded Veterans wrote the following:

> [This] legislation will eliminate these co-payments for severely disabled veterans who are blind, paralyzed, or suffered amputations, who often as non-service connected veterans live on small social security disability SSDI payments, and unable to pay for these admissions. With this change these disabled veterans will be able to access daily living blind or other rehabilitation training that will improve their ability to live independently at home.

TITLE IV—CONSTRUCTION AND NAMING MATTERS

Sec. 401. Major Medical Facility Project Department of Veterans Affairs Medical Center, Walla Walla, Washington.

Section 401, in a freestanding provision which is derived from S. 509, would authorize VA to design and construct a new multiple specialty outpatient facility, perform campus renovation and upgrades, and provide additional parking at the VA Medical Center, Walla Walla, Washington. According to VA, the project will serve nearly 50,000 enrolled veterans, and will be carried out in an amount not to exceed $71,400,000. These funds were already appropriated for this project in VA's fiscal year 2009 major construction budget.

Sec. 402. Merril Lundman Department of Veterans Affairs Outpatient Clinic.

Section 402, in a freestanding provision which is derived from S. 226, would allow for the VA outpatient clinic in Havre, Montana to be designated as the "Merril Lundman Department of Veterans Affairs Outpatient Clinic."

In 2007, Merril Lundman, a veteran from Havre, Montana, started a petition drive to ask for a clinic in Havre. Merril Lundman died in December 2007, about a month before VA announced it would open a clinic in Havre. As required by the Committee's rules, the full Montana Congressional delegation, and the Montana State

Veterans' Organizations with national membership of 500,000 or more, endorse this facility being named in honor of Merril Lundman.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the CBO, estimates that enactment of the Committee bill would, relative to current law, increase discretionary spending by almost $6.7 billion over the 2010–2014 period, assuming appropriation of the necessary amounts. Enacting the bill would increase direct spending but those effects would not be significant. Enactment of the Committee bill would minimally affect receipts and would not affect the budget of state and local governments. Tribal governments would see minimal impact from enactment.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 31, 2009.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 801, the Caregiver and Veterans Health Services Act of 2009.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure.

S. 801—Caregiver and Veterans Health Services Act of 2009

Summary: S. 801 would authorize new programs for caregivers of disabled veterans and make several changes to existing veterans' health care programs. In total, CBO estimates that implementing the bill would cost about $6.7 billion over the 2010–2014 period, assuming appropriation of the specified and estimated amounts. Enacting the bill would increase direct spending, but CBO estimates those effects would not be significant. Enacting the bill would not affect revenues.

S. 801 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (hereinafter, "UMRA").

Estimated cost to the Federal government: The estimated budgetary impact of S. 801 is shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted near the start of fiscal year 2010, that the authorized and estimated amounts will be appropriated each year,

and that outlays will follow historical spending patterns for existing or similar programs.

Table 1.—Budgetary Impact of S. 801, the Caregiver and Veterans Health Services Act of 2009

	By fiscal year, in millions of dollars—					
	2010	2011	2012	2013	2014	2010–2014
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [a]						
Assistance for Caregivers						
Estimated Authorization Level	125	249	913	1,509	2,154	4,950
Estimated Outlays	113	234	845	1,441	2,076	4,709
Rural Demonstration Projects						
Estimated Authorization Level	255	258	263	268	274	1,318
Estimated Outlays	230	255	261	266	272	1,284
Travel Reimbursements						
Estimated Authorization Level	22	45	91	92	93	343
Estimated Outlays	20	43	86	91	92	332
Education Assistance						
Estimated Authorization Level	22	30	41	51	62	206
Estimated Outlays	20	29	40	50	61	200
Medical Construction						
Authorization Level	71	0	0	0	0	71
Estimated Outlays	3	19	23	17	6	68
Copayments from Certain Disabled Veterans						
Estimated Authorization Level	8	8	8	8	8	40
Estimated Outlays	7	8	8	8	8	39
Transportation Grants						
Authorization Level	3	3	3	3	3	15
Estimated Outlays	3	3	3	3	3	15
Rural Centers of Excellence						
Estimated Authorization Level	2	2	2	2	2	10
Estimated Outlays	2	2	2	2	2	10
Coordinators of Care for Native American Veterans						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Training for Mental Health Providers						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Peer Reviews						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Emergency Care						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Other Provisions						
Authorization Level	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	1
Total Changes						
Estimated Authorization Level	512	599	1,325	1,937	2,600	6,974
Estimated Outlays	402	597	1,271	1,881	2,523	6,678

Note: * = less than $500,000.

[a] In addition to the effects on spending subject to appropriation shown in this table, CBO estimates that enacting S. 801 would increase direct spending by less than $500,000 over the 2010–2014 period and 2010–2019 period.

Spending subject to appropriation

CBO estimates that implementing S. 801 would cost $6.7 billion over the 2010–2014 period, assuming appropriation of the specified and estimated amounts.

Assistance for Caregivers. Title I would require the Department of Veterans Affairs (hereinafter, "VA") to provide several benefits to caregivers of certain disabled veterans. In total, CBO estimates that implementing those provisions would cost $4.7 billion over the

2010–2014 period, assuming appropriation of the necessary amounts (see Table 2).

Table 2.—Components of the Estimated Changes in Spending Subject to Appropriation Under Title I of S. 801

	By fiscal year, in millions of dollars—					
	2010	2011	2012	2013	2014	2010–2014
Stipends						
Estimated Authorization Level	14	33	401	838	1,313	2,599
Estimated Outlays	13	31	364	791	1,258	2,457
Travel Benefits						
Estimated Authorization Level	77	159	332	346	361	1,275
Estimated Outlays	69	150	314	342	357	1,232
Oversight of Caregivers						
Estimated Authorization Level	2	5	56	116	182	361
Estimated Outlays	2	4	50	110	174	340
Personnel and Other Costs						
Estimated Authorization Level	28	45	58	88	119	338
Estimated Outlays	26	43	56	84	115	324
Benefits During Caregiver Training						
Estimated Authorization Level	1	3	39	64	89	196
Estimated Outlays	1	2	36	61	86	186
Medical Care						
Estimated Authorization Level	1	3	21	44	69	138
Estimated Outlays	1	3	19	41	66	130
Respite Care						
Estimated Authorization Level	*	1	6	13	21	41
Estimated Outlays	*	*	6	12	20	38
Survey						
Estimated Authorization Level	2	0	0	0	0	2
Estimated Outlays	1	1	0	0	0	2
Total Changes in Title I						
Estimated Authorization Level	125	249	913	1,509	2,154	4,950
Estimated Outlays	113	234	844	1,441	2,076	4,709

Note: * = less than $500,000.

Stipends. Section 102 of the bill would require VA to pay a monthly stipend to caregivers of severely injured veterans. CBO estimates that implementing the provision would cost about $2.5 billion over the 2010–2014 period.

Under section 102, caregivers of veterans whose severe service-connected injuries were incurred or aggravated on or after September 11, 2001, would be eligible for monthly stipends and other benefits. (The other benefits are discussed below.) Based on information from the Department of Defense (hereinafter, "DOD") on military retirees, CBO estimates that in 2010 caregivers to about 2,000 veterans would be eligible for VA benefits. Starting in 2012, the bill would widen the eligible population to include caregivers of other veterans with severe service-connected injuries. Based on information from VA on how they would implement the bill, CBO estimates that caregivers to 52,500 veterans would become eligible for VA benefits. CBO further estimates that the program would be implemented gradually, with only 475 caregivers receiving stipends in 2010 and full implementation in 2015.

Based on data from the Bureau of Labor Statistics on average hourly pay for home health care aides, CBO estimates that in 2010, VA would pay 475 family caregivers a stipend of $2,350 a month (an hourly rate of $10.50 for an average of 225 hours a month), for a cost of $13 million in 2010. After adjusting for gradual implemen-

tation of the program over the 2010–2014 period and for inflation, CBO estimates that number of family caregivers receiving stipends would grow to 39,400 in 2014, at a cost of $1.3 billion that year.

Travel Benefits. Section 103 would authorize VA to pay transportation, lodging, and subsistence expenses of family members and other caregivers of veterans. Over the 2010–2014 period, CBO estimates that implementing this provision would cost $1.2 billion, assuming appropriation of the necessary amounts.

Lodging and subsistence expenses of nonveterans are not reimbursable under current law. Based on information from VA about veterans who have received travel benefits in 2009, CBO estimates that in 2010 VA would reimburse $1,950 each to 34,000 nonveterans (an average per diem rate of $130 for 15 days a year), for a cost of $66 million in 2010. After adjusting for gradual implementation of the program over the 2010–2014 period and for inflation, CBO estimates that the number of nonveterans receiving per diems would grow to almost 150,000 a year by 2014 and VA would spend about $1.2 billion a year over the 2010–2014 period.

CBO estimates that under the bill almost all family members or caregivers would either travel in the same vehicle with the veteran or would be deemed medically necessary attendants (VA is currently authorized to pay transportation expenses in those instances), but that a few nonveterans would become newly eligible for reimbursement of travel costs starting in 2010. CBO further estimates that 6,000 nonveterans would receive reimbursements worth $500 in 2010, for a total cost that year of $3 million. After adjusting for gradual implementation of the program over the 2010–2014 period and for inflation, CBO estimates that VA would spend about $55 million on travel costs for nonveterans over the 2010–2014 period.

Oversight of Caregivers. Section 102 also would require regular oversight of caregivers, including home visits. CBO estimates that implementing the provision would cost $340 million over the 2010–2014 period.

Based on information from VA, CBO estimates that VA would contract with home-health agencies to conduct oversight of 500 caregivers at a cost of almost $325 a month per caregiver (an hourly rate of $108 for an average of 3 hours a month), for a cost of $2 million in 2010. After adjusting for gradual implementation of the program over the 2010–2014 period and for inflation, CBO estimates that the number of caregivers being overseen would grow to 39,400 in 2014, at a cost of about $175 million that year.

Personnel and Other Costs. To implement the new caregiver benefits under section 102 of the bill, VA would need additional personnel at medical centers and at its headquarters in Washington, DC. Those personnel would evaluate veterans and their caregivers to determine the type of care veterans need and the training their caregivers require, and provide training, counseling, and support to caregivers. VA also would be required to design an interactive Web site to provide information on caregiver services, conduct outreach, and report periodically to the Congress. CBO estimates that implementing those provisions would cost about $325 million over the 2010–2014 period.

Based on information from VA, CBO estimates that each of the 153 medical centers would require a team consisting of a nurse, a

social worker, a psychologist, a physical therapist, an occupational therapist, and a program support assistant. An additional staff of three people would be required at VA headquarters to monitor and coordinate implementation. Assuming an average annual salary of $115,000 per person and after adjusting for inflation, CBO estimates that about 25 percent of the necessary staff would be hired in 2010 at an annual cost of $26 million, and that all necessary staff would be hired by 2014, at a cost that year of $115 million.

Benefits During Caregiver Training. Section 102 would provide respite care and travel benefits to caregivers while they undergo training at VA facilities. CBO estimates that implementing those provisions would cost about $185 million over the 2010–2014 period.

The bill would require VA to provide training to family members or other individuals to prepare them to provide care to disabled veterans. Based on information from VA, CBO expects VA would provide initial training for two weeks and refresher training for one week each year. During those training periods, VA also would provide respite care (if the veteran had no substitute caregivers), reimbursement of travel costs, and per diem expenses.

CBO estimates that in 2010 about 450 veterans would require respite care during the two-week period of initial training—at a daily cost of $210—for a total cost of $1 million that year. The following year, CBO estimates that 1,000 veterans would need respite care (550 during initial training and 450 during refresher training) at a total cost of $2 million in 2011. By 2014, CBO estimates that almost 35,500 veterans would require respite care during training, for a cost of $57 million that year.

CBO further estimates that 550 caregivers would undergo initial training and be eligible for travel benefits in 2010. (That figure is higher than the number of veterans requiring respite care because CBO assumes some veterans will have more than one caregiver.) CBO estimates that half—or 275—live close enough to the training site that they would commute daily and be eligible for mileage reimbursements averaging $375 (90 miles round trip for 10 weekdays at a reimbursement rate of $0.415 per mile). The other 275 would travel to the training site and stay there for the duration of training. Those caregivers would be eligible for reimbursement for travel costs averaging $150 (two 180 mile round trips at $0.415 per mile) as well as per diems averaging $130 a day. CBO estimates that total costs for caregivers undergoing training in 2010 would be less than $500,000. In 2011, 605 caregivers would commute for training (330 for initial training and 275 for refresher training), while another 605 would travel to the training site and stay there for the duration of their training, for total costs that year of about $1 million. By 2014, CBO estimates that about 43,300 caregivers would undergo training and would receive travel benefits and per diems worth about $30 million that year.

Medical Care. Section 102 also would authorize VA to provide medical care to caregivers, if such caregivers are not covered under other health plans. CBO estimates that implementing the provision would cost $130 million over the 2010–2014 period.

The population eligible for this benefit also is similar to the population eligible for the monthly stipend; however, CBO estimates that only one-quarter of the caregivers would be eligible (i.e. would

not be covered under other health plans) and would seek medical care from VA. Based on information from VA on the cost of health care it provides to non-veterans, CBO estimates that in 2010 they would provide medical care to 250 family caregivers at an average cost of almost $6,000 each, for a total cost of $1 million in 2010. After adjusting for inflation and gradual implementation of the program, CBO estimates that the number of family caregivers receiving medical care would grow to 13,100 by 2014, at a cost of $66 million that year.

In addition, section 101 would prohibit VA from recovering the cost of certain emergency care provided to family members and caregivers of veterans whose severe service-connected injuries were incurred or aggravated on or after September 11, 2001. The bill would only affect emergencies that occur while the family member or caregiver accompanies a veteran who is receiving care at a VA facility (or a non-VA facility VA has contracted with). Based on information from VA, CBO estimates that about 250 people each year would receive such care at an average cost of $330 each, for total costs of less than $500,000 over the 2010–2014 period.

Respite Care. Section 102 would expand VA's authority to provide respite care to veterans. CBO estimates that implementing that provision would cost $38 million over the 2010–2014 period.

Under current law, veterans who receive medical services, hospital care, nursing home care, or domiciliary care from VA are eligible for up to 30 days of respite care. The bill would extend eligibility for that benefit to enrolled veterans who do not receive such care. Based on information from VA, CBO estimates that the majority of disabled, enrolled veterans who require caregivers currently receive care from VA, and that about 50 additional veterans would receive respite care in 2010 under this provision. CBO further estimates that VA would provide an average of 21 days of respite care to each veteran—at a daily cost of $210 in 2010—for a total cost of less than $500,000 that year. After adjusting for inflation and gradual implementation of the program, CBO estimates that by 2014 about 4,000 veterans would receive respite care at a total cost of $20 million.

Survey. Section 104 would require VA and DOD to conduct a national survey of family caregivers of seriously disabled veterans and servicemembers (covering the size and characteristics of the population and types of care provided), and to report to the Congress on their findings. CBO estimates that implementing this provision would cost $2 million over the 2010–2014 period.

Rural Demonstration Projects. Section 205 would authorize VA to carry out demonstration projects, including by establishing partnerships with the Department of Health and Human Services and the Indian Health Service, to expand care for veterans in rural areas. In 2009, VA received appropriations of $250 million for similar purposes. After adjusting that amount for inflation, CBO estimates that implementing this provision would require additional appropriations of $255 million in 2010 and $1.3 billion over the 2010–2014 period.

Travel Reimbursements. Section 208 would authorize VA to pay mileage reimbursements in excess of the cost of that travel by public transportation; under current law, VA pays the lesser of mileage reimbursements or the cost of public transportation. CBO esti-

mates that implementing this provision would cost $332 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Based on VA's estimate that it expects to pay $300 million in mileage reimbursements in 2009 and data on bus fares to major VA medical facilities, CBO estimates that under the bill those costs would increase by 25 percent starting in 2010. After adjusting for gradual implementation of the program, CBO estimates that VA would pay an additional $272 million in travel reimbursements over the 2010–2014 period. Enacting this provision also would increase spending on VA's vocational rehabilitation program, however, CBO estimates those effects would be insignificant (see discussion under "Direct Spending.")

Section 208 also would allow VA to reimburse the cost of air travel, if that mode of travel was the only practical way to reach a VA medical facility; under current law, VA pays for such travel in very few cases. VA was unable to provide data on the number of veterans currently using air travel or the cost of such travel. Assuming that 5 percent of the existing users of the beneficiary travel program—about 30,000 people—would each make one round trip a year at a cost of $500 and after adjusting for gradual implementation of the program, CBO estimates that VA would pay an additional $60 million over the 2010–2014 period.

Education Assistance. Two sections of the bill would authorize VA to provide scholarships and assistance with education loans to certain employees. Taken together, CBO estimates that implementing those provisions would cost $200 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Debt Reduction. Section 201 would amend the Education Debt Reduction Program, which helps certain employees repay education loans, by deleting the ceiling of $44,000 per employee and allowing VA to pay up to the total principal and interest owed. Section 201 also would require VA to inform those job applicants who would be eligible for the program of their eligibility when making job offers, and to accept into the program any applicants who accept a job offer. In 2008, about 6,500 employees received an average annual benefit of $5,800 under this program, which reimburses employees over a five-year period.

CBO estimates that under the proposed program changes, 650 additional employees each year would become eligible and that the average payment per new employee in 2010 would be $8,500. (Existing participants would receive an additional payment of $2,500 each in 2010.) After adjusting for inflation, CBO estimates that implementing this provision would cost $197 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Scholarship Program. Section 202 would authorize a new scholarship program for individuals studying to rehabilitate the visually impaired. Under the bill, VA would pay such individuals up to $15,000 a year for tuition and fees (each recipient could receive a maximum of $45,000), in exchange for the participant's agreement to work at VA for at least three years after graduation. Based on information from VA, CBO estimates that the department would offer 20 scholarships each year (each for a three-year period) to interns in occupations working with the visually impaired, and that the average payment would be $11,250 in 2010. After adjusting for

inflation, CBO estimates that implementing this provision would cost $3 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Medical Construction. Section 401 would authorize the appropriation of $71 million to construct a new outpatient facility and renovate existing facilities in Walla Walla, Washington. CBO estimates that implementing that provision would cost $68 million over the 2010–2014 period, assuming appropriation of the authorized amounts. (The remaining $3 million would be spent after 2014.)

Copayments from Certain Disabled Veterans. Section 302 would prohibit the collection of copayments and other fees from catastrophically disabled veterans who receive hospital care or medical services from VA. In 2008, VA collected about $8 million in copayments for medical care and prescription drugs from those veterans. CBO estimates that implementing this provision would decrease collections by $8 million per year. Such collections are offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, CBO estimates that implementing this provision would cost about $40 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Transportation Grants. Section 215 would authorize the appropriation of $3 million each year over the 2010–2014 period. VA would use those amounts to make grants to organizations that improve access to medical care for veterans living in highly rural areas (counties with a population density fewer than seven persons per square mile). CBO estimates that implementing that provision would cost $15 million over the 2010–2014 period, assuming appropriation of the authorized amounts.

Rural Centers of Excellence. Section 212 would require VA to establish between one and five centers of excellence for research, education, and clinical activities focused on rural health services. VA has indicated that the proposed centers of excellence would be similar to existing Rural Health Resource Centers, and that under the bill it would establish one center of excellence. Based on operating costs of the existing resource centers, CBO estimates that implementing this provision would cost $2 million a year over the 2010–2014 period, assuming appropriation of the necessary amounts.

Coordinators of Care for Native American Veterans. Section 207 would require VA to appoint a coordinator of care for Native American veterans at each of the 10 medical centers that serve the greatest number of such veterans. The coordinators would improve outreach to and expand access to care for tribal communities, coordinate the medical needs of veterans living on reservations, act as an ombudsman for Native American veterans using the VA health care system, and advocate for the use of traditional medicine in VA treatments. CBO estimates that implementing this provision would require VA to hire 10 employees at an annual cost of $1 million a year over the 2010–2014 period, assuming appropriation of the necessary amounts.

Training for Mental Health Providers. Section 206 would require VA to train veterans and clinicians to provide peer support, readjustment counseling, and other mental health services to veterans of Operation Iraqi Freedom and Operation Enduring Freedom (hereinafter, "OIF/OEF") and to assist family members of OIF/OEF veterans with their recovery and readjustment to civilian life. Under current law, VA has the authority to provide such services through Vet Centers and existing mental health programs, and may also contract with non-VA entities to provide services, especially in rural areas.

Based on information from VA, CBO estimates that about 20,000 veteran peer counselors and clinicians would undergo initial training in 2010 at a cost of $1 million. Additional training for new staff and refresher training for existing staff also would average about $1 million each year over the 2011–2014 period. CBO estimates that implementing this provision would cost $5 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Peer Reviews. Section 210 would authorize VA to review the quality of health care provided by non-VA contractors. Under the bill, non-VA providers in each of VA's 21 regional networks of medical facilities would provide a sample of patient records to VA for review. Based on information from VA, CBO estimates that VA would require 10 additional employees to analyze records and prepare reports at a cost of $1 million a year over the 2010–2014 period, assuming appropriation of the necessary amounts.

Emergency Care. Section 301 would require VA to pay for the emergency care that certain veterans receive at non-VA medical facilities, or to reimburse veterans if they have paid for that care. It also would permit VA, subject to the Secretary's discretion, to reimburse veterans for emergency treatment that was provided prior to the date of enactment. CBO estimates that implementing those provisions would cost $5 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Under current law, VA has the authority to reimburse certain veterans or pay for emergency treatment of a nonservice-connected condition, if VA is the payer of last resort. Veterans who have recourse against a third party that would partly cover those medical expenses are not eligible for such reimbursement from VA. Section 301 would remove that restriction.

Based on information from VA, CBO estimates that under the bill VA would approve about 700 new claims a year over the 2010–2014 period and about 2,000 claims for emergency treatment provided over the 2005–2009 period. (CBO assumes that few veterans have retained records for emergency treatment provided before 2005.) CBO estimates that VA would pay an average of $730 per claim in 2010, rising to about $900 per claim in 2014, for total costs of $1 million a year.

Other Provisions. Two sections of the bill, when taken individually, would increase spending subject to appropriation by less than $500,000 each year. Taken together, CBO estimates that implementing the following provisions would have a total cost of $1 million over the 2010–2014 period, assuming availability of appropriated funds:

• Section 209 would require the Office of Rural Health to develop a five-year strategic plan. VA has indicated that the office is developing a similar plan and that the necessary modifications would have insignificant costs.

• Section 214 would require annual reports to the Congress on the implementation of several sections of the bill.

Direct Spending

Section 208 would increase mileage reimbursements paid to veterans using VA's vocational rehabilitation program. However, CBO estimates that few beneficiaries would be affected, that the increased amounts paid per veteran would be quite low, and thus, that enacting section 208 would increase direct spending by less than $500,000 each year and over the 2010–2014 and 2010–2019 periods.

Intergovernmental and private-sector impact: S. 801 contains no intergovernmental or private-sector mandates as defined in UMRA. State, local, and tribal governments that provide assistance to veterans would benefit from grants and program activities authorized in the bill.

Previous CBO estimates: On July 23, 2009, CBO transmitted a cost estimate for H.R. 3155, the Caregiver Assistance and Resource Enhancement Act, as ordered reported by the House Committee on Veterans' Affairs on July 15, 2009. H.R. 3155 is similar to title I of S. 801, however H.R. 3155 affected a much smaller population, and its estimated costs were correspondingly lower.

On July 23, 2009, CBO transmitted a cost estimate for H.R. 3219, the Veterans' Insurance and Health Care Improvement Act of 2009, as ordered reported by the House Committee on Veterans' Affairs on July 15, 2009. Section 203 of H.R. 3219 is similar to section 302 of S. 801, and their estimated costs are identical.

On March 25, 2009, CBO transmitted a cost estimate for H.R. 1377, a bill to amend title38, United States Code, to expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility, and for other purposes, as ordered reported by the House Committee on Veterans' Affairs on March 25, 2009. H.R. 1377 is similar to section 301 of S. 801, and their estimated costs are identical.

Estimate prepared by: Federal Costs: Sunita D'Monte; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Elizabeth Bass.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by Members of the Committee on Veterans' Affairs at its May 21, 2009, meeting. On that date, the Committee ordered S. 801 reported favorably to the Senate by roll call vote, without dissent.

Yeas	Senator	Nays
X (by proxy)	Mr. Rockefeller	
X	Mrs. Murray	
X (by proxy)	Mr. Sanders	
X	Mr. Brown	
X	Mr. Webb	
X	Mr. Tester	
X	Mr. Begich	
X	Mr. Burris	
X (by proxy)	Mr. Specter	
X	Mr. Burr	
X	Mr. Isakson	
X (by proxy)	Mr. Wicker	
X	Mr. Johanns	
	Mr. Graham	
X	Mr. Akaka, Chairman	
14	TALLY	0

AGENCY REPORT

On April 22, 2009, Gerald M. Cross, M.D., Principal Deputy Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee and submitted testimony on various bills incorporated into the Committee bill. In addition, on May 14, 2009, VA provided views on S. 801. Excerpts of both the testimony and Department views are reprinted below:

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on a number of bills that would affect Department of Veterans Affairs (VA) programs of benefits and services. With me today are Walter A. Hall, Assistant General Counsel and Joleen Clark, Chief Workforce Management and Consulting Officer for VHA. Unfortunately, we do not yet have views and estimates on several bills including S. 239, S. 498, S. 699, S. 772, S. 793, subsection (f) of S. 252 and S. 821. We will forward those as soon as they are available. Our support for the bill provisions discussed below is contingent upon VA's ability to fund such activities within the President's 2010 budget.

* * * * * * *

S. 801 "FAMILY CAREGIVER PROGRAM ACT OF 2009"

S. 801 is divided into four separate sections. I will address each section separately; however, VA has not yet evaluated the costs of implementing the provisions of S. 801. We will provide an estimate to the Committee as soon as it is completed.

Section 2 would authorize VA to waive charges for humanitarian care provided to caregivers accompanying certain severely injured veterans as they receive medical care. VA does not object to the concept of providing humanitarian medical benefits to caregivers but we must oppose this section. As currently written, Section 2 identifies an extensive list of family members as potential caregivers and provides no criteria regarding the extent or duration of their service to the Veteran. Family caregivers could change frequently and we are concerned that the provision of humanitarian care could become a primary factor in designating a caregiver rather than that person's ability to assist the veteran. Further, language that has historically appeared in VA appropriation statutes (requiring reimbursement for hospital care and medical services provided to individuals who are not otherwise eligible for these benefits) may restrict VA's ability to waive charges as outlined in this provision of the bill. We are also considering the impact of Section 2 on the implementation of the family medical care provisions of the National Defense Authorization Act of 2008 (§ 1672(b) of Public Law 110–181).

Section 3 of S. 801 addresses family caregiver assistance. I have previously discussed the family caregiver provisions of S. 252 and S. 543, which would require the Secretary to conduct pilot programs to assess the feasibility of training family caregivers as personal care attendants. While the eligibility criteria for this section

are very similar to those in S. 543, S. 801 differs dramatically from S. 252 and S. 543 because it would establish a program of instruction, preparation, training, certification and ongoing support for designated family caregivers across VA. The mechanics of the program under S. 801 are also different as eligible veterans and their family member (or other designated individual) would make a joint application to VA which would then evaluate the veteran to identify the personal care services needed by that individual and determine if they could be provided by a family member. The applicant family member is also evaluated to determine the training they would need to provide those services. Unlike S. 252 and S. 253, S. 801 does not address the development of the training curriculum. However, it does distinguish between a family member who provides personal care services and a family member who is designated as the veteran's primary personal care attendant. The agency would be required to provide training, certification, technical support, and counseling to both; however, a primary personal care attendant would also be furnished mental health services, medical care under 38 U.S.C. 1781, respite care and a stipend.

VA strongly opposes Section 3. The same concerns identified in conjunction with caregiver provisions of S. 252 and S. 543 apply here as well. VA currently contracts for caregiver services with various providers and this arrangement is preferable because it does not divert VA from its primary mission of treating veterans and training clinicians. We also would like to reiterate that S. 801 would establish the caregiver program across the agency and we caution against implementing a program of this magnitude without first exploring its feasibility and effectiveness. Should the Committee decide to proceed with a caregiver assistance proposal, we urge you to opt for the program defined in section 209 of S. 252 which would allow VA to conduct a three-year pilot providing assistance to caregivers of TBI patients. Moreover, the concerns that I addressed in discussing Section 2 relative to the large cadre of eligible caregivers would make this proposal challenging to administer and monitor for quality and effectiveness. The administrative burden on VA to re-identify and track caregivers could be considerable.

Finally, S. 801 in general, and Section 3 in particular, would create preferential benefits for one generation of Veterans that are not available to others. VA believes that caregiver assistance would benefit veterans of all ages and periods of service and any initiative to support caregivers should not be limited to post-September 11 veterans.

Section 4 would amend VA's beneficiary travel statute (38 U.S.C. 111) to include lodging and subsistence as travel expenses for attendants of certain veterans receiving VA health care. This provision would also define the travel period to include travel to and from the facility and the duration of the treatment episode. We believe that the proposed amendments would apply to all attendants eligible for beneficiary travel under 38 U.S.C. 111, not just those attendants defined by S. 801. VA opposes Section 4 as this benefit expansion would divert resources from medical care. In addition, 38 U.S.C. 111 already provides travel benefit attendants for severely injured veterans.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, May 14, 2009.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This letter is in response to your invitation to submit for the record the Department's views on six bills, S. 239, S. 498, S. 699, S. 772, S. 793, and S. 821. As you know, we received some of these legislative items too late to address in testimony before the Committee on April 22, 2009. In addition, while our views remain the same, we are submitting additional information and costs on four bills that were addressed in the April 22 testimony, S. 252, S. 404, S. 423, and S. 801. Thank you for giving us this valuable opportunity to submit our views before the hearing record closes.

* * * * * * *

S. 801 "FAMILY CAREGIVER PROGRAM ACT OF 2009"

VA's opposition to S. 801 was detailed in the April 22, 2009, testimony. The costs for each section of the bill are outlined below.

Section 2 would amend 38 U.S.C. § 1784 to allow for waiver of charges for hospital care or medical services provided to certain family members of Veterans receiving VA health care. We project that this provision would cost approximately $330,000 in 2010, $2 million over five years, and $5.3 million over ten years.

Section 3 addresses family caregiver assistance. VA has identified 65,798 Veterans with a serious injury incurred on or after September 11, 2001, that would be eligible for this program during its first two years. It is expected that an additional 1,440 Veterans would become eligible each subsequent year. VA estimates that this provision would cost $5.056 billion in fiscal year 2010, $26.859 billion over five years, and $62.8 billion over 10 years. Note that these costs do not include Veterans severely injured prior to September 11, 2001, that may become eligible for this program after the first two years.

Section 4, Lodging and Subsistence for Attendants, would amend 38 U.S.C. § 111 to allow for travel, including lodging and subsistence, for the period consisting of travel to and from a treatment facility and the duration of the treatment episode for certain family members of certain Veterans receiving VA health care. We estimate the cost of this provision to be $8.6 million in 2010, $57.7 million over five years, and $163 million over ten years.

* * * * * * *

The Office of Management and Budget advises that there is no objection to the submission of this letter from the standpoint of the Administration.

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

Sincerely,

ERIC K. SHINSEKI.

* * * * * * *

EXCERPT FROM APRIL 22, 2009, HEARING RECORD REGARDING S. 801

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In written testimony, the Department expressed concern "that the provision of humanitarian care could become a primary factor in designating a caregiver rather than the person's ability to assist the Veteran." Since the legislation states that the designated caregiver receives waived charges for emergency medical care in the sole instance he or she is accompanying the Veteran, the likelihood of the caregiver receiving health care benefits is very small. Please elaborate as to why VA has a reservation with this provision?

Response. Given the extensive list of persons eligible to be the Veteran's caregiver, the Veteran may elect to designate, or be under pressure to designate, as their caregiver someone who has need for medical care and would benefit greatly from the Department of Veterans Affairs' (VA) providing that care. This person may not be the best choice to assist the Veteran with their daily needs. Moreover, the legislation does not provide for limits on the number of times or how frequently the Veteran may change caregivers. Potentially, a number of persons could receive needed medical care by being designated as caregiver.

Question 2. The Department objects to section 3 of S. 801 because of a concern that it will force VA to create preferential benefits for one group of Veterans. Yet, the legislation allows VA to extend this benefit to "include the largest number of Veterans possible." Please explain, in detail, why the Department raises an objection to this provision?

Response. The number of Veterans meeting the eligibility of section 3 for the first 2 years of enactment is small compared to eligible Veterans from previous generations. VA believes that any program that would benefit one cadre of combat Veterans over another is inequitable, whether for a 2-year period or permanently.

VA has been working on the family caregiver issue for some time and believes that the newly developed Veteran directed-home and community-based service (VD-HCBS) creates a workable infrastructure for family caregivers to be paid for the relevant service they provide. The VD-HCBS program provides Veterans of all ages the opportunity to receive home and community based services in a consumer-directed fashion that enables them to avoid nursing home placement and continue to live in their homes. The VD-HCBS program addresses the home care needs for Veterans of all ages, allowing services to be provided to younger, seriously-injured and Traumatic Brain Injury (TBI) Veterans. This program will also help address the demand for paid family caregivers in a comprehensive and structured manner.

We would be pleased to discuss this program and other alternatives to section 3 of S. 801 with Members of the Committee staff.

VA is committed to working with the Congress to create a viable family caregiver program.

Sincerely,

ERIC K. SHINSEKI.

* * * * * * *

CHANGES IN EXISTING LAW

In compliance with paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman).

TITLE 38. VETERANS' BENEFITS

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PART I. GENERAL PROVISIONS

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PART I. GENERAL PROVISIONS

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CHAPTER 1. GENERAL

SEC. 101. DEFINITIONS

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SEC. 111. PAYMENTS OR ALLOWANCES FOR BENEFICIARY TRAVEL

(a) Under regulations prescribed by the President pursuant to the provisions of this section, the Secretary may pay the actual necessary expense of travel (including lodging and subsistence), or in lieu thereof an allowance based upon mileage [traveled,] *(at a rate of 41.5 cents per mile) when not traveling by air,* of any person to or from a Department facility or other place in connection with vocational rehabilitation, counseling required by the Secretary pursuant to chapter 34 or 35 of this title, or for the purpose of examination, treatment, or care. *Actual necessary expense of travel includes the reasonable costs of airfare if travel by air is the only practical way to reach a Department facility.* In addition to the mileage allowance authorized by this section, there may be allowed reimbursement for the actual cost of ferry fares, and bridge, road, and tunnel tolls.

(b)(1) * * *

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(4) In determining for purposes of subsection (a) whether travel by air is the only practical way for a veteran to reach a Department facility, the Secretary shall consider the medical condition of the veteran and any other impediments to the use of ground transportation by the veteran.

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(e) [When any] *(1) When any* person entitled to mileage under this section requires an attendant (other than an employee of the Department) in order to perform such travel, the attendant may be allowed expenses of travel *(including lodging and subsistence)* upon the same basis as such person *for the period consisting of travel to and from a treatment facility and the duration of the treatment episode at that facility*.

(2) The Secretary may prescribe regulations to carry out this subsection. Such regulations may include provisions—

(A) to limit the number of individuals that may receive expenses of travel under paragraph (1) for a single treatment episode of a person; and

(B) to require attendants to use certain travel services.

(3) In this subsection:

(A) The term "attendant" includes, with respect to a person described in paragraph (1), the following:

(i) A family member of the person.

(ii) An individual approved as a personal care attendant under section 1717A(d)(3) of this title.

(iii) Any other individual whom the Secretary determines—

(I) has a preexisting relationship with the person; and

(II) provides a significant portion of the person's care.

(B) The term "family member" shall have such meaning as the Secretary shall determine by policy or regulation.

* * * * * * *

[(g)(1) Subject to paragraph (3), in determining the amount of allowances or reimbursement to be paid under this section, the Secretary shall use the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a Government vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.

[(2) In no event shall payment be provided under this section—

[(A) unless the person claiming reimbursement has been determined, pursuant to regulations which the Secretary shall prescribe, to be unable to defray the expenses of such travel (except with respect to a person receiving benefits for or in connection with a service-connected disability under this title, a veteran receiving or eligible to receive pension under section 1521 of this title, or a person whose annual income, determined in accordance with section 1503 of this title, does not exceed the maximum annual rate of pension which would be pay-

able to such person if such person were eligible for pension under section 1521 of this title;

[(B) to reimburse for the cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless (i) public transportation is not reasonably accessible or would be medically inadvisable, or (ii) the cost of such travel is not greater than the cost of public transportation; and

[(C) in excess of the actual expense incurred by such person as certified in writing by such person.

[(3) Subject to the availability of appropriations, the Secretary may modify the amount of allowances or reimbursement to be paid under this section using a mileage reimbursement rate in excess of that prescribed under paragraph (1).]

(g)(1) Beginning one year after the date of the enactment of the Caregiver and Veterans Health Services Act of 2009, the Secretary may adjust the mileage rate described in subsection (a) to be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees on official business (when a Government vehicle is available), as prescribed by the Administrator of General Services under section 5707(b) of title 5.

(2) If an adjustment in the mileage rate under paragraph (1) results in a lower mileage rate than the mileage rate otherwise specified in subsection (a), the Secretary shall, not later than 60 days before the date of the implementation of the mileage rate as so adjusted, submit to Congress a written report setting forth the adjustment in the mileage rate under this subsection, together with a justification for the decision to make the adjustment in the mileage rate under this subsection.

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PART II. GENERAL BENEFITS

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CHAPTER 11. COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH

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CHAPTER 17. HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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Subchapter I. General

SEC. 1701. DEFINITIONS

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SEC. 1703A. OVERSIGHT OF CONTRACT AND FEE-BASIS CARE

(a) RURAL OUTREACH COORDINATORS.—The Secretary shall designate a rural outreach coordinator at each Department community based outpatient clinic at which not less than 50 percent of the veterans enrolled at such clinic reside in a highly rural area. The coordinator at a clinic shall be responsible for coordinating care and collaborating with community contract and fee-basis providers with respect to the clinic.

(b) INCENTIVES TO OBTAIN ACCREDITATION OF MEDICAL PRACTICE.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department to encourage such providers to obtain accreditation of their medical practice from recognized accrediting entities.

(2) In making adjustments under paragraph (1), the Secretary shall consider the increased overhead costs of accreditation described in paragraph (1) and the costs of achieving and maintaining such accreditation.

(c) INCENTIVES FOR PARTICIPATION IN PEER REVIEW.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (e).

(2) The Secretary shall provide incentives under paragraph (1) to a provider of health care services under the Department in an amount which may reasonably be expected (as determined by the Secretary) to encourage participation in the voluntary peer review under subsection (d).

(d) PEER REVIEW.—(1) The Secretary shall provide for the voluntary peer review of providers of health care services under the Department who provide such services on a fee basis as part of a medical practice that is not accredited by a recognized accrediting entity.

(2) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, the Chief Quality and Performance Officer in each Veterans Integrated Services Network (VISN) shall select a sample of patient records from each participating provider in the Officer's Veterans Integrated Services Network to be peer reviewed by a facility designated under paragraph (3).

(3) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

(4) Each year, beginning with the first fiscal year beginning after the date of the enactment of this section, each provider who elects to participate in the program shall submit the patient records selected under paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

(A) peer review such records in accordance with policies and procedures established by the Secretary;

(B) ensure that peer reviews are evaluated by the Peer Review Committee; and

(C) develop a mechanism for notifying the Under Secretary for Health of problems identified through such peer review.

(6) The Under Secretary for Health shall develop a mechanism by which the use of fee-basis providers of health care are terminated when quality of care concerns are identified with respect to such providers.

(7) The Chief Quality and Performance Officer in each Veterans Integrated Services Network shall be responsible for the oversight of the program of peer review under this subsection in that network.

* * * * * * *

SEC. 1709. TELECONSULTATION AND TELERETINAL IMAGING

(a) TELECONSULTATION.—(1) The Secretary shall carry out a program of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that are not otherwise able to provide such assessments without contracting with third party providers or reimbursing providers through a fee-basis system.

(2) The Secretary shall, in consultation with appropriate professional societies, promulgate technical and clinical care standards for the use of teleconsultation services within facilities of the Department.

(b) TELERETINAL IMAGING.—The Secretary shall carry out a program of teleretinal imaging in each Veterans Integrated Services Network (VISN).

(c) ANNUAL REPORTS.—In each fiscal year beginning with fiscal year 2010 and ending with fiscal year 2015, the Secretary shall sub-

mit to Congress a report on the programs required by subsections (a) and (b). Such report shall include the following:

(1) A description of the efforts made by the Secretary to make teleconsultation available in rural areas and to utilize teleconsultation in rural areas.

(2) The rates of utilization of teleconsultation by Veterans Integrated Services Network disaggregated by each fiscal year for which a report is submitted under this subsection.

(d) DEFINITIONS.—In this section:

(1) The term "teleconsultation" means the use by a health care specialist of telecommunications to assist another health care provider in rendering a diagnosis or treatment.

(2) The term "teleretinal imaging" means the use by a health care specialist of telecommunications, digital retinal imaging, and remote image interpretation to provide eye care.

Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

SEC. 1710. ELIGIBILITY FOR HOSPITAL, NURSING HOME, AND DOMICILIARY CARE

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SEC. 1712A. ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

(a) * * *

* * * * * * *

(c) **[**The Under Secretary**]** *(1) The Under Secretary* for Health may provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively**[**, and, in carrying out this section, may utilize the services of paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities**]**.

(2) In carrying out this section, the Under Secretary may utilize the services of the following:

(A) Paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

(B) Eligible volunteer counselors in the provision of counseling and related mental health services.

(3) For purposes of this subsection, an eligible volunteer counselor is an individual—

(A) who—

(i) provides counseling services without compensation at a center;

(ii) is a licensed psychologist or social worker;

(iii) has never been named in a tort claim arising from professional activities; and

(iv) has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

(B) who is otherwise credentialed and privileged to perform counseling services by the Secretary.

(4) Eligible volunteer counselors shall be issued credentials and privileges for the provision of counseling and related mental health services under this section on an expedited basis in accordance with such procedures as the Secretary shall establish. Such procedures shall provide for the completion by the Secretary of the processing of an application for such credentials and privileges not later than 60 days after receipt of the application.

(d) * * *

(e) [The Secretary] *(1) The Secretary*, in cooperation with the Secretary of Defense, shall take such action as the Secretary considers appropriate to notify veterans who may be eligible for assistance under this section of such potential eligibility.

(2) Each center shall develop an outreach plan to ensure that the community served by the center is aware of the services offered by the center.

* * * * * * *

SEC. 1717A. FAMILY CAREGIVER ASSISTANCE

(a) IN GENERAL.—(1) As part of home health services provided under section 1717 of this title, the Secretary shall, upon the joint application of an eligible veteran and a family member of such veteran (or other individual designated by such veteran), furnish to such family member (or designee) family caregiver assistance in accordance with this section. The purpose of providing family caregiver assistance under this section is—

(A) to reduce the number of veterans who are receiving institutional care, or who are in need of institutional care, whose personal care service needs could be substantially satisfied with the provision of such services by a family member (or designee); and

(B) to provide eligible veterans with additional options so that they can choose the setting for the receipt of personal care services that best suits their needs.

(2) The Secretary shall only furnish family caregiver assistance under this section to a family member of an eligible veteran (or other individual designated by such veteran) if the Secretary determines it is in the best interest of the eligible veteran to do so.

(b) ELIGIBLE VETERANS.—(1) For purposes of this section, an eligible veteran is a veteran (or member of the Armed Forces undergoing medical discharge from the Armed Forces)—

(A) who has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after the date described in paragraph (2); and

(B) whom the Secretary determines, in consultation with the Secretary of Defense as necessary, is in need of personal care services because of—

(i) an inability to perform one or more independent activities of daily living;

(ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury; or

(iii) such other matters as the Secretary shall establish in consultation with the Secretary of Defense as appropriate.

(2) The date described in this paragraph—

(A) during the period beginning on the date of the enactment of the Caregiver and Veterans Health Services Act of 2009 and ending two years after the date of the enactment of that Act, is September 11, 2001; and

(B) beginning on the first day after the date that is two years after the date of the enactment of the Caregiver and Veterans Health Services Act of 2009, is the earliest date the Secretary determines is appropriate to include the largest number of veterans (and members of the Armed Forces) possible under this section without reducing the quality of care provided to such veterans (and members).

(c) EVALUATION OF ELIGIBLE VETERANS AND FAMILY CAREGIVERS.—(1) The Secretary shall evaluate each eligible veteran who makes a joint application under subsection (a)(1)—

(A) to identify the personal care services required by such veteran; and

(B) to determine whether such requirements could be significantly or substantially satisfied with the provision of personal care services from a family member (or other individual designated by the veteran).

(2) The Secretary shall evaluate each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) to determine—

(A) the basic amount of instruction, preparation, and training such family member (or designee) requires, if any, to provide the personal care services required by such veteran; and

(B) the amount of additional instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under subsection (e).

(3) An evaluation carried out under paragraph (1) may be carried out—

(A) at a Department facility;

(B) at a non-Department facility determined appropriate by the Secretary for purposes of such evaluation; and

(C) at such other locations as the Secretary considers appropriate.

(d) TRAINING AND APPROVAL.—(1) Except as provided in subsection (a)(2), the Secretary shall provide each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) the basic instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(A).

(2) The Secretary may provide to a family member of an eligible veteran (or other individual designated by the veteran) the additional instruction, preparation, and training determined to be required by such family member (or designee) under subsection (c)(2)(B) if such family member (or designee)—

(A) is approved as a personal care attendant for the veteran under paragraph (3); and

(B) requests, with concurrence of the veteran, such additional instruction, preparation, and training.

(3) Upon the successful completion by a family member of an eligible veteran (or other individual designated by the veteran) of basic instruction, preparation, and training provided under paragraph (1), the Secretary shall approve the family member as a personal care attendant for the veteran.

(4) If the Secretary determines that a primary personal care attendant designated under subsection (e) requires additional training to maintain such designation, the Secretary shall make such training available to the primary personal care attendant.

(5) The Secretary shall, subject to regulations the Secretary shall prescribe, provide for necessary travel, lodging, and per diem expenses incurred by a family member of an eligible veteran (or other individual designated by the veteran) in undergoing training under this subsection.

(6) If the participation of a family member of an eligible veteran (or other individual designated by the veteran) in training under this subsection would interfere with the provision of personal care services to the veteran, the Secretary shall, subject to regulations as the Secretary shall prescribe and in consultation with the veteran, provide respite care to the veteran during the provision of such training to the family member so that such family caregiver (or designee) can participate in such training without interfering with the provision of such services.

(e) DESIGNATION OF PRIMARY PERSONAL CARE ATTENDANT.—(1) For each eligible veteran with at least one family member (or other individual designated by the veteran) who is described by subparagraphs (A) through (E) of paragraph (2), the Secretary shall designate one family member of such veteran (or other individual designated by the veteran) as the primary personal care attendant for such veteran to be the primary provider of personal care services for such veteran.

(2) A primary personal care attendant designated for an eligible veteran under paragraph (1) shall be selected from among family members of such veteran (or other individuals designated by such veteran) who—

(A) are approved under subsection (d)(3) as a personal care attendant for such veteran;

(B) complete all additional instruction, preparation, and training, if any, provided under subsection (d)(2);

(C) elect to provide the personal care services to such veteran that the Secretary determines such veteran requires under subsection (c)(1);

(D) has the consent of such veteran to be the primary provider of such services for such veteran; and

(E) the Secretary considers competent to be the primary provider of such services for such veteran.

(3) An eligible veteran receiving personal care services from a family member (or other individual designated by the veteran) designated as the primary personal care attendant for the veteran

under paragraph (1) may revoke consent with respect to such family member (or designee) under paragraph (2)(D) at any time.

(4) If an individual designated as the primary personal care attendant of an eligible veteran under paragraph (1) subsequently fails to meet the requirements set forth in paragraph (2), the Secretary—

(A) shall immediately revoke the individual's designation under paragraph (1); and

(B) may designate, in consultation with the eligible veteran or the eligible veteran's surrogate appointed under subsection (g), a new primary personal care attendant for the veteran under such paragraph.

(5) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under paragraph (1) does not interfere with the provision of personal care services required by a veteran.

(f) ONGOING FAMILY CAREGIVER ASSISTANCE.—(1) Except as provided in subsection (a)(2) and subject to the provisions of this subsection, the Secretary shall provide ongoing family caregiver assistance to family members of eligible veterans (or other individuals designated by such veterans) as follows:

(A) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran the following:

(i) Direct technical support consisting of information and assistance to timely address routine, emergency, and specialized caregiving needs.

(ii) Counseling.

(iii) Access to an interactive Internet website on caregiver services that addresses all aspects of the provision of personal care services under this section.

(B) To each family member of an eligible veteran (or designee) who is designated as the primary personal care attendant for the veteran under subsection (e) the following:

(i) The ongoing family caregiver assistance described in subparagraph (A).

(ii) Mental health services.

(iii) Respite care of not less than 30 days annually, including 24–hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite.

(iv) Medical care under section 1781 of this title if such family member (or designee) is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title).

(v) A monthly personal caregiver stipend.

(2)(A) The Secretary shall provide respite care under paragraph (1)(B)(iii), at the election of the Secretary—

(i) through facilities of the Department that are appropriate for the veteran; or

(ii) through contracts under section 1720B(c) of this title.

(B) If the primary personal care attendant of an eligible veteran designated under subsection (e)(1) determines in consultation with the veteran or the veteran's surrogate appointed under subsection

(g), and the Secretary concurs, that the needs of the veteran cannot be accommodated through the facilities and contracts described in subparagraph (A), the Secretary shall, in consultation with the primary personal care attendant and the veteran (or the veteran's surrogate), provide respite care through other facilities or arrangements that are medically and age appropriate.

(3) If the Secretary determines that the Department lacks the capacity to furnish medical care under clause (iv) of paragraph (1)(B), the Secretary may contract, in accordance with such regulations as the Secretary shall prescribe, for such insurance, medical services, or health plans as the Secretary considers appropriate to furnish such medical care.

(4)(A) The Secretary shall provide monthly personal caregiver stipends under paragraph (1)(B)(v) in accordance with a schedule established by the Secretary that specifies stipends provided based upon the amount and degree of personal care services provided.

(B) The Secretary shall ensure, to the extent practicable, that the schedule required by subparagraph (A) specifies that the amount of the personal caregiver stipend provided to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount a commercial home health care entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

(C) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary may establish the schedule required by subparagraph (A) with respect to the veteran by considering the costs of commercial providers of personal care services in geographic areas other than the geographic area of the veteran with similar costs of living.

(5) Provision of ongoing family caregiver assistance under this subsection for provision of personal care services to an eligible veteran shall terminate if the veteran no longer requires the personal care services.

(g) SURROGATES.—If an eligible veteran lacks the capacity to submit an application, provide consent, make a request, or concur with a request under this section, the Secretary may, in accordance with regulations and policies of the Department regarding the appointment of guardians or the use of powers of attorney, appoint a surrogate for the veteran who may submit applications, provide consent, make requests, or concur with requests on behalf of the veteran under this section.

(h) OVERSIGHT.—(1) The Secretary shall enter into contracts with appropriate entities to provide oversight of the provision of personal care services under this section by primary personal care attendants designated under subsection (e)(1).

(2) The Secretary shall ensure that each eligible veteran receiving personal care services under this section from a primary personal care attendant designated under subsection (e)(1) is visited in the veteran's home by an entity providing oversight under paragraph (1) at such frequency as the Secretary shall determine under paragraph (3).

(3)(A) Except as provided in subparagraph (B), the Secretary shall determine the manner of oversight provided under paragraph (1)

and the frequency of visits under paragraph (2) for an eligible veteran as the Secretary considers commensurate with the needs of such veteran.

(B) The frequency of visits under paragraph (2) for an eligible veteran shall be not less frequent than once every six months.

(4)(A) An entity visiting an eligible veteran under paragraph (2) shall submit to the Secretary the findings of the entity with respect to each visit, including whether the veteran is receiving the care the veteran requires.

(B) If an entity finds under subparagraph (A) that an eligible veteran is not receiving the care the veteran requires, the entity shall submit to the Secretary a recommendation on the corrective actions that should be taken to ensure that the veteran receives the care the veteran requires, including, if the entity considers appropriate, a recommendation for revocation of a caregiver's approval under subsection (d)(3) or revocation of the designation of an individual under subsection (e)(1).

(5) After receiving findings and recommendations, if any, under paragraph (4) with respect to an eligible veteran, the Secretary may take such actions as the Secretary considers appropriate to ensure that the veteran receives the care the veteran requires, including the following:

(A) Revocation of a caregiver's approval under subsection (d)(3).

(B) Revocation of the designation of an individual under subsection (e)(1).

(6) If the Secretary terminates the provision of ongoing family caregiver assistance under subsection (f) to a family member of an eligible veteran (or other individual designated by the veteran) because of findings of an entity submitted to the Secretary under paragraph (4), the Secretary may not provide compensation to such entity for the provision of personal care services to such veteran, unless the Secretary determines it would be in the best interest of such veteran to provide compensation to such entity to provide such services.

(i) OUTREACH.—The Secretary shall carry out a program of outreach to inform eligible veterans and their family members of the availability and nature of family caregiver assistance under this section.

(j) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of family caregiver assistance shall be considered a medical determination.

(2) Nothing in this section shall be construed to create an employment relationship between the Secretary and an individual in receipt of family caregiver assistance under this section.

(3) Nothing in this section shall be construed to create any entitlement to any services or stipends provided under this section.

(k) DEFINITIONS.—In this section:

(1) The term "family caregiver assistance" includes the instruction, preparation, training, and approval provided under subsection (d) and the ongoing family caregiver assistance provided under subsection (f).

(2) The term "family member" shall have such meaning as the Secretary shall determine by policy or regulation.

(3) The term "personal care services", with respect to a veteran, includes the following:

(A) Supervision of the veteran.

(B) Protection of the veteran.

(C) Services to assist the veteran with one or more independent activities of daily living.

(D) Such other services as the Secretary considers appropriate.

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Subchapter III. Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

SEC. 1725. REIMBURSEMENT FOR EMERGENCY TREATMENT

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(b) ELIGIBILITY.

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*(3) * * **

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(C) has no other contractual or legal recourse against a third party that would[, in whole or in part,] extinguish such liability to the provider; and

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(c) LIMITATIONS ON REIMBURSEMENT.

* * * * * * *

(4)(A) If the veteran has contractual or legal recourse against a third party that would, in part, extinguish the veteran's liability to the provider of the emergency treatment and payment for the treatment may be made both under subsection (a) and by the third party, the amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).

(B) In any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary shall be the secondary payer.

(C) A payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider.

(D) The Secretary may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract.

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(f) DEFINITIONS.—For purposes of this section:

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(3) The term "third party" means any of the following:

(A) A Federal entity*, including the Secretary of Health and Human Services with respect to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.)*.

(B) A State or political subdivision of a State*, including a State Medicaid agency with respect to payments made under a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.)*.

* * * * * * *

SEC. 1730A. PROHIBITION ON COLLECTION OF COPAYMENTS FROM CATASTROPHICALLY DISABLED VETERANS

Notwithstanding subsections (f) and (g) of section 1710 and section 1722A(a) of this title or any other provision of law, the Secretary may not require a veteran who is catastrophically disabled to make any copayment for the receipt of hospital care or medical services under the laws administered by the Secretary.

Subchapter VIII. Health Care of Persons Other Than Veterans

SEC. 1781. MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

(a) The Secretary is authorized to provide medical care, in accordance with the provisions of subsection (b) of this section, for—

(1) the spouse or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability,

(2) a family member of a veteran (or other individual designated by the veteran) designated as the primary personal care attendant for such veteran under section 1717A(e) of this title who is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title),

[(2)**]** *(3)* the surviving spouse or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, and

[(3)**]** *(4)* the surviving spouse or child of a person who died in the active military, naval, or air service in the line of duty and not due to such person's own misconduct,

who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS).

* * * * * * *

SEC. 1784. HUMANITARIAN CARE

[The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases, but the Secretary shall charge for such care and services at rates prescribed by the Secretary.**]**

(a) IN GENERAL.—The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases.

(b) REIMBURSEMENT.—Except as provided in subsection (c), the Secretary shall charge for care and services provided under subsection (a) at rates prescribed by the Secretary.

(c) WAIVER OF CHARGES.—(1) Except as provided in paragraph (2), the Secretary shall waive the charges required by subsection (b) for care or services provided under subsection (a) to an attendant of a covered veteran if such care or services are provided to such attendant for an emergency that occurs while such attendant is accompanying such veteran while such veteran is receiving approved inpatient or outpatient treatment at—

(A) a Department facility; or

(B) a non-Department facility—

(i) that is under contract with the Department; or

(ii) at which the veteran is receiving fee-basis care.

(2) If an attendant is entitled to care or services under a health-plan contract (as that term is defined in section 1725(f) of this title) or other contractual or legal recourse against a third party that would, in part, extinguish liability for charges described by subsection (b), the amount of such charges waived under paragraph (1) shall be the amount by which such charges exceed the amount of such charges covered by the health-plan contract or other contractual or legal recourse against the third party.

(d) DEFINITIONS.—In this section:

(1) The term "attendant", with respect to a veteran, includes the following:

(A) A family member of the veteran.

(B) An individual eligible to receive ongoing family caregiver assistance under section 1717A(e)(1) of this title for the provision of personal care services to the veteran.

(C) Any other individual whom the Secretary determines—

(i) has a relationship with the veteran sufficient to demonstrate a close affinity with the veteran; and

(ii) provides a significant portion of the veteran's care.

(2) The term "covered veteran" means any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001.

(3) The term "family member" shall have such meaning as the Secretary shall determine by policy or regulation.

(4) The term "severe injury", in the case of a covered veteran, means any physiological, psychological, or neurological condition that renders a veteran unable to live independently as determined by the Secretary.

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PART V. BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 73. VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

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SUBCHAPTER II. GENERAL AUTHORITY AND ADMINISTRATION

Sec.

7311. Quality assurance.

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7330A. Epilepsy centers of excellence

7330B. Indian Veterans Health Care Coordinators.

7330C. Centers of excellence for rural health research, education, and clinical activities.

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Subchapter II. General Authority and Administration

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SEC. 7330A. EPILEPSY CENTERS OF EXCELLENCE

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SEC. 7330B. INDIAN VETERANS HEALTH CARE COORDINATORS

(a) IN GENERAL.—(1) The Secretary shall assign at each of the 10 Department Medical Centers that serve communities with the greatest number of Indian veterans per capita an official or employee of the Department to act as the coordinator of health care for Indian veterans at such Medical Center. The official or employee so assigned at a Department Medical Center shall be known as the "Indian Veterans Health Care Coordinator" for the Medical Center.

(2) The Secretary shall, from time to time—

(A) survey the Department Medical Centers for purposes of identifying the 10 Department Medical Centers that currently serve communities with the greatest number of Indian veterans per capita; and

(B) utilizing the results of the most recent survey conducted under subparagraph (A), revise the assignment of Indian Veterans Health Care Coordinators in order to assure the assignment of such coordinators to appropriate Department Medical Centers as required by paragraph (1).

(b) DUTIES.—The duties of an Indian Veterans Health Care Coordinator shall include the following:

(1) Improving outreach to tribal communities.

(2) Coordinating the medical needs of Indian veterans on Indian reservations with the Veterans Health Administration and the Indian Health Service.

(3) Expanding the access and participation of the Department of Veterans Affairs, the Indian Health Service, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program.

(4) Acting as an ombudsman for Indian veterans enrolled in the health care system of the Veterans Health Administration.

(5) Advocating for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

(c) INDIAN DEFINED.—In this section, the term "Indian" has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

SEC. 7330C. CENTERS OF EXCELLENCE FOR RURAL HEALTH RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES

(a) ESTABLISHMENT OF CENTERS.—The Secretary, through the Director of the Office of Rural Health, shall establish and operate at least one and not more than five centers of excellence for rural health research, education, and clinical activities, which shall—

(1) conduct research on the furnishing of health services in rural areas;

(2) develop specific models to be used by the Department in furnishing health services to veterans in rural areas;

(3) provide education and training for health care professionals of the Department on the furnishing of health services to veterans in rural areas; and

(4) develop and implement innovative clinical activities and systems of care for the Department for the furnishing of health services to veterans in rural areas.

(b) USE OF RURAL HEALTH RESOURCE CENTERS.—In selecting locations for the establishment of centers of excellence under subsection (a), the Secretary may select a rural health resource center that meets the requirements of subsection (a).

(c) GEOGRAPHIC DISPERSION.—The Secretary shall ensure that the centers established under this section are located at health care facilities that are geographically dispersed throughout the United States.

(d) FUNDING.—(1) There are authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account of the Department of Veterans Affairs such sums as may be necessary for the support of the research and education activities of the centers operated under this section.

(2) There shall be allocated to the centers operated under this section, from amounts authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account by paragraph (1), such amounts as the Under Secretary of health considers appropriate for such centers. Such amounts shall be allocated through the Director of the Office of Rural Health.

(3) Activities of clinical and scientific investigation at each center operated under this section—

(A) shall be eligible to compete for the award of funding from funds appropriated for the Medical and Prosthetics Research Account; and

(B) shall receive priority in the award of funding from such account to the extent that funds are awarded to projects for research in the care of rural veterans.

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CHAPTER 74. VETERANS HEALTH ADMINISTRATION—PERSONNEL

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CHAPTER 75. VISUAL IMPAIRMENT AND ORIENTATION AND MOBILITY PROFESSIONALS EDUCATION ASSISTANCE PROGRAM

Sec.

7501. Establishment of scholarship program; purpose.

7502. Application and acceptance.

7503. Amount of assistance; duration.

7504. Agreement.

7505. Repayment for failure to satisfy requirements of agreement.

SEC. 7501. ESTABLISHMENT OF SCHOLARSHIP PROGRAM; PURPOSE

(a) ESTABLISHMENT.—Subject to the availability of appropriations, the Secretary shall establish and carry out a scholarship program to provide financial assistance in accordance with this chapter to an individual—

(1) who is accepted for enrollment or currently enrolled in a program of study leading to a degree or certificate in visual impairment or orientation and mobility, or a dual degree or certification in both such areas, at an accredited (as determined by the Secretary) educational institution that is in a State; and

(2) who enters into an agreement with the Secretary as described in section 7504 of this chapter.

(b) PURPOSE.—The purpose of the scholarship program established under this chapter is to increase the supply of qualified blind rehabilitation specialists for the Department and the Nation.

(c) OUTREACH.—The Secretary shall publicize the scholarship program established under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to such institutions with high numbers of Hispanic students and to Historically Black Colleges and Universities.

SEC. 7502. APPLICATION AND ACCEPTANCE

(a) APPLICATION.—(1) To apply and participate in the scholarship program under this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7504 of this chapter under which the participant agrees to serve a period of obligated service in the Department as provided in the agreement in return for payment of educational assistance as provided in the agreement.

(2) In distributing application forms and agreement forms to individuals desiring to participate in the scholarship program, the Secretary shall include with such forms the following:

(A) A fair summary of the rights and liabilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary.

(B) A full description of the terms and conditions that apply to participation in the scholarship program and service in the Department.

(b) APPROVAL.—(1) Upon the Secretary's approval of an individual's participation in the scholarship program, the Secretary shall, in writing, promptly notify the individual of that acceptance.

(2) An individual becomes a participant in the scholarship program upon such approval by the Secretary.

SEC. 7503. AMOUNT OF ASSISTANCE; DURATION

(a) AMOUNT OF ASSISTANCE.—The amount of the financial assistance provided for an individual under this chapter shall be the amount determined by the Secretary as being necessary to pay the tuition and fees of the individual. In the case of an individual enrolled in a program of study leading to a dual degree or certification in both the areas of study described in section 7501(a)(1) of this chapter, the tuition and fees shall not exceed the amounts necessary for the minimum number of credit hours to achieve such dual certification or degree.

(b) RELATIONSHIP TO OTHER ASSISTANCE.—Financial assistance may be provided to an individual under this chapter to supplement other educational assistance to the extent that the total amount of educational assistance received by the individual during an academic year does not exceed the total tuition and fees for such academic year.

(c) MAXIMUM AMOUNT OF ASSISTANCE.—(1) In no case may the total amount of assistance provided under this chapter for an academic year to an individual who is a full-time student exceed $15,000.

(2) In the case of an individual who is a part-time student, the total amount of assistance provided under this chapter shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the program of study being pursued by the individual as the coursework carried by the individual to full-time coursework in that program of study.

(3) In no case may the total amount of assistance provided to an individual under this chapter exceed $45,000.

(d) MAXIMUM DURATION OF ASSISTANCE.—The Secretary may provide financial assistance to an individual under this chapter for not more than six years.

SEC. 7504. AGREEMENT

An agreement between the Secretary and a participant in the scholarship program under this chapter shall be in writing, shall be signed by the participant, and shall include—

(1) the Secretary's agreement to provide the participant with financial assistance as authorized under this chapter;

(2) the participant's agreement—

(A) to accept such financial assistance;

(B) to maintain enrollment and attendance in the program of study described in section 7501(a)(1) of this chapter;

(C) while enrolled in such program, to maintain an acceptable level of academic standing (as determined by the educational institution offering such program under regulations prescribed by the Secretary); and

(D) after completion of the program, to serve as a full-time employee in the Department for a period of three

years, to be served within the first six years after the participant has completed such program and received a degree or certificate described in section 7501(a)(1) of this chapter; and

(3) any other terms and conditions that the Secretary determines appropriate for carrying out this chapter.

SEC. 7505. REPAYMENT FOR FAILURE TO SATISFY REQUIREMENTS OF AGREEMENT

(a) IN GENERAL.—An individual who receives educational assistance under this chapter shall repay to the Secretary an amount equal to the unearned portion of such assistance if the individual fails to satisfy the requirements of the agreement entered into under section 7504 of this chapter, except in circumstances authorized by the Secretary.

(b) AMOUNT OF REPAYMENT.—The Secretary shall establish, by regulations, procedures for determining the amount of the repayment required under this subsection and the circumstances under which an exception to the required repayment may be granted.

(c) WAIVER OR SUSPENSION OF COMPLIANCE.—The Secretary shall prescribe regulations providing for the waiver or suspension of any obligation of an individual for service or payment under this chapter (or an agreement under this chapter) whenever noncompliance by the individual is due to circumstances beyond the control of the individual or whenever the Secretary determines that the waiver or suspension of compliance is in the best interest of the United States.

(d) OBLIGATION AS DEBT TO UNITED STATES.—An obligation to repay the Secretary under this section is, for all purposes, a debt owed the United States. A discharge in bankruptcy under title 11 does not discharge a person from such debt if the discharge order is entered less than five years after the date of the termination of the agreement or contract on which the debt is based.

CHAPTER 76. HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

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Subchapter VII. Education Debt Reduction Program

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SEC. 7682. ELIGIBILITY

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(d) NOTICE TO POTENTIAL EMPLOYEES.—In each offer of employment made by the Secretary to an individual who, upon acceptance of such offer would be treated as eligible to participate in the Education Debt Reduction Program, the Secretary shall, to the maximum extent practicable, include the following:

(1) A notice that the individual will be treated as eligible to participate in the Education Debt Reduction Program upon the individual's acceptance of such offer.

(2) A notice of the determination of the Secretary whether or not the individual will be selected as a participant in the Education Debt Reduction Program as of the individual's acceptance of such offer.

SEC. 7683. EDUCATION DEBT REDUCTION

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(d) MAXIMUM ANNUAL AMOUNT.—(1) Subject to paragraph (2), the amount of education debt reduction payments made to a participant under the Education Debt Reduction Program may not exceed [$44,000 over a total of five years of participation in the Program, of which not more than $10,000 of such payments may be made in each of the fourth and fifth years of participation in the Program] *the total amount of principle and interest owed by the participant on loans referred to in subsection (a).*

(2) * * *

(e) SELECTION OF PARTICIPANTS.—(1) The Secretary shall select for participation in the Education Debt Reduction Program each individual eligible for participation in the Education Debt Reduction Program who—

(A) the Secretary provided notice with an offer of employment under section 7682(d) of this title that indicated the individual would, upon the individual's acceptance of such offer of employment, be—

(i) eligible to participate in the Education Debt Reduction Program; and

(ii) selected to participate in the Education Debt Reduction Program; and

(B) accepts such offer of employment.

(2) The Secretary may select for participation in the Education Debt Reduction Program an individual eligible for participation in the Education Debt Reduction Program who is not described by subparagraphs (A) and (B) of paragraph (1).

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