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HEARING ON PENDING HEALTH CARE LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

MAY 9, 2013

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MAY 9, 2013

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HEARING ON PENDING HEALTH CARE LEGISLATION

THURSDAY, MAY 9, 2013

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

The Committee met, pursuant to notice, at 10:03 a.m., in room 418, Russell Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Begich, Burr, and Boozman.

OPENING STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. Welcome to today's hearing to examine health legislation before this Committee. We have got a lot of work to cover. Let us get started.

This Committee intends to be aggressive in bringing forth legislation. We need to have stakeholders, people who are familiar with the issues that we are dealing with, comment on the concepts that we are bringing forth and then make those modifications that make sense.

Today's agenda reflects important work by Senators on both sides of the aisle. We have a number of pieces of legislation that Members on this Committee have authored as well as pieces authored by Members who are not on this Committee.

I think people are aware of the fact that veterans throughout this country are addressing many serious issues. I think both sides of the aisle in this Committee, as well as outside of this Committee, you see Members who want to introduce legislation to address some of those problems.

In the 111th Congress, I was pleased to support the Caregivers and Veterans Omnibus Health Services Act of 2010, which expanded services and benefits for caregivers of post-9/11 veterans. The Caregiver Program allows these seriously wounded veterans to receive care at home, provided by a family caregiver. As of the end of February, more than 8,600 veterans and their caregivers have benefited from this important program.

For as long as injured veterans have returned from the battlefield, family members have worked tirelessly to provide the safe environment for these heroes to live comfortably at home.

Historically, these caregivers have done this without any support from the Federal Government. This changed with the 2010 law when, for the first time, veterans' caregivers became eligible for supportive services and benefits.

These benefits included: a tax-free monthly stipend, reimbursement for travel expenses, health insurance, mental health services and counseling, training, and respite care. These benefits and services gave caregivers the support they needed to provide the best possible care for their loved ones. I am very proud of the success of that piece of legislation.

However, when the law was passed, these services were only made available to post-9/11 veterans and family members. The legislation I have introduced, S. 851, expands the Caregiver Program and extends these services and benefits to the caregivers of veterans of all eras.

Through this expansion, family members who have been providing care to eligible veterans from all other eras will be able to access the same supportive services as the caregivers of our most recent generation of veterans.

I hope that my colleagues will join with me in passing this important bill so that all of our veterans and the their families will be able to get the support that they need. There are so many families out there who have done the right thing by their loved ones, people who have been injured in war, and I think we need to support them.

The other piece of legislation that I am working on is a very consequential piece of legislation. In Vermont and all over this country there is an increasing understanding that health care is not just treating illness but it is preventing disease, supporting wellness and utilizing complementary and alternative medicine.

This broader understanding is growing by leaps and bounds. I can remember not so many years ago—Senator Burr, you may remember as well—when chiropractic care was thought to be somewhat outside of the mainstream. That has certainly come into the mainstream now. In fact, it is practiced within VA health care today. We have some legislation before us today, introduced by Senator Blumenthal, to expand access to chiropractic care in VA.

Acupuncture is also being practiced in VA facilities. Meditation and yoga are also being utilized in VA centers. I was recently in Brooklyn, NY, and out in Los Angeles. What the clinicians there tell me is that many veterans utilize these complementary and alternative medicine services with success, and the veterans enjoy it.

So, we are going to be introducing legislation to expand those concepts. I will go into that in more length, but Senator Burr, please say a few words. Senator Landrieu is also here, and I know she has legislation that she wants to talk about. We look forward to hearing from her.

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

Senator BURR. Thank you, Mr. Chairman. Thank you for calling this important hearing. I welcome all of our witnesses today and look forward to all of your testimony.

I also want to especially thank Tom Bowman for being here. Boy, he is somebody who has devoted his career to the VA and we are grateful for that, and I am grateful that you are here today to testify.

Mr. Chairman, as we consider all the bills on today's agenda, I think it is just as important to consider a few things, especially before creating or expanding programs. I believe we should start by considering how well existing programs work and identify any gaps in services and inefficiencies that exist.

By examining current programs, this will help us focus on the changes that are truly needed and avoid creating any duplication or overlap which is often very frustrating for veterans and for their families.

Last, it is also important to consider the fiscal challenges facing our Nation. We need to know the costs of any program before that program is moved forward, and we must find responsible ways to pay for all of these programs.

With all that in mind, I look forward to a productive discussion about the bills on today's agenda. To start, I would like to mention several of those bills which I have sponsored.

One is S. 543, the VISN Reorganization Act of 2013. This legislation would reform VA's Veterans Integrated Service Networks, or VISNs. In 1995, the veterans health care system was divided into 22 geographic areas. That is now 21 VISNs. Each region had its own headquarter with a limited management structure to support the medical facilities in that region.

Since that time, there has been a huge growth in staff at the VISN headquarters and increasing duplication in the duties they carry out. So, this bill would consolidate the boundaries of nine VISNs, move some oversight functions away from VISN management, and limit the number of employees at each VISN headquarters. All of this should make these networks more efficient and, more importantly, should allow resources to be reallocated to direct patient care.

Another bill is S. 529, which would change the start date for eligibility of hospital care and medical services in connection with exposure to the contaminated water at Camp Lejeune, NC.

This legislation is very simple. It would change the date from January 1, 1957, to August 1, 1953, which is based on a letter sent to Under Secretary Hickey from Dr. Christopher Portier, the Director of the National Center for Environmental Health and Agency for Toxic Substance and Disease Registry.

In this letter, Dr. Portier states, "according to our water modeling, we estimate that the first month any VOC exceeded the current EPA MCL in finished water was August 1953, and at least one VOC exceeded its current MCL in Hadnot Point drinking water from August 1953 through January 1985." Therefore, I believe there is credible evidence that warrants the change in the commencement date.

I would ask unanimous consent at this time that this letter be made a part of the record.

Chairman SANDERS. Without objection.

[The letter follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30341-3724

January 16, 2013

General Allison Hickey
Under Secretary for Benefits
Department of Veterans Affairs
810 Vermont Ave., NW
Washington, D.C. 20420

Dear General Hickey:

The purpose of this letter is to provide the Department of Veterans Affairs preliminary information regarding our assessment of volatile organic compound (VOC) exposures in drinking water distributed by the Hadnot Point and Holcomb Boulevard water treatment plants at the United States Marine Corps (USMC) Base Camp Lejeune.

The Agency for Toxic Substances and Disease Registry (ATSDR) has conducted a series of environmental and epidemiologic assessments of contaminated drinking water at USMC Base Camp Lejeune. The foundation of our effort is based on modeling of the contamination of the drinking water supply before 1987. The modeling was necessary because there were relatively few drinking water samples tested for VOCs during the period of contamination; none prior to 1982, when VOC contamination was first detected.

ATSDR has focused on three different drinking water distribution systems: Tarawa Terrace, Hadnot Point, and Holcomb Boulevard. We released the final Tarawa Terrace drinking water system report in June 2007. That report concluded that former Marines and their families who lived in Tarawa Terrace family housing units during the period November 1957 through February 1987 received drinking water contaminated with the dry-cleaning solvent tetrachloroethylene (PCE) at levels above the current EPA maximum contaminant level (MCL) of 5 ppb. The executive summary of the report is located on our website at:
http://www.atsdr.cdc.gov/sites/lejeune/docs/TT_Executive_Summary_June142007_508.pdf

ATSDR has developed additional models for the Hadnot Point and Holcomb Boulevard water distribution systems. We have drafted our final report and completed peer review. The report is currently in clearance. We expect to release the final report of these water models sometime in spring 2013. Preliminary findings for Hadnot Point indicate that the dates of contaminated drinking water differ from the dates of contamination at Tarawa Terrace. The dates of operation and the sources of contamination to the drinking water supplied by Hadnot Point are independent of the drinking water from Tarawa Terrace.

Page 2 – General Allison Hickey

According to our water modeling, we estimate that the first month any VOC exceeded the current EPA MCL in finished water was August 1953, and at least one VOC exceeded its current MCL in Hadnot Point drinking water from August 1953 through January 1985.

I hope this information is useful as the Department of Veterans Affairs evaluates claims from veterans who served at USMC Camp Lejeune prior to the release of our full water modeling report in the spring. ATSDR is also on schedule to release its mortality study and birth defects and childhood cancers study in spring 2013. When we finalize our water modeling and these epidemiologic studies, I will make certain that we brief the Department of Veterans Affairs staff on our findings. I would also like to recognize the efforts of your Department in supporting ATSDR's work and serving Camp Lejeune veterans and their families who were exposed to contaminated drinking water.

Sincerely,

Christopher J. Portier, Ph.D.
Director, National Center for
Environmental Health, and
Agency for Toxic Substances and
Disease Registry

cc:
B Flohr – VA Benefits
T. Walters – VA Health
Camp Lejeune Community Assistance Panel
Department of Navy

Senator BURR. Last, I would like to touch on one other bill, S. 825, which is a bill Chairman Sanders and I introduced together that would improve VA homeless prevention programs and VA transitional housing.

This legislation will reduce barriers many homeless veterans face including providing legal services, provide services to dependent children of those veterans seeking services through the transitional housing program and ensure the safety of women by requiring facilities to meet the gender-specific needs of homeless women veterans.

Mr. Chairman, all of these bills would provide common-sense solutions to real issues affecting our Nation's veterans, their families, and their survivors. I look forward to working with you and with the rest of our colleagues to see that these and other worthwhile bills on today's agenda can soon become law.

I thank the Chair.

Chairman SANDERS. Senator Burr, thank you very much and thank you for your support on the Homeless Veterans' Prevention Act of 2013. I look forward to working with you to make sure that we pass that important piece of legislation.

I also want to concur with you. Our job is, as an oversight committee, to make sure that we do not see duplication, we do not see waste. I happen to believe that, by and large, the VA has a very

strong health care system. They are doing a good job. But it is a huge system and nobody, I think, can tell us that everything is perfect. Our job is to see how we can improve it, make it cost effective, and add new programs which strengthen it.

With that, I am delighted to welcome our colleague from Louisiana who is here to talk about a very important issue.

Senator Landrieu, thank you very much for being here.

STATEMENT OF HON. MARY L. LANDRIEU, U.S. SENATOR FROM LOUISIANA

Senator LANDRIEU. Thank you so much, Senator Sanders, and thank you, Senator Burr for your focus on the needs of our veterans and improving our outreach to them and our health care to them. I thank you for the diligence, Mr. Chairman, that you bring to this issue particularly.

I wanted to bring to both of your attention a bill that I have filed, S. 412, and I am happy that Senator Blumenthal, Senator Isakson, and Senator Hirono have joined me at cosponsoring this important legislation that is pending before your Committee.

The bill is called Keep Our Commitment to Veterans Act. It would give the go ahead to authorize major medical facilities that have been in a holding pattern due to an unexpected and recent change in the CBO scoring.

I am sure your Committee has heard many complaints about this. I am sure both of you are very familiar with it, but I wanted to bring it to your attention today very briefly.

Last September, the Veterans' Affairs Committees in the House and the Senate were not able to authorize the VA-requested fiscal year 2013 major medical facility leases in the annual construction and extenders package due to a new scoring method.

CBO changed the scoring method for major medical facilities, significantly increasing the costs of these facilities. Now, we find ourselves here in a situation in Louisiana where we have had two clinics, Mr. Chairman, on the board now in proposal for several years that are now in complete limbo, and we have 20,000 veterans in this area of our State, which is in southwest Louisiana—a growing, vibrant area of our State—without access to a clinic.

Under the old scoring method, these 13 clinics would be $126 million. Under the new scoring method, it is $1.4 billion. We have got to find, I think, an administrative way forward here, not just for the clinics in Louisiana, of course, which I am here to advocate for and the veterans communities that are really in desperate need of these facilities and have been promised year after year. But I understand, Mr. Chairman, that this affects other States as well. I am sure you are well aware.

So, on behalf on the 20,000 veterans and their families that I am here to represent, I look forward to working with you to find a solution to help these veterans that have served our Nation so proudly and so ably.

We need to fix this situation. As an appropriator I most certainly understand the challenges in our budget, yet perhaps with some work between the Appropriations Committee and this good oversight and authorizing Committee, we can find a way forward.

It is an opportunity for us to make clear to our veterans that the promises we made to them we want to hold to those promises.

Thank you, Mr. Chairman, and I will submit the rest of my statement for the record, and thank you, Senator Burr.

[The prepared statement of Senator Landrieu follows:]

PREPARED STATEMENT OF HON. MARY L. LANDRIEU,
U.S. SENATOR FROM LOUISIANA

Thank you Chairman Sanders and Ranking Member Burr for affording me the opportunity to speak in support of S. 412, the "Keep Our Commitment to Veterans Act."

I would also like to thank Senators Blumenthal, Isakson and Hirono for cosponsoring this important legislation.

The Keep Our Commitment to Veterans Act would give the go ahead to authorize major medical facilities that have been in a holding pattern due to a change in Congressional Budget Office (CBO) scoring.

Last September, the Veterans' Affairs Committees in the House and the Senate were not able to authorize VA's requested FY 2013 Major Medical Facility Leases in the annual construction and extenders package due to the way the leases were scored by the CBO.

The CBO changed the scoring methodology for major medical facility leases, significantly increasing the cost of the facilities, by requiring 19 years rent up front.

Now we find ourselves in a situation with no path forward. Regardless of whether the CBO scoring method is right or wrong, this sort of bureaucratic bottleneck is unacceptable.

Under the scoring method used in the past, the cost of the FY 2013 clinics would be a little over $126 million dollars. This amount was factored into the budget baseline.

However, the 15 FY 2013 clinics are now being scored at a cost of nearly $1.4 billion dollars. This is a thousand percent increase!! The 12 FY 2014 clinics would now cost $1.16 billion dollars.

Given the current budgetary climate, this is no time to implement burdensome financial requirements. This scoring system will have widespread implications for veterans nationwide, pulling the rug out from under our Nation's vets.

The FY 2013 and FY 2014 clinics would serve over 1.3 million veterans in 18 states.

Nearly 20,000 veterans would be served by the 2 delayed clinics in my home state of Louisiana. Those are 20,000 veterans who have served our Nation proudly.

These veterans served in international engagements such as World War II, Korea, Vietnam, Iraq, and Afghanistan. They served in the Navy, Marines, Army, and the Air Force. They served their country with pride and have earned the care they were promised.

We need to fix this issue as it is only going to get worse. There are approximately 50 leases that are due to expire before the end of FY 2016 and will be impacted if the budgetary treatment of major medical facilities is not resolved.

This is an opportunity to make it clear that this Congress recognizes the importance of properly authorizing and appropriating funds in order to provide our veterans receive the care that they deserve. The "Keep Our Commitment to Veterans Act" will do just that.

Chairman SANDERS. Senator Landrieu, thank you very much for focusing on an issue which, as you indicated, goes well beyond Louisiana.

One of the great advances made by the VA in recent years has been the expansion of the CBOC program which is what you are talking about, Community-Based Outreach Clinics.

I think we all know that when veterans or nonveterans are able to access affordable primary health care that keeps them healthier, keeps them out of the hospital, in the long run it saves our system money. The CBOC program has been very successful in Vermont and all over this country. I do not want to see an impediment from the way the CBO deals with this issue limit our ability to expand CBOCs.

So, you raise a very important question which is something that this Committee has got to address. Senator Burr, did you want to add anything to that?

Senator BURR. As one who participated before the CBO determination and exercise, the lease option I understand, the benefits that it provided especially at the clinic and outpatient level, and I look forward to working with you on this.

Chairman SANDERS. We will be dealing with CBO on this issue to do our best.

Thank you, Senator, very much.

I would now like to bring up our first panel which is Dr. Robert Jesse, Principal Deputy Under Secretary for Health at the Department of Veterans Affairs. Dr. Jesse is accompanied by Susan Blauert, Deputy Assistant General Counsel.

Thank you both very much for providing the Department's perspective on the pending health care legislation. We look forward to hearing your testimony. Dr. Jesse, why do you not begin please.

STATEMENT OF ROBERT JESSE, M.D., Ph.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SUSAN BLAUERT, DEPUTY ASSISTANT GENERAL COUNSEL

Dr. JESSE. Good Morning, Chairman Sanders, Ranking Member Burr, and Members of the Committee. We thank you for the opportunity to address the bills on today's agenda and to discuss the impact of these bills on Veterans' Administrating health care delivery.

As you mentioned, joining me today is Susan Blauert, VA's Deputy Assistant General Counsel.

Chairman Sanders, we greatly appreciate your continued efforts to support and improve veterans' health care. VA is carefully reviewing two of your bills, one concerning complementary and alternative medicine and the other expanding the Family Caregiver Assistance Act.

We anticipate providing full views on these bills soon. In the meantime, we will work with your staff to provide technical assistance. We believe we can provide valuable insight as to how VA can better integrate complementary and alternative medicine into our mission to provide personalized proactive and patient-driven care that support the health and well-being of veterans.

In my oral remarks, I am going to briefly explain VA's position on a few of the bills being considered today. A much more detailed discussion of all the bills on the agenda can be found in my written statement.

Generally, VA supports bills expanding services to veterans. These bills include S. 325, which would increase the maximum age for eligibility of children covered under CHAMPVA Program and S. 455, which would make permanent our ability to use paid drivers to expand access to VA health care for individuals traveling for the purposes of medical care.

The VA also supports S. 529, which would expand the period of eligibility for benefits for the Camp Lejeune veterans by 4 years. I would like to thank Ranking Member Burr for his ongoing efforts to support our Camp Lejeune veterans.

VA has made a number of recommendations on the Camp Lejeune program to make it easier to implement and easier for family members and veterans alike. These include simplifying the administrative eligibility requirements and shifting to DOD the determination of whether the veteran and qualified family members meet the 30-day requirement on Camp Lejeune. We believe these modifications to S. 529 would greatly improve our ability to implement the Camp Lejeune law.

We support much of bill S. 131, which would permit VA to provide expanded reproductive services, including in-vitro fertilization for certain veterans and their spouses suffering from infertility. However, we do not support extending these services to engage in surrogates who would bear children for veterans primarily because variations and complexities in the State laws and policies would make a surrogacy provision extremely difficult to implement. We are concerned about our authority to support veterans in dealing with the entirety of the many complex issues involving surrogates.

So, a few of the provisions in this bill will require a little more time before VA can provide a position. For now, we remain hopeful, though, that Congress will enact the much-needed extension of our authority to operate our existing child care pilot so that we can continue to collect and analyze cost and utilization data.

VA supports the intent of S. 422, the Chiropractic Care Available to All Veterans Act of 2013, which would expand access to chiropractic care to all veterans. However, VA believes that the health administration is best situated to determine the parameters of such an expansion.

Decisions regarding the delivery, care through staffing versus a fee basis should be predicated both on demand and local capability. That would include the availability of licensed chiropractic professionals for hire into the VA system or through referral to them in the community.

We acknowledge that there is need for a thorough assessment of our current chiropractic services. In fact, such a study is now nearing completion, and we would welcome the opportunity to work closely with the Committee to ensure that legislation in this area supports veterans' preferences.

And finally, I would like to address S. 543, which would consolidate our existing 21 VISNs into 12 and proscribe a specific VISN organizational structure and staffing model.

As we discussed last year, VA shares the goal of increasing the efficiency of our operations. However, we do not support the imposition of a staffing and organizational structure that is not based on a complete assessment of business needs.

Last month, we provided the Committee staff an update on our progress toward implementing our internal reorganization and realignment. Standards have been established and we expect all VISNs to have completed the first phase of the reorganization by the end of this year. This will enhance quality and consistency of the management processes and will enable VHA to better assess cost effectiveness.

For phase two, a work group has been charted to undertaken an analysis of VISN geographic boundaries and contemporary referral patterns. A process we believe is necessary to form any decision

about redrawing the VISN scope. We look forward to keeping the Committee advised on our analysis and the status of work in this area.

I would like to conclude by thanking you all for the opportunity to testify before the Committee and I will be pleased to respond to questions that you or the other Members have about the bills I have touch upon or other bills that were addressed in my written statement.

Thank you.

[The prepared statement of Dr. Jesse follows:]

PREPARED STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning Chairman Sanders, Ranking Member Burr, and Members of the Committee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

We do not yet have cleared views on sections 4, 10, 11, or 12 of S. 131, S. 287, section 3 of S. 522, S. 800, S. 832, S. 845, S. 851, S. 852, or the draft bill described as "The Veterans Affairs Research Transparency Act of 2013." Also, we do not have estimated costs associated with implementing S. 131, S. 422, S. 455, or S. 825. We will forward the views and estimated costs to you as soon as they are available.

S. 49 VETERANS HEALTH EQUITY ACT OF 2013

S. 49 would amend Title 38, Part II, Chapter 17, of the United States Code (U.S.C.) to include a new section 1706A. Section 1706A would require the Secretary to ensure that Veterans in each of the 48 contiguous States have access to at least one full-service Department medical center or to comparable hospital care and medical services through contract with other in-State health care providers. Section 1706A would define a full-service Department medical center as a facility that provides medical services including, hospital care, emergency medical services, and standard-level-complexity surgical care. Additionally, the Secretary would be required to submit a report to Congress within one year describing VA's compliance with these requirements and how the quality and standards of care provided to Veterans has been impacted.

VA objects to this legislation because it is unnecessary. VA engages in an extensive analysis of factors in order to identify appropriate locations to site VA health care facilities in order to best serve the patient population. These factors include, but are not limited to, projected total Veteran population, Veteran enrollee population, and utilization trends. VA analyzes this demand projection data over a 20-year period and takes into account Veteran access to various types of care and services. VA also utilizes its access guidelines, which take into account an acceptable amount of time a Veteran should reasonably travel to receive care depending upon whether the Veteran resides in an urban, rural, or highly rural community.

VA engages in population-based planning and seeks to provide services through a continuum of delivery venues, including outreach clinics, community-based outpatient clinics, and medical facilities or hospitals. When it is determined that a full-service hospital is not required, VA uses a combination of interventions to ensure the delivery of high quality health care such as contracting for care in the community, use of telehealth technologies and referral to other VA facilities. VA improves Veteran access to health care by providing care within or as close to the Veteran's community as possible, regardless of state boundary lines.

As an example, we note that VA is providing expanded acute care services to New Hampshire Veterans through contracts with local health care providers, in order to address the needs and concerns of the New Hampshire constituency. This model has been used for more than a decade to provide VA-coordinated care in a safe and cost effective manner. Providing services in this manner ensures that Veterans who use the Manchester VA Medical Center (VAMC) have available locally the same level of acute care services as other Veterans within the VA New England Healthcare System and elsewhere. Patients who require tertiary care, such as cardiac surgery or neurosurgery, and extended inpatient psychiatry will continue to be referred to appropriate VA facilities for this care.

S. 62 CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013

S. 62 would amend the Internal Revenue Code of 1986 to establish in the Treasury a trust fund known as the "Homeless Veterans Assistance Fund," and would allow taxpayers to designate a specified portion (not less than $1) of any overpayment of tax to be paid over to the Homeless Veterans Assistance Fund. Amounts in the Fund would be available "for the purpose of providing services to homeless veterans." S. 62 would require that in the President's annual budget submission for fiscal year (FY) 2014 and each year thereafter, VA, Department of Labor, and Department of Housing and Urban Development (HUD) include a description of the use of the funds from the Homeless Veterans Assistance Fund from the previous fiscal year and proposed use of such funds for the next fiscal year.

VA appreciates the sentiment behind this legislation, and we believe in emphasizing that Veteran homelessness is a national issue where communities and individuals across America can make great contributions, in many different ways. We are glad to have a dialog with the Committee on what VA is doing now to engage the public and communities across the Nation, and discuss innovative ways we can increase that engagement. Turning to S. 62, we applaud its intent, but cannot offer VA's support for its way of increasing that engagement . VA views its services to homeless Veterans as an obligation of the Nation, earned by those Veterans by their service. That is also reflected in Congress' enactment of laws to allow VA to provide these services. The Secretary has made clear that this is in fact one of VA's most important obligations. While we appreciate sincerely the motive of bringing this issue before the taxpayers, we believe the presence of a check-off to fund VA's programs could lead some to see these obligations as a discretionary charity. VA does involve charities and community organizations in its work, and they provide vital partners and complements to the work VA is doing to end Veteran homelessness. But VA prefers that all Federal funding come from affirmative appropriations provided by the Congress, rather than voluntary apportionments through the tax code.

S. 131 WOMAN VETERANS AND OTHER HEALTH CARE IMPROVEMENT ACT OF 2013

Section 2 of S. 131 would amend 38 U.S.C. section 1701(6) to include fertility counseling and treatment, including treatment using assisted reproductive technology, among those things that are considered to be "medical services" under chapter 17 of title 38, U.S.C.

VA supports section 2 of the bill, but must condition this support on assurance of the additional resources that would be required were this provision enacted. The provision of Assisted Reproductive Technologies (including any existing or future reproductive technology that involves the handling of eggs or sperm) is consistent with VA's goal to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives. For many, having children is an important and essential aspect of life. Those who desire but are unable to have children of their own commonly experience feelings of depression, grief, inadequacy, poor adjustment, and poor quality of life.

Section 3 of the bill would add a new section 1788 to title 38, U.S.C., that would require VA to furnish fertility counseling and treatment, including through the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill, or injured enrolled Veteran who has an infertility condition incurred or aggravated in the line of duty, if the spouse or surrogate and the Veteran apply jointly for such counseling and treatment through a process prescribed by VA. This section would authorize VA to "coordinate fertility counseling and treatment" for other spouses and surrogates of other Veterans who are seeking fertility counseling and treatment. Section 1788 would not be construed to require VA to furnish maternity care to a spouse or surrogate of a Veteran, or to require VA to find or certify a surrogate for or connect a surrogate with a Veteran. Subsection (d) of proposed section 1788 would define the term "assisted reproductive technology" to include "in vitro fertilization and other fertility treatments in which both eggs and sperm are handled when clinically appropriate."

VA supports section 3 in part, but must condition this support on assurance of the additional resources that would be required were this provision enacted. VA supports providing infertility services including assisted reproductive technology to severely wounded, ill, or injured enrolled Veterans described in section 3, and their spouses or partners. VA does not, however, support coverage of such services for surrogates at this time. The complex legal, medical, and policy arrangements of surrogacy vary from state to state due to inconsistent regulations between States, and we believe would prove to be very difficult to implement in practice. Moreover, the additional coverage of surrogates is inconsistent with coverage provided by the Department of Defense (DOD), Medicaid, Medicare, and several private insurers and

health systems. Current DOD policy addressing assisted reproductive services for severely injured Servicemembers specifically excludes coverage of surrogates. VA acknowledges that surrogacy may offer the only opportunity for Veterans and their spouses or partners to have a biological child. However, there may be other options to consider when exploring how best to compensate these Veterans for their loss and to facilitate procreation.

VA recommends the language of the bill be modified to account for different types of family arrangements, so that benefits are not limited to only spouses of Veterans described in proposed section 1788; VA recommends that section 1788 be revised to refer to a "spouse or partner" of a specified Veteran. In addition, the meaning and scope of the coordination contemplated under proposed section 1788(b) (which would authorize VA to "coordinate fertility counseling and treatment" for the spouses and surrogates of other Veterans not described in section 1788(a)) is unclear, and could potentially account for spouses and surrogates of all other Veterans. VA recommends that this be clarified.

Section 5 of the bill would require VA to report annually to the Committees on Veterans' Affairs of the Senate and House of Representatives on the fertility counseling and treatment furnished by VA during the preceding year. The first report would be required no later than one year after enactment. Each report submitted under section 5 would be required to contain specified information, including the number of Veterans, spouses, and surrogates who received fertility counseling and treatment furnished by VA; the costs of furnishing such counseling and treatment; and coordination of such counseling and treatment with similar services of DOD. VA does not object to such reporting.

Section 6(a) would require VA, no later than 540 days after enactment, to prescribe regulations to carry out proposed sections 1788 and 1789, and on fertility treatment to Veterans using assisted reproductive technology. Section 6(b) would prohibit VA from providing, until regulations are prescribed, fertility counseling and treatment under 1788, assistance under 1789, and to a Veteran "any fertility treatment that uses an assisted reproductive technology that the Secretary has not used in the provision of a fertility treatment to a veteran before the date of the enactment." The term "assisted reproductive technology" under section 6 would have the same meaning given to the term in proposed section 1788 of section 3.

VA does not support Section 6(a). While 540 days accorded for the drafting of regulations may seem like a long period of time, given the complexities of the issues involved, VA estimates that amount of time could be insufficient.

Section 7 of S. 131 would require the Secretary of VA and the Secretary of Defense to share best practices and facilitate referrals, as they consider appropriate, on the furnishing of fertility counseling and treatment. VA does not object to this requirement.

Section 8 of the bill would add a new section 7330B to title 38, U.S.C., entitled "Facilitation of reproduction and infertility research." This new section would require the Secretary of VA to "facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services" to improve VA's ability to meet the long-term reproductive health care needs of Veterans with service-connected genitourinary disabilities or conditions incurred or aggravated in the line of duty that affect the Veterans' ability to reproduce, such as spinal cord injury. The Secretary of VA would be required to ensure that information produced by research facilitated under section 7330B that may be useful for other activities of the Veterans Health Administration (VHA) is disseminated throughout VHA. No later than 3 years after enactment, VA would be required to report to Congress on the research activities conducted under section 7330B.

VA supports section 8 of S. 131. Generally, VA supports implementing research findings that are scientifically sound and that would benefit Veterans and improve health care delivery to Veterans. VA's goal is to restore the capabilities of Veterans with disabilities to the greatest extent possible. We utilize new research into various conditions to improve the quality of care we provide. Of note, rather than requiring VA to conduct research, this section would require VA to facilitate research that is conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services. It is not clear how the term "facilitate" would be defined, which could raise privacy and security issues with respect to identifiable Veteran information. Given the ambiguity over the meaning of this term, VA is unable to provide a cost estimate at this time. If facilitation requires fairly minor involvement (coordination, distribution, etc.), VA expects the costs of this provision would be nominal; however, if facilitation is intended to mean direct funding, proposal reviews, and additional staff, costs would be greater.

Section 9 of S. 131 would require VA to enhance the capabilities of the VA Women Veterans Call Center (WVCC) in responding to requests by women Veterans for as-

sistance with accessing VA health care and benefits, as well as in referring such Veterans to community resources to obtain assistance with services not furnished by VA.

VA supports section 9 and has established an inbound calling system specifically for women Veterans. By building on capabilities within WVCC, the incoming call center allows women Veterans to call WVCC to connect them to resources, assist with specific concerns, and provide information on services and benefits. Many of the Veterans are calling VA daily requesting more details on how to enroll, how to find their DD–214, and what benefits they have earned. WVCC can directly connect women Veterans to Health Eligibility Center employees for enrollment information and to discuss the benefits that might be available to them. The call could also be transferred to the appropriate medical center to assist eligible Veterans with obtaining a health care appointment. Once the woman Veteran is connected to VA health care services, the Women Veterans Program Manager can also assist her in finding community resources that may not be provided by VA.

VA is unable to provide views on sections 4, 10, 11, and 12 at this time, but will provide views on those provisions in a later submission to the Committee.

S. 229 CORPORAL MICHAEL J. CRESCENZ ACT OF 2013

S. 229 would designate the Department of VAMC located at 3900 Woodland Avenue in Philadelphia, Pennsylvania, as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center." VA defers to Congress in the naming of this facility.

S. 325 INCREASE OF MAXIMUM AGE FOR CHILDREN ELIGIBLE FOR MEDICAL CARE UNDER CHAMPVA PROGRAM

Contingent upon Congress providing additional funding to support the change in eligibility, VA supports S. 325, which would amend 38 U.S.C. section 1781(c) to extend eligibility for coverage of children under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) until they reach age 26 so that eligibility for coverage of children under CHAMPVA will be consistent with certain private sector coverage under the Affordable Care Act. S. 325 would extend eligibility for coverage of children under CHAMPVA regardless of age, marital status, and school enrollment status up to the age of 26; and the bill would ensure that CHAMPVA eligibility would not be limited for individuals described in section 101(4)(A)(ii) (individuals who, before attaining age 18, became permanently incapable of self-support). The bill would not extend eligibility for children who, before January 1, 2014, are eligible to enroll in an eligible employer-sponsored plan (as defined in Internal Revenue Code section 5000A(f)(2)). This means that the age, school status, and marital status requirements in 38 U.S.C. section 101(4) would, before 2014, apply to children who are eligible to enroll in an eligible employer-sponsored health plan and the bill would not extend eligibility for coverage of those individuals. This provision in the bill is in accordance with the discretion provided to grandfathered health plans that are group health plans in the private sector under the Affordable Care Act. The amendments made by S. 325 would apply with respect to medical care provided on or after the date of enactment of the bill.

VHA estimates that this provision would cost $51 million in FY 2014; $301 million over 5 years; and $750 million over 10 years.

S. 412 KEEP OUR COMMITMENT TO VETERANS ACT

S. 412 would authorize the Secretary to carry out certain major medical facility leases in FY's 2013 and 2014 for VA.

Section 2 of S. 412 would authorize the Secretary to carry out twelve major medical facility leases, all of which were included in VA's FY 2013 Budget Submission. Specifically, Section 2 would authorize the Secretary to carry out a major medical facility lease for a Clinical Research and Pharmacy Coordination Center in Albuquerque, New Mexico; a replacement Community Based Outpatient Clinic in Brick, New Jersey; a New Primary Care/Dental Clinic Annex in Charleston, South Carolina; a Community-Based Outpatient Clinic in Cobb County, Georgia; an Outpatient Healthcare Access Center in Honolulu, Hawaii, to include a co-located clinic with DOD and the co-location of VBA's Honolulu Regional Office and the Kapolei VA Vet Center; a Community-Based Outpatient Clinic in Lafayette, Louisiana; a Community-Based Outpatient Clinic in Lake Charles, Louisiana; an Outpatient Clinic Consolidation in New Port Richey, Florida; an Outpatient Clinic Expansion in Ponce, Puerto Rico; a Lease Consolidation in San Antonio, Texas; an Errera Community Care Center in West Haven, Connecticut; and a Community-Based Outpatient Clinic in Worcester, Massachusetts.

Section 3 of S. 412 would provide new authorizations for the Secretary to carry out a major medical facility lease, previously authorized in FY 2010, for a Community-Based Outpatient Clinic in Johnson County (Lenexa), Kansas; a major medical facility lease, previously authorized in FY 2011, for a Community-Based Outpatient Clinic in San Diego, California; and, a major medical facility lease, previously authorized in FY 2006, for a Community-Based Outpatient Clinic in Tyler, Texas.

VA supports this section, but requests that the amounts for each lease be revised to be consistent with the prospectuses included in VA's 2014 Budget Submission. The lease authorizations amounts and project scopes changed to reflect more current estimates. VA suggests modifying the language as set forth below.

> "The Secretary of Veterans Affairs may carry out the following major medical facility leases in FY 2014:
>
> (1) Johnson County, Kansas, Community-Based Outpatient Clinic, in an amount not to exceed $2,263,000.
>
> (2) San Diego, California, Community-Based Outpatient Clinic, in an amount not to exceed $11,946,100.
>
> (3) Tyler, Texas, Community-Based Outpatient Clinic, in an amount not to exceed $4,327,000."

VA supports S. 412. VA's leasing program is an important component of providing health care to Veterans. Leasing has been and continues to be an essential part of VA's capital portfolio management, and significantly supports VA's mission to meet the service needs of our Nation's Veterans.

In addition, VA has put forth, in its FY 2014 budget, 12 additional major medical facility lease projects, for a total of 27 major medical facility leases. The 27 leases included in the FY 2014 Budget Request are new and replacement leases. The 2014 Budget Request also proposes changes to legislation to allow greater collaboration with other Federal agencies and proposes changes to legislation to amend VA's Enhanced-Use Lease statute. The proposed changes would enhance the repurposing of VA's assets and improve the ability to develop joint DOD/VA facilities. The details of the leases and proposed legislation can be found in the VA budget documents transmitted to Congress on April 10, 2013.

S. 422 CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

S. 422 would require VA to establish programs for the provision of chiropractic care and services at not fewer than 75 medical centers by not later than December 31, 2014, and at all VAMCs by not later than December 31, 2016. Currently, VA is required (by statute) to have at least one site for such program in each VHA geographic services area.

Section 3(a) would amend the statutory definition of "medical services" in section 1701 of chapter 17, U.S.C., to include chiropractic services. Subsection (b) would amend the statutory definition of "rehabilitative services" in that same section to include chiropractic services. Finally, subsection (c) would amend the statutory definition of "preventive health services" in that same section to include periodic and preventive chiropractic examinations and services.

The bill would also make technical amendments needed to effect these substantive amendments.

In general, VA supports the intent of S. 422, but believes the decision to provide on-site or fee care should be determined based on existing clinical demands and business needs. Chiropractic care is available to all Veterans and is already part of the standard benefits package.

As VA increases the number of VA sites providing on-site chiropractic care, we will be able to incrementally assess demand for chiropractic services and usage, and to best determine the need to add chiropractic care at more sites.

Currently, VA does not have an assessment that would support providing on-site chiropractic care at all VAMCs by the end of 2016. Such a mandate could potentially be excessive, given the availability of resources for on-site chiropractors and non-VA care to meet the current need for services. VA does not object to sections 3(a) and (b) as those changes reflect VA's consideration of chiropractic care as properly part of what should be considered medical and rehabilitative services. VA, however, cannot support section 3(c) for lack of a conclusive consensus on the use of chiropractic care as a preventative intervention.

S. 455 TRANSPORTATION IN CONNECTION WITH REHABILITATION, COUNSELING, EXAMINATION, TREATMENT, AND CARE

S. 455 would make permanent VA's broad authority to transport individuals to and from VA facilities in connection with vocational rehabilitation, counseling, ex-

amination, treatment, or care. That authority currently will expire on January 10, 2014. This authority has allowed VA to operate the Veterans Transportation Program which uses paid drivers to complement the Volunteer Transportation Network, which uses volunteer drivers. The Volunteer Transportation Network supported by Veterans Service Organizations, especially the Disabled American Veterans, is invaluable; however, with increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers to serve the level of need. Furthermore, volunteer drivers are generally precluded from transporting Veterans who are not ambulatory, require portable oxygen, have undergone a procedure involving sedation, or have other clinical issues. Also, some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. Paid drivers have resulted in better access to VA health care, often for those for whom travel is the most difficult.

VA thus supports enactment of this bill, and proposed a five-year extension of this authority in the FY 2014 President's Budget. The budget assumes savings of $19.2 million in FY 2014 and $102.7 million over five years. As a technical matter, we suggest the bill's insertion of a new section 111A be changed to instead reflect the intent to replace the existing section 111A with the revised version.

S. 522, WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

S. 522, the Wounded Warrior Workforce Enhancement Act, would direct VA to establish two grant award programs. Section 2 of the bill would require VA to award grants to institutions to: (1) establish a master's or doctoral degree program in orthotics and prosthetics, or (2) expand upon an existing master's degree program in such area. This section would require VA to give a priority in the award of grants to institutions that have a partnership with a VAMC or clinic or a DOD facility. Grant awards under this provision must be at least $1 million and not more than $1.5 million. Grant recipients must either be accredited by the National Commission on Orthotic and Prosthetic Education or demonstrate an ability to meet such accreditation requirements if receiving a grant. VA would be required to issue a request for proposals for grants not later than 90 days after the date of enactment of this provision.

In addition to the two purposes noted above, grantees would be authorized to use grants under this provision to train doctoral candidates and faculty to permit them to instruct in orthotics and prosthetics programs, supplement the salary of faculty, provide financial aid to students, fund research projects, renovate buildings, and purchase equipment. Not more than half of a grant award may be used for renovating buildings. Grantees would be required to give a preference to Veterans who apply for admission in their programs.

VA does not support enactment of section 2 of this bill. We believe VHA has adequate training capacity to meet the requirements of its health care system for recruitment and retention of orthotists and prosthetists. VA offers one of the largest orthotic and prosthetic residency programs in the Nation. In FY 2013, VA allocated $837,000 to support 19 Orthotics/Prosthetics residents at 10 VAMCs. The training consists of a year-long post masters residency, with an average salary of $44,000 per trainee. In recent years, VA has expanded the number of training sites and the number of trainees. Moreover, recruitment and retention of orthotists and prosthetists has not been a challenge for VA. Nationally, VA has approximately 240 orthotic and prosthetic staff; there are currently only 7 positions open and being actively recruited.

Much of the specialized orthotic and prosthetic capacity of VA is met through contract mechanisms. VA contracts with more than 600 vendors for specialized orthotic and prosthetic services. Through both in-house staffing and contractual arrangements, VA is able to provide state-of-the-art commercially-available items ranging from advanced myoelectric prosthetic arms to specific custom fitted orthoses.

We also note the bill would not require these programs to affiliate with VA or send their trainees to VA as part of a service obligation. We also have technical concerns about the language in section 2, subsection (e). Specifically, the language directs the appropriators to provide funding ($15 million) in only one fiscal year, FY 2014, which would expire after three fiscal years. This subsection contemplates that unobligated funds would be returned to the General Fund of the Treasury immediately upon expiration. Under 31 U.S.C. section 1553(a), expired accounts are generally available for 5 fiscal years following expiration for the purpose of paying obligations incurred prior to the account's expiration and adjusting obligations that were previously unrecorded or under recorded. If the unobligated balance of these funds were required to be returned to the Treasury immediately upon expiration, then VA would be unable to make obligation adjustments to reflect unrecorded or

under recorded obligations. A bookkeeping error could result in an Antideficiency Act violation. Accordingly, we recommend the deletion of paragraph (2) of subsection (e). Further, we recommend that the words "for obligation" be deleted from paragraph (e)(1) of section 2 because they are superfluous. Last, we note that 90 days after the date of enactment of this provision is not enough time for VA to prepare a request for proposals for these grants.

VA is unable to provide views on section 3 at this time, but will provide views for the record at a future time.

S. 529 MODIFICATION OF CAMP LEJEUNE ELIGIBILITY

Public Law 112–154 provided authority for VA to provide hospital services and medical care to Veterans and family members who served on active duty or resided at Camp Lejeune for no less than 30 days from January 1, 1957, to December 31, 1987, for care related to 15 illnesses specified in the public law. S. 529 would modify the commencement date of the period of service at Camp Lejeune, North Carolina for eligibility under 1710(e)(1)(F) from January 1, 1957, to August 1, 1953, or to such earlier date as the Secretary, in consultation with the Agency for Toxic Substances and Disease Registry (ATSDR), specifies.

VA supports this change due to information provided in the scientific studies conducted by ATSDR. We do not believe this change would result in substantial additional costs.

VA also recommends that the Committee consider including language to simplify the administrative eligibility determination process and thereby relieve some of the burden from the Veteran and family member. Other special eligibility authorities included participation by DOD to determine exposure while on active duty. The current statute for Camp Lejeune Veterans and family members does not include this provision. VA recommends including a requirement for DOD to determine if the Veteran or family member met the 30-day presence requirement on Camp Lejeune.

S. 543 VISN REORGANIZATION ACT OF 2013

Section 2 of S. 543 would require VHA to consolidate its 21 Veterans Integrated Service Networks (VISN) into 12 geographically defined VISNs, would require that each of the 12 VISN headquarters be co-located with a VAMC, and would limit the number of employees at each VISN headquarters to 65 full-time equivalent employees (FTEE). VA opposes section 2 for the following reasons.

By increasing the scope of responsibility for each VISN headquarters while reducing the number of employees at each, the legislation would impede VA's ability to implement national goals. Currently, VISN headquarters are capable of providing assistance to supplement resource needs at facilities and are able to support transitions in staff within local facilities when there are personnel changes; with a responsibility for oversight of more facilities and fewer staff, the VISN headquarters would lose the opportunity to provide this essential service when needed. VHA has reviewed each VISN headquarters and is working with each to streamline operations, create efficiencies internal to each VISN, and realign resources. This will achieve savings without the negative impact of the restructuring proposed in S. 543.

The requirement in section 2 that VISN budgets be balanced at the end of each fiscal year may have unintended consequences. Currently, each VISN balances its accounts at the end of each fiscal year. Sometimes this is achieved by providing additional resources from VHA. These resources may be needed for a number of reasons, including greater-than-anticipated demand, a national disaster or emergency, new legal requirements enacted during the year, and other factors. Under S. 543, VA may lose the flexibility to supplement VISNs with additional resources, potentially compromising patient care.

Section 2 would also require VA to identify and reduce duplication of functions in clinical, administrative, and operational processes and practices in VHA. We are already doing this by identifying best practices and consolidating functions, where appropriate. Further, section 2 describes how the VISNs should be consolidated but fails to articulate clearly the flow of leadership authority. Consequently, S. 543 would blur the lines of authority from VHA Central Office, regions, and VISNs to medical centers, which could actually impede oversight and create confusion.

Additionally, the original VISN boundaries were drawn carefully based on the health needs of the local population. By contrast, the proposed combination of VISNs does not account for the underlying referral patterns within each VISN. For example, it is unclear why VISNs 19 and 20 should be consolidated. This would produce a single Network responsible for overseeing 12 states, 15 VA health care systems or medical centers, and a considerable land mass, while VISN 6 would continue to oversee three states and eight health care systems or medical centers. VA

would appreciate the opportunity to review the Committee's criteria for determining these boundaries.

Finally, section 2 seems to assume that locating the management function away from a medical center represents an inefficient organizational approach. That assumption is not valid in all cases. Currently, six VISNs (1, 2, 3, 20, 21, and 23) are co-located with a VAMC. The legislation's requirement for co-location with a VAMC would require either construction to expand existing medical centers, using resources that would otherwise be devoted to patient care to cover administrative costs, or would require the removal of certain clinical functions to create administrative space for VISN staff in at least nine VISNs.

As a result, Veterans potentially would be forced to travel to different locations for services or would be unable to access new services that would have been available had construction resources not been required to modify existing facilities to accommodate VISN staff. While section 4 states that nothing in the bill shall be construed to require any change in the location or type of medical care or service provided by a VA medical center, the reality is that requiring co-location would necessitate this result.

VA also does not support section 3 of S. 543. Section 3 would require VA to create up to four regional support centers to "assess the effectiveness and efficiency" of the VISNs. Section 3 identifies a number of functions to be organized within the four regional support centers including:

- Financial quality assurance;
- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn outreach;
- Women's Veterans programs assessments;
- Homelessness effectiveness assessments;
- Energy assessments; and
- Other functions as the Secretary deems appropriate.

Certain services are more appropriately organized as national functions rather than regional ones. For example, regional functions addressing homelessness and women Veterans issues would duplicate existing national services. The current structure (VISN accountability and national oversight) ensures accountable leadership oversight that is proximate to health care services provided to Veterans at VA facilities. By contrast, S. 543 would create competing oversight entities.

In addition, the functions listed in section 3 may not be the most appropriate ones for consolidation. VHA has created seven Consolidated Patient Account Centers to achieve superior levels of sustained revenue cycle management, established national call centers to respond to questions from Veterans and their families, and is assessing consolidation of claims payment functions to achieve greater efficiencies and accuracy. We believe these types of functions are more appropriate to move off-station. S. 543 appears to contemplate a reduction in the FTEE associated with regional management but in practice, the proposed regional support centers are likely to increase overall staffing needs, resulting in a diversion of resources from patient care. If each of the four regional support centers is 110 FTEE, a realistic assumption given the scope of responsibilities identified in the legislation, the proposed model would result in overall growth of regional staff compared with VHA's current plans.

Currently, it is not possible to identify costs for the proposed legislation; however, it is expected that the requirement to collocate functions with Medical Centers will result in costlier clinical leases. Additionally, the proposed VA Central Office, VISN, and Regional Support Center structure will result in increased FTEE requirements.

S. 633 COVERAGE UNDER DEPARTMENT OF VETERANS AFFAIRS BENEFICIARY TRAVEL PROGRAM OF TRAVEL IN CONNECTION WITH CERTAIN SPECIAL DISABILITIES REHABILITATION

S. 633 would amend VA's beneficiary travel statute to ensure beneficiary travel eligibility for Veterans with vision impairment, Veterans with spinal cord injury (SCI) or disorder, and Veterans with double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program (including programs provided by spinal cord injury centers, blind rehabilitation centers, and prosthetics rehabilitation centers), but only when such care is provided on an in-patient basis or during a period in which VA provides the Veteran with temporary lodging at a VA facility to make the care more accessible. VA would be required to report to the Committees on Veterans' Affairs of the Senate and House of Representatives no later than 180 days after enactment on the beneficiary travel program as amended by this legislation, including the cost of the program, the number of Veterans served by the program, and any other matters the Secretary

considers appropriate. The amendments made by this legislation would take effect on the first day of the first fiscal year that begins after enactment.

VA supports the intent of broadening beneficiary travel eligibility for those Veterans who could most benefit from the program, contingent on provision of funding, but believes this legislation could be improved by changing its scope. As written, the bill could be construed to apply for travel only in connection with care provided through VA's special rehabilitation program centers and would apply only when such care is being provided to Veterans with specified medical conditions on an inpatient basis or when the Veteran must be lodged. VA provides rehabilitation for many injuries and diseases, including for Veterans who are "Catastrophically Disabled," at numerous specialized centers other than those noted in S. 633, including programs for Closed and Traumatic Brain Injury (CBI+TBI), Post-traumatic Stress Disorder and other mental health issues, Parkinson's Disease, Multiple Sclerosis, Epilepsy, War Related Injury, Military Sexual Trauma, Woman's Programs, Pain Management, and various addiction programs. In addition, many of these programs provide outpatient care to Veterans who might not require lodging but must travel significant distances on a daily basis who would not be eligible under this legislation.

Therefore, VA feels that the legislation as written would provide disparate travel eligibility to a limited group of Veterans. However, VA does support the idea of travel for a larger group of "Catastrophically Disabled" Veterans (including Veterans who are blind or have SCI and amputees) and those with special needs who may not be otherwise eligible for VA travel benefits. VA welcomes the opportunity to work with the Committee to craft appropriate language as well as ensure that resources are available to support any travel eligibility increase that might impact upon provision of VA health care.

VHA estimates costs for this provision as $2.4 million for FY 2014; $13.1 million over 5 years; and $29.8 million over 10 years.

S. 825 HOMELESS VETERANS PREVENTION ACT OF 2013

This bill would amend title 38 to improve the provision of services for homeless Veterans and their families. VA supports many of the sections of this bill, including increasing the amount of per diem payments for Veterans that are participating in the Grant and Per Diem (GPD) program through a "transition in place" grant, providing permanent authority for VA's Veteran Justice Outreach program, authorizing VA to fund entities to provide legal services to Veterans who are homeless or at risk of homelessness, and extending a number of VA's existing homeless authorities, provided that any additional resources necessary to implement these provisions are enacted. However, we do have reservations concerning the following sections.

Section 4 would amend 38 U.S.C. section 2012(a) to permit a grantee receiving per diem payments under VA's Homeless Provider GPD program to use part of these payments for the care of a dependent of a homeless Veteran who is receiving services covered by the GPD program grant. This authority would be limited to the time period during which the Veteran is receiving services under the grant.

VA supports the intent of section 4. We feel that this authority is needed to fully reach the entire homeless population. However, we are concerned that full implementation of the legislation would require additional funding to avoid diminished services for the population of homeless Veterans now being served by VA.

Section 5 would require the Secretary to assess and measure the capacity of programs receiving grants under 38 U.S.C. section 2011.

VA does not support section 5 because it would be an unnecessary and duplicative reporting requirement. VA already monitors occupancy rates and geographic distribution of GPD grantees through a number of resources. Furthermore, section 5 would impose a new reporting requirement on GPD grantees, a burden that would be felt by community providers not just the Department.

Section 9 would extend dental benefits under 38 U.S.C. section 2062 to a Veteran enrolled in VA's health care system who is also receiving for a period of 60 consecutive days assistance under section 8(o) of the United States Housing Act of 1937 (commonly referred to as section 8 vouchers).

VA supports the intent of section 9, but must condition this support on assurance of the additional resources that would be required were this provision enacted. VA recognizes the need for dental care and supports the improvement of oral health and well-being for Veterans experiencing homelessness. Studies have shown that after dental care, Veterans report significant improvement in perceived oral health, general health, and overall self-esteem; thus, supporting the notion that dental care is an important aspect of the overall concept of homeless rehabilitation. Increasing ac-

cess to dental care for HUD-VA Supportive Housing program participants is, therefore, an important step in VA's Plan to End Veteran Homelessness.

Additionally, to help clarify that subsection (c) of section 8 describes legal services provided, rather than the organizations that provide them, we recommend adding the phrase "capable of providing the legal services" after the word "organizations" in section 8(d)(1).

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members may have.

ADDITIONAL VIEWS RECEIVED FROM THE
U.S. DEPARTMENT OF VETERANS AFFAIRS

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 11, 2013

The Honorable Bernie Sanders
Chairman
Senate Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The agenda for the Senate Committee on Veterans Affairs' May 9, 2013, legislative hearing included a number of bills that the Department of Veterans Affairs was unable to address in our testimony. We are aware of the Committee's interest in receiving our views and cost estimates for those bills. By this letter, we are providing views and cost estimates on section 4 and sections 10-12 of S. 131; S. 287; section 3 of S. 522; S. 800; sections 2-3 and 5-10 of S. 825; S. 832; S. 845; S. 851; and S. 877. We are also providing views for S. 852. In addition, we are providing cost estimates for sections 2 and 3 of S. 131; S. 422; section 2 of S. 522; and sections 6 and 7 of S. 852.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

Eric K. Shinseki

Enclosure

S. 131, WOMAN VETERANS AND OTHER HEALTH CARE IMPROVEMENT ACT OF 2013

Section 2 of S. 131 would amend 38 U.S.C. § 1701(6) to include fertility counseling and treatment, including assisted reproductive technology, among those things that are considered "medical services" under chapter 17 of title 38, U.S.C. As discussed in VA's May 9, 2013, testimony, VA supports section 2 of the bill, conditioned on the availability of the additional resources needed to implement this provision.

VA estimates that section 2 would cost $81.5 million in fiscal year (FY) 2015; $296 million over five years; and $652 million over ten years. These estimates reflect the costs of new services that are not included currently in the medical benefits package and costs associated with maternity services for additional pregnancies that may result from the use of assisted reproductive technology. These estimates do not reflect potential costs associated with additional enrollment or utilization of currently covered services that may result if the bill is enacted.

Among other things, section 3 of S. 131 would add a new section 1788 to title 38, U.S.C., that would require VA to furnish fertility counseling and treatment, including assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill or injured enrolled Veteran who has an infertility condition that was incurred or aggravated in the line of duty, if the spouse or surrogate and Veteran apply jointly through a process prescribed by VA. As discussed in VA's May 9, 2013 testimony, VA supports section 3 of the bill in part, conditioned on the availability of the additional resources that would be required to implement this provision.

VA estimates that section 3 would cost $102 million in FY 2015; $319 million over five years; and $717 million over ten years. These estimates include coverage of spouses and partners of covered Veterans. These estimates do not include costs associated with coverage of surrogates; as discussed in VA's May 9, 2013 testimony, VA does not support coverage of surrogates at this time.

Section 4 of S. 131 would authorize the Secretary to provide adoption assistance to severely wounded, ill, or injured Veterans who suffer from infertility conditions incurred or aggravated in the line of duty. VA understands the intent of this provision but has numerous concerns that merit further consideration. VA would need to consider the possible associated responsibilities that could go along with monetary adoption support, including adequate oversight of the agencies or entities that would receive the funds and potential issues of State law. VA also must carefully consider additional demands on its resources that would not be directed at core medical services for Veterans.

VA estimates that section 4 would cost $96.27 million in FY 2015; $521.46 million over five years; and $1.16 billion over ten years.

Section 10 of S. 131 would expand the locations and duration of the pilot program required by section 203 of Public Law 111–163. Section 203 required VA to carry out a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services in group retreat settings to women Veterans recently separated from service after a prolonged deployment. Section 10(a) would increase the number of locations at which VA is required to carry out the pilot program from three to fourteen. Section 10(b) would extend the duration of the pilot from two to four years. Section 10(c) would amend section 203(f) to authorize the appropriation of $400,000 for each of FY 2013 and FY 2014 to carry out the pilot program.

VA supports section 10 of S. 131. VA has completed the final year of the original two-year pilot program, and the report required by section 203 was submitted to Congress on May 9, 2013. Initial reports show favorable results, indicating that the retreats, which focus on building trust and developing peer support in a therapeutic environment, supply participants with tools needed for successful reintegration into civilian life. Additional retreats would generate more data to inform a comprehensive assessment of the program during the new final reporting phase under section 10.

Although VA supports section 10, there may not be fourteen distinct geographic locations that satisfy the retreat requirements, such as the need for specialized locations for outdoor team-building exercises. VA would continue to look for new locations, but recommends that section 10(a) be amended to require VA to carry out the pilot program in up to fourteen locations, some of which may be repeat locations from the original pilot program.

In addition, VA recommends that section 10(b) be amended to require the pilot program be "carried out through September 30, 2015," rather than requiring that it be "carried out during the four-year period beginning on the date of the commencement of the pilot program." This would ensure that VA has a sufficient period of time to carry out additional retreats for eligible women Veterans and generate data for analysis. For the same reason, we recommend section 10(c) be amended to authorize the appropriation of $400,000 "for each of fiscal years 2013 through 2015" to carry out the pilot program.

VA estimates section 10 would cost $337,320 in FY 2014 and, if the pilot extends through FY 2015, $350,520 in FY 2015, for a total cost of $687,840.

Section 11(a) of S. 131 would add a new section 1709B to title 38, U.S.C. that would make permanent VA's authority to provide assistance to qualified Veterans to obtain child care so that such Veterans can receive certain health care services.

VA would be required to carry out the program in no fewer than three Veterans Integrated Service Networks. This section would also identify certain forms of assistance that may be provided. VA's pilot program providing such services under section 205 of Public Law 111–163 would expire upon enactment of section 11(a).

VA does not support a permanent mandatory authority to provide child care assistance. VA has four operational pilot locations where child care assistance is provided pursuant to section 205 of Public Law 111–163. The first pilot began operation in October 2011. The remaining pilots were set up in a staggered fashion with the most recent pilot not beginning until 2013. Under current law, all pilots are scheduled to end on October 2, 2013, therefore, not affording three pilots the benefit of two full years of operation.

Without two full years of operational data from each pilot, VA is not able to adequately assess long-term utilization needs and cost implications of the program. In light of this longer term analysis that includes an evaluation of resources, VA believes permissive authority to allow expansion of the program would be preferable to a permanent mandatory authority to provide child care assistance. Permissive authority would allow facilities at the local level to make a determination based on need and utilize resources, space and security as necessary.

VA is unable to provide an accurate cost estimate for a permanent mandatory child care program, in part, because of the lack of data on the existing pilots that have run for less than two years, but also because such an estimate would be dependent on location of the sites, the ability to contract in the area of the designated sites, and the utilization of services.

Section 11(b) of S. 131 would add a new section 1709C to title 38, U.S.C. that would require VA to carry out a program to provide assistance to qualified Veterans to obtain child care so that such Veterans can receive readjustment counseling and related mental health services. The program would be carried out in at least three Readjustment Counseling Service Regions selected by VA. This section would identify certain forms of child care assistance that may be provided, and it would define "Vet Center" as "a center for readjustment counseling and related mental health services for veterans under section 1712A of [title 38, U.S.C.]."

VA supports section 11(b) in principle. Some Veterans who use Vet Center services, especially those who have served in Iraq or Afghanistan, have voiced concern that a lack of child care has impacted their ability to use Vet Center services consistently. Although Vet Center staff are always searching for new initiatives to increase Veteran access to services, VA has concerns about implementing child care assistance under section 11(b) without the opportunity to pilot this type of benefit. A pilot program is needed because VA currently is unable to predict utilization of this type of assistance. Comparisons to medical center pilots are not useful because Vet Centers provide services during non-traditional hours, including after normal business hours and on weekends when requested by the Veteran. This inability to predict utilization affects VA's ability to budget the program appropriately. VA recommends that section 11(b) be modified to authorize a pilot program to determine the feasibility, advisability, and costs of providing child care assistance to Veterans who utilize Vet Center services.

VA is not able to provide an accurate cost estimate for section 11(b) because VA lacks child-care experience for the special Vet Center context as described above and comparable models.

Section 12 of S. 131 would add a new section 323 to title 38, U.S.C., entitled "Contractor user fees." Under proposed section 323(a), VA would be required to impose a fee on each person with whom the Secretary engages in a contract for a good or service as a condition of the contract. The fee amount would be the lesser of: (1) seven percent of the total value of the contract, and (2) the total value of the contract multiplied by an applicable percentage calculated for the fiscal year. Before each fiscal year, VA would be required to establish an annual estimate of the total value of contracts for the next fiscal year and an annual estimate of the total cost of furnishing fertility counseling and treatment—including the use of assisted reproductive technology—and payments under proposed section 1789 (under section 4 of S. 131) for the next fiscal year, both of which would be used in estimating the applicable percentage for the fiscal year (the percentage by which the former exceeds the latter). The Secretary would have discretion to waive the fee for a person as the Secretary considers appropriate if the person is an individual or "small business concern" (as defined in section 3 of the Small Business Act). Fees could not be collected under proposed section 323(a) unless the expenditure of the fee is provided for in advance in an appropriations Act.

Proposed section 323(e) would establish a fund in the Treasury to be known as the "Department of Veterans Affairs Fertility Counseling and Treatment Fund," and all amounts received under proposed section 323(a) would be deposited in the fund.

Subject to the provisions of appropriations Acts, amounts in the fund would be made available, without fiscal year limitation, to VA to furnish fertility counseling and treatment—including the use of assisted reproductive technology—to eligible individuals and to make payments under proposed section 1789 (under section 4 of S. 131). Amounts received by VA under proposed section 323(a) would be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 as offsets to discretionary appropriations (rather than as offsets to direct spending), to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified.

VA does not support section 12, which VA estimates could result in up to 7 percent less money available for contract actions. That is because contractors could be expected to pass this cost back to VA in the form of higher contract prices. Applying the proposed fee to "a contract for a good or service" without limitation would subject VA Administrations' and Offices' (e.g., Veterans Benefits Administration, National Cemetery Administration, Office of Human Resources and Administration, and Office of General Counsel) budget dollars for contracts to funding health care services. This would impact these entities' budgets, particularly in smaller offices, for a purpose that is wholly unrelated to their primary functions. In this difficult time of budget limitations, this is impractical and could negatively impact overall VA performance. In addition, determining a percentage and implementing it for the beginning of each fiscal year would be difficult administratively, as would the process of collecting and accounting for these funds. (As a technical matter, the word "person" should be replaced with "contractor" throughout this provision.)

In many industries and for many contractors, the existing profit margins would not tolerate a 7 percent cut.

S. 287, EXPANSION OF THE DEFINITION OF HOMELESS VETERAN

VA supports S. 287, which would broaden the definition of "homeless Veteran" in 38 U.S.C. § 2002(1). Section 2002(1) currently defines homeless Veteran by reference to the definition of homeless person found in subsection (a) of the McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11302. The bill would amend § 2002(1) to also refer to subsection (b) of § 11302, which includes in the definition of homeless person "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing."

VA serves Veterans fleeing from domestic violence and intimate partner violence (DV/IPV) when they otherwise meet the definition of homeless and when it is clinically appropriate to do so. Even when it is not clinically appropriate to place a Veteran affected by DV/IPV in a VA homeless program, VA works closely with local community organizations to identify resources that would most effectively address the needs of the Veteran. S. 287 would more closely align the definitions of homeless used by VA and the Department of Housing and Urban Development. This would facilitate data sharing and promote comprehensive interagency program evaluation.

Although VA supports the bill, we note that it may not always be clinically appropriate to merely place a victim of DV/IPV in a VA homeless program. VA clinical experience and empirical research has shown that effective DV/IPV intervention involves collaboration among many programs and agencies. An array of services, from crisis intervention to long-term assistance, is needed to serve Veterans fleeing violent relationships. Immediate crisis intervention may include medical care and assistance with food, shelter, child care and general safety. Long-term assistance may include ongoing medical care, counseling to cope with the lasting emotional and psychological effects of DV/IPV, and services to address economic and housing stability.

In recognition of the complex needs of Veterans affected by DV/IPV, VA recently chartered a Domestic Violence Task Force. The Task Force will develop a national plan to address DV/IPV issues in depth. However, as noted, effectively addressing the problem of DV/IPV will require collaboration between many programs and local, State, and Federal agencies.

Within VA, there is a continuum of care with homeless services ranging from rapid stabilization to permanent supportive housing. VA's homeless programs may help prevent future DV/IPV by providing Veterans with alternative housing options so that they can safely exit abusive relationships. VA is committed to Veterans affected by DV/IPV, and VA programs addressing DV/IPV specifically will continue to collaborate with VA homeless programs to ensure those fleeing DV/IPV get the care and support they need.

VA is not able to provide an accurate cost estimate for S. 287 because we lack detailed data regarding the size and characteristics of this population. We do note that many VA providers have limited training related to DV/IPV, and that S. 287 would likely require additional training. This would generate additional costs and a commensurate requirement for funding.

The definition of "homeless veteran" in 38 U.S.C. §2002(1) also applies to the Homeless Veterans Reintegration Programs (HVRP) administered by the U.S. Department of Labor. VA defers to the Secretary of Labor on the application of the new definition of homelessness to the HVRP program.

S. 422, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

VA provided views on S. 422 in our testimony on May 9, 2013. In general, VA supports the intent of S. 422, but believes the decision to provide on-site or fee care should be determined based on existing clinical demands and business needs. Chiropractic care is available to all Veterans and is already part of the standard benefits package. As VA increases the number of VA sites providing on-site chiropractic care, we will be able to incrementally assess demand for chiropractic services and usage, and to best determine the need to add chiropractic care at more sites.

Currently, VA does not have an assessment that would support providing on-site chiropractic care at all VAMCs by the end of 2016. Such a mandate could potentially be excessive, given the availability of resources for on-site chiropractors and non-VA care to meet the current need for services. VA does not object to sections 3(a) and (b) as those changes reflect VA's consideration of chiropractic care as properly part of what should be considered medical and rehabilitative services. VA, however, cannot support section 3(c) for lack of a conclusive consensus on the use of chiropractic care as a preventative intervention. VA estimates the costs associated with S. 422 to be $4.99 million in FY 2014; $26.8 million over five years; and $59 million over ten years.

S. 522, WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

Section 3 of S. 522 would require VA to award a $5 million grant to an institution to: (1) establish the Center of Excellence in Orthotic and Prosthetic Education (the Center) and (2) improve orthotic and prosthetic outcomes by conducting orthotic and prosthetic-based education research. Under the bill, grant recipients must have a robust research program; offer an education program that is accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs; be well recognized in the field of orthotics and prosthetics education; and have an established association with a VA medical center or clinic and a local rehabilitation hospital. This section would require VA to give priority in the grant award to an institution that has, or is willing and able to enter into: (1) a memorandum of understanding with VA, the Department of Defense (DOD), or other Government agency; or (2) a cooperative agreement with a private sector entity. The memorandum or agreement would provide resources to the Center or assist with the Center's research. VA would be required to issue a request for proposals for grants not later than 90 days after the date of enactment of this provision.

VA does not support section 3 because VA would not have oversight of the Center and there would be no guarantee of any benefit to VA or Veterans. Further, we believe that a new Center is unnecessary. DOD has an Extremity Trauma and Amputation Center of Excellence (EACE), and VA works closely with EACE to provide care and conduct scientific research to minimize the effect of traumatic injuries and improve outcomes of wounded Veterans suffering from traumatic injury. VA also has six Research Centers of Excellence that conduct research related to prosthetic and orthotic interventions, amputation, and restoration of function following trauma:

1. Center of Excellence for Limb Loss Prevention and Prosthetic Engineering in Seattle, WA.
2. Center of Excellence in Wheelchairs and Associated Rehabilitation Engineering in Pittsburgh, PA.
3. Center for Functional Electrical Stimulation in Cleveland, OH.
4. Center for Advanced Platform Technology (APT) in Cleveland, OH.
5. Center for Neurorestoration and Neurotechnology in Providence, RI.
6. Maryland Exercise and Robotics Center of Excellence (MERCE) in Baltimore, MD.

These centers provide a rich scientific environment in which clinicians work closely with researchers to improve and enhance care. They are not positioned to confer terminal degrees for prosthetic and orthotic care/research but they are engaged in training and mentoring clinicians and engineers to develop lines of inquiry that will

have a positive impact on amputee care. Finally, the requirement to issue a request for proposals within 90 days of enactment would be very difficult to meet as VA would first need to promulgate regulations prior to being able to issue the RFP.

VA estimates that sections 2 (views previously provided) and 3 of S. 522 would cost $160,000 in FY 2014 and $21.7 million over 5 years.

S. 800, TRETO GARZA FAR SOUTH TEXAS VETERANS INPATIENT CARE ACT OF 2013

VA does not support S. 800. The bill would require VA to ensure that the South Texas Health Care Center in Harlingen, Texas, which currently operates as an expanded outpatient clinic, include a full service inpatient health care facility. More specifically, S. 800 would require the facility to provide 50 inpatient beds, an urgent care center, and a full range of services for women Veterans that are already provided at the outpatient clinic on location.

The region served by the South Texas VA Health Care Center in Harlingen, referred to in S. 800 as Far South Texas, has been the subject of three studies by VA since 2007 (two conducted internally and one by an outside contractor) to assess the need for an acute care inpatient facility. The conclusions of the most recent study affirm those of previously conducted studies, indicating no sound basis for building an inpatient facility in this area. Completed analysis of enrolled Veteran population demographics, demand for services or utilization, and geospatial analysis of drive time access measures indicate that Veterans in the area have access to acute inpatient care through contracts at rates that meet or exceed the current VA standard. Based on these studies and for the following reasons, VA believes the Harlingen facility should remain an expanded outpatient clinic.

Currently, VA provides inpatient care in the relevant geographic region through contracts with non-VA providers. Nearly all enrollees in the relevant counties have access to acute care facilities within a 60-minute drive from their home. Through these contracts, supplemented by referrals of complex cases to San Antonio VA Medical center, VA provides complete inpatient care for Veterans in Far South Texas. The expenditure to build and operate a new 50 bed inpatient facility would not significantly increase the percentage of Veterans gaining access to inpatient care within a 60 minute drive from their home. Consolidating inpatient care for Veterans at a new VA hospital, when compared to the current contract model, would increase operating expenses by approximately $14–15 million annually without significantly increasing the percentage of enrollees meeting VA's access standard.

VA estimates that construction to add inpatient care to this facility would cost $406.5 million. VA estimates that total salary expenditures for the first year full year of operation, FY 2121, would be $51.29 million.

S. 825, HOMELESS VETERANS PREVENTION ACT OF 2013

S. 825 would amend title 38 to improve the provision of services for homeless Veterans and their families. In our May 9, 2013 testimony, VA indicated that it supported many of the sections of S. 825 but did not provide detailed views on all sections. Outlined below are VA's views and costs on sections 2–3 and 5–10 of S. 825. VA is working to develop a cost estimate for section 4.

Section 2(a) of S. 825 would amend current law to authorize the Secretary, when awarding grants under the Grant and Per Diem (GPD) Program, to assist eligible entities not only in establishing, but also in maintaining programs to furnish services for homeless Veterans (i.e., outreach services; rehabilitative services; vocational counseling and training; and transitional housing assistance). VA supports Section 2(a). As VA works toward ending Veteran homelessness, VA does not anticipate a pressing need to create additional transitional housing beds. Consequently, rehabilitating and maintaining current GPD beds would be a more cost effective way of maintaining GPD transitional beds nationwide.

Section 2(b) would amend current law to prohibit the Secretary from making a grant under the GPD Program unless the prospective grantee agrees to maintain the physical privacy, safety and security needs of homeless Veterans receiving services though the project. VA supports Section 2(b). This new requirement would reinforce the GPD Program's inspection efforts and ensure that grantees comply with VA's ongoing efforts to meet the privacy, safety and security needs of Veterans participating in the program. As a practical matter, current GPD grantees would absorb the costs of these improvements because VA lacks authority to remodel or renovate existing GPD facilities.

VA does not anticipate that section 2(a) would lead to additional costs beyond the current authorization of appropriations (38 U.S.C. 2013). The provision would allow VA to allocate existing funds to support rehabilitating and maintaining existing GPD projects. Section 2(b) also would not result in any additional costs. If subse-

quent legislation provided more specific definitions of physical, privacy, safety and security, however, it is possible that VA could incur costs or costs that cannot presently be determined.

Section 3 would amend current law to increase the per diem payments for Veterans who are participating in the GPD Program through a "transition in place" (TIP) grant. The per diem payments under GPD TIP would be increased by 150 percent of the VA State Home rate. VA supports Section 3. Supporting Veterans' transition from homelessness to permanent housing is fundamental to ending homelessness among Veterans. By allowing Veterans to "transition in place" to permanent housing, the Department would provide a valuable alternative for Veterans who may not need or be interested in participating in the Housing and Urban Development—VA Supportive Housing (HUD-VASH) program.

VA estimates that section 3 would be cost neutral since the funds would come from existing appropriations to the GPD program.

As indicated in our testimony on May 9, 2013, VA supports the intent of section 4. VA has not yet completed its cost analysis for this provision, however, and will provide the completed cost estimate as soon as it is completed.

Section 5 would require VA to assess and measure the capacity of programs receiving grants under 38 U.S.C. 2011 or per diem payments under 38 U.S.C. 2012 and 2061 and to use the information to set goals, inform funding allocation decisions, and improve the referral of homeless Veterans to programs receiving funding. VA supports the intent of section 5 but does not believe legislation is needed because VA conducts internal assessments of service programs.

VA estimates that section 5 would cost approximately $21,000 to gather and analyze the required information, and to draft the required report.

Section 6 would repeal section 2065 of 38 U.S.C. to remove the requirement that VA report to the Senate and House of Representatives Veterans' Affairs Committees on VA's activities during the preceding calendar year related to VA's programs homeless assistance programs.

VA supports section 6. Time spent on this reporting function would be better used by VA personnel to internally asses the programs and implement changes to enhance the benefits and services provided to homeless Veterans. VA conducts ongoing data analysis of VA homeless programs and remains committed to reporting data to the Committees upon request.

Section 6 would result in a small cost savings for VA. In FY 2013, VHA Homeless Programs prepared the FY 2012 VA Specialized Homeless Programs Report to Congress. At that time, VHA Homeless Programs estimated that it cost approximately $2,800 to produce the report. If Section 6 were enacted, VA expects that this would save at least $2,800 in each subsequent FY.

Section 7 would strike section 2023(d) of 38 U.S.C. and replace it with section 2023(e). This would eliminate the September 30, 2013 end date for VA's Veteran Justice Outreach (VJO) Program and VA's Healthcare for Reentry Veterans (HCRV) Program, programs that provide referral and counseling services for Veterans who are transitioning out of penal institutions and are at risk of homelessness. VJO's goal is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans involved with the criminal justice system have timely access to VA's mental health and substance use services when clinically indicated, and other VA services and benefits as appropriate. Similarly, HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment, and decrease the likelihood of re-incarceration for Veterans leaving prison.

VA supports section 7. Making these programs permanent would recognize the crucial role these programs play in preventing and ending Veteran homelessness.

Section 7 would not result in any new costs. The provision permanently authorizes VA's Veterans Justice Programs, including VJO and HCRV, but does not require direct spending and would be subject to available appropriations.

Section 7 would also eliminate the September 30, 2013 end date for the Department of Labor's Incarcerated Veterans Transition Program. VA defers to the Secretary of Labor for his views on the extension of this program.

Section 8 would authorize the Secretary to fund entities to provide legal services to Veterans, particularly those who are homeless or at risk of homelessness. Section 8 recognizes that the Secretary may partner with a wide variety of organizations for the provision of services. Additionally, the language authorizes VA to fund only a portion of the cost of legal services; VA may not pay for all of these services. This would require VA to properly leverage any expenditure under this authority by finding viable public or private entities capable of providing legal services.

VA supports section 8. Homeless and at-risk Veteran access to legal services remains a crucial but largely unmet need. Lack of access to legal representation for

outstanding warrants or fines, child support arrearages, driver's license revocation, and other legal matters continues to contribute to Veterans' risk of becoming and remaining homeless. A demonstration project conducted by the Department of Veterans Affairs, the Department of Health and Human Services' Office of Child Support Enforcement, and the American Bar Association indicates that legal services are instrumental in assisting Veterans who have child support arrearages."

VA estimates that section 8 would cost $750,000 in FY 2014; $3.9 million over five years; and $8.2 million over ten years.

Section 9 would extend dental benefits under 38 U.S.C. § 2062 to enrolled Veterans who are receiving, for a period of 60 consecutive days, assistance under section 8(o) of the United States Housing Act of 1937 (commonly referred to as section 8 vouchers). Section 9 would also amend current law to permit breaks in the continuity of assistance or care for which the Veteran is not responsible.

VA supports the intent of section 9, conditioned on the availability of additional resources that would be required if the provision is enacted. VA recognizes the need for dental care and supports the improvement of oral health and well-being for Veterans experiencing homelessness. Studies have shown that after dental care, Veterans report significant improvement in perceived oral health, general health and overall self-esteem, thus, supporting the notion that dental care is an important aspect of the overall concept of homeless rehabilitation. Increasing access to dental care for HUD-VASH program participants is, therefore, an important step in VA's Plan to End Veteran Homelessness.

VA estimates that section 9 would cost $88.6 million in FY 2014; $148.5 million over five years; and $216 million over 10 years.

Section 10 contains extensions to various existing VA authorities in U.S. Code. Section 10(a) would authorize appropriations of $250,000,000 for FY 2014 and $150,000,000 each fiscal year thereafter for VA's GPD Program.

VA supports Section 10(a) in part. Under current law, the amount authorized to be appropriated for FY 2014 will be reduced from $250,000,000 to $150,000,000 and then remain the same for each subsequent fiscal year. We support section 10(a) to the extent that it would retain the program's current level of authorization for FY 2014. We have concerns, however, about decreasing the authorization level to $150,000,000 for FY 2015 and each subsequent year. Such a decrease would be highly problematic. At the current rate, GPD expenditures would far exceed the amount authorized to be appropriated for the program for FY 2015 and thereafter. VA would require additional funding to support the existing projects at anticipated per diem and occupancy rates in FY 2015 and beyond. Otherwise, VA would be forced to cut per diem payments to GPD community providers or to summarily terminate GPD projects presently serving homeless Veterans.

Section 10(b) would extend the authorization of annual appropriations of $50,000,000 for the U.S. Department of Labor's Homeless Veterans Reintegration Programs through fiscal year 2014. We defer to the views of the Secretary of Labor on this provision.

Section 10(c) would extend VA's general treatment and rehabilitation authority (codified at 38 U.S.C. 2031(a)) for seriously mentally ill and homeless Veterans from December 31, 2013 to December 31, 2014. VA supports reauthorizing VA's Health Care for Homeless Veterans Program, VA's program offering outreach services and contract therapeutic housing, but suggests that section 2031 be amended in subsection (b) by striking "2013" and inserting "2016." VA does not anticipate any additional costs associated with this section.

Section 10(d) would extend VA's operation of comprehensive service centers for homeless Veterans under section 2033 of 38 U.S.C. from December 31, 2013 to December 31, 2014. VA supports section 10(d), which would re-authorize VA's Community Resource and Referral Centers but suggests that section 2033 be amended in subsection (d) by striking "2013" and inserting "2016." VA does not anticipate any additional costs associated with this section.

Section 10(e) would extend through December 31, 2014, the Secretary's authority under section 2041 of 38 U.S.C. to sell, lease, or donate properties to nonprofit organizations that provide shelter to homeless Veterans. Under current law, the authority will expire on December 31, 2013. VA supports section 10(e) because it will help VA meet the Secretary's goal of ending Veteran homelessness by 2015. While any extension of authority under 38 U.S.C. 2041 would result in a reduction in property sales proceeds, neither a one-year, nor a five-year extension would result in any significant loan subsidy costs.

Section 10(f) would require VA to make available (from amounts appropriated for Medical Services) $300,000,000 for FY 2013 for its program under section 2044 of 38 U.S.C. offering financial assistance for supportive services for very low-income Veteran families in permanent housing (Supportive Services for Veterans Families,

or SSVF). VA has already budgeted $300 million for the SSVF Program in FY 2014. VA supports section 10(f), which would re-authorize appropriations for the SSVF Program, VA's premier prevention and rapid re-housing program. However, VA suggests that 38 U.S.C. 2044(e)(1) be amended by adding after subparagraph (E): "(F) Such sums as may be necessary for fiscal year 2014, and thereafter." This change would provide VA with the flexibility to devote the necessary funding to operations under the SSVF Program. SSVF is an essential part of VA's plan to end Veteran homelessness, and VA may need to devote more resources to SSVF as VA concludes the Veteran homelessness initiative. There are no costs associated with this section as it provides authorization for appropriations beginning in FY 2014.

VA also suggests that 38 U.S.C. 2044(e)(3) be amended to read: "From amounts appropriated to the Department for Medical Services, there shall be authorized $1,500,000 for each fiscal year to carry out the provisions of subsection (d)." These changes would allow VA to devote more resources to technical assistance for SSVF grantees. By the beginning of FY 2014, VA will have more than tripled the number of SSVF grantees from the first grant round. With this influx of grantees, VA needs a larger authorization so that VA can provide ongoing training and assistance to these grantees.

Section 10(g) would extend VA's GPD Program for homeless Veterans with Special Needs through 2015. VA supports this measure but suggests that 38 U.S.C. 2061 be amended in subsection (d) by striking "for each of fiscal years 2007 through 2013." VA does not anticipate any additional costs associated with this section.

Section 10(h) would extend VA's authority under 39 U.S.C. 2064 to offer technical assistance grants for non-profit community-based groups. VA supports this measure. VA does not anticipate any additional costs associated with this section.

Section 10(i) would extend VA's Advisory Committee on Homeless Veterans from December 31, 2013, to December 31, 2014. VA supports this measure but suggests that 38 U.S.C. 2066 be amended in subsection (d) by striking "2013 and inserting "2016." This technical change would authorize the Advisory Committee through the end of the Veteran homelessness initiative so that the Committee can assess the successes of the initiative and identify actions that could be taken to improve other VA Programs as well as other homelessness programs across the country. VA does not anticipate any additional costs associated with this section.

S. 832, IMPROVING THE LIVES OF CHILDREN WITH SPINA BIFIDA ACT OF 2013

Section 2 of S. 832 would require VA to carry out a three-year pilot program to assess the feasibility and advisability of furnishing children of Vietnam Veterans and certain Korea service Veterans born with spina bifida and children of women Vietnam Veterans born with certain birth defects with case management services under a national contract with a third party. The Secretary would have the option to extend the program for an additional 2 years.

Under the bill, a covered individual is any person who is entitled to health care under chapter 18 of title 38 and who lives in a rural area and does not have access to case management services. The Secretary would be responsible for determining the appropriate number of covered individuals to participate in the pilot. S. 832 would require VA to provide these individuals with coordination and management of needed health care, monetary, and general care services authorized under Chapter 18; transportation services; and such other services as the Secretary considers appropriate. The bill would also require the Secretary to inform all covered individuals of the services available under the pilot program and to submit preliminary and final reports to the Senate and House Committees on Veterans Affairs.

VA supports section 2 of the bill but notes that VA already has authority to provide case management services, and currently reimburses beneficiaries for case management services by an approved provider. Support of section 2 of S. 832 is contingent on appropriation of any additional funds for services beyond what are currently provided by VA. See 38 U.S.C. § 1803(c)(1)(A). In addition, VA is reviewing the viability of providing case management via contract to increase access to these services to all covered beneficiaries, including those in rural areas. As this beneficiary population ages into adulthood, increased case management and care coordination services are needed to meet their unique health care challenges, and a systematic approach to offering these services may better serve this group of beneficiaries.

In addition, VA has several technical comments to the bill language. As noted above, section 2(e)(2) would require VA to provide "transportation services" to all covered individuals in the program. These services could include transportation for both health care purposes and personal purposes such as for vacations etc. The services could also include transportation for visiting family and friends and for those

providing health care and other services to the covered individuals. It is unclear whether the Committee intends to require VA to provide the full extent of transportation services described above and not permit VA to limit transportation services provided. If this is not the case, we recommend that the Committee clearly authorize VA to limit the scope of transportation services by adding "as the Secretary considers appropriate" after "transportation services" in section 3(e)(2).

As noted above, section 2(e)(1) would require VA to provide "[c]oordination and management of needed health care, monetary, and general care services authorized under chapter 18 of title 38, United States Code." The reference to "monetary, and general care services" is confusing. The term "health care" is already defined in chapter 18, and that definition does not include monetary and general care services. It is unclear whether monetary and general care services are intended to be services in addition to what is included in the definition of "health care." If so, we recommend revising this provision to read: "[c]oordination and management of needed health care authorized under chapter 18 of title 38, United States Code, and monetary and general care services." We further recommend defining the terms "monetary services" and "general care services." Finally, we note that section 2(a) would require VA to enter into "a national contract with a third party entity" to carry out the pilot program while section 2(f)(2) would require VA to enter into "contracts" for the same purpose. It may be possible to provide these services through a national contract but in case that is not feasible, we would prefer the flexibility to enter into contracts regionally as needed. Accordingly, we recommend replacing the words "a national contract with a third party entity" in section 2(a) with the words "contracts with third party entities."

VA estimates the total costs for section 2, including case management, care coordination and oversight, to be $3.024 million in FY 2014; $15.98 million over five years; and $36.97 million over ten years.

Section 3 of S. 832 would require VA to carry out a three-year pilot program to assess the feasibility and advisability of providing assisted living, group home care, and similar services in lieu of nursing home care to covered individuals. The Secretary would have the option to extend the pilot for an additional two years. Section 3(d) of the bill would require VA to provide covered individuals with assisted living, group home care, or such other similar services; transportation services; and such other services as the Secretary considers appropriate. The bill would also direct the Secretary to provide covered individuals with notice of the services available under the pilot; to consider contracting with appropriate providers of these services; and to determine the appropriate number of covered individuals to be enrolled in the pilot and criteria for enrollment. Section 3 of the bill would also specify preliminary and final reporting requirements.

VA does not support section 3 of the S. 832. The provision would extend benefits to spina bifida beneficiaries beyond what VA is authorized to provide to Veterans, including service-connected veterans. Service-connected Veterans who need assisted living, group home care, and similar services are equally deserving of receiving these benefits.

VA is unable to develop an accurate cost estimate at this time; however, we have several technical comments to the bill language. Section 3(a) would require VA to commence carrying out this program not later than 180 days after enactment of this Act. This would not be sufficient time because VA would be required to issue regulations, including a notice and public comment period, prior to carrying out this program. In particular, regulations would be required to define assisted living and group home care, to designate what services are similar to assisted living and group home care, and to identify any other services appropriate for the care of covered individuals under the pilot program. Finally, VA would be required by regulation to establish the criteria for enrollment of the appropriate number of covered individuals.

By requiring VA to carry out the program of providing assisted living, group home care, or similar services to covered individuals "in lieu of nursing home care," VA could only provide these services if the spina bifida beneficiary would otherwise need nursing home care. We question whether many spina bifida beneficiaries who need nursing home care could be provided care instead in assisted living facilities, group homes or similar institutions. The Committee may wish to consider deleting the reference to "in lieu of nursing home care."

Section 3(b) defines "covered individuals" for purposes of this section to be spina bifida beneficiaries who are entitled to health care under subchapter I or III of chapter 18 of title 38, United States Code. This would include many beneficiaries who do not need assisted living, group home care, or similar services. The scope of services that VA is required to provide under this program includes services that could be useful to these beneficiaries even if they do not need assisted living, group home

care, or similar services. These services include transportation services and such other services as the Secretary considers appropriate for the care of covered individuals under the program. This section thus could be interpreted to require VA to provide these additional services to covered beneficiaries even if they are not in need of assisted living, group home care, or similar services in lieu of nursing home care. If the Committee intends this program to be for only spina bifida beneficiaries who need care in assisted living facilities, group homes or similar institutions, we recommend amending the definition of covered individual to require that they be determined to need assisted living, group home care, or similar services.

As noted above, section 3(d)(2) would require VA to provide "transportation services" to all covered individuals in the program. These services could include transportation for both health care purposes and personal purposes such as for vacations. The services could also include transportation for visiting family and friends and for those providing health care and other services to the covered individuals. It is unclear whether the Committee intends to require VA to provide the full extent of transportation services described above and not permit VA to limit transportation services provided. If this is not the case, we recommend that the Committee clearly authorize VA to limit the scope of transportation services by adding "as the Secretary considers appropriate" after "transportation services."

Section 3(g) would limit funding for this program to amounts appropriated or otherwise made available before the date of enactment of this Act. This would severely limit funding for the program. We suggest deleting "before the date of enactment of this Act."

Finally, this section does not provide for what happens to covered beneficiaries who are in assisted living when the pilot ends, who have no place else to go, and who have insufficient personal funds to stay in their current location. Although VA does not support section 3 of S. 832, if enacted we recommend authorizing VA to continue providing assisted living, group home care, or similar services to those who had received these services prior to the completion of the program to avoid adverse impact on this population.

S. 845, TO IMPROVE THE PROFESSIONAL EDUCATIONAL ASSISTANCE PROGRAM

VA supports S. 845, which would amend 38 U.S.C. § 7619 by eliminating the December 31, 2014 sunset date for the Health Professionals Scholarship Program (HPSP). The HPSP authorizes VA to provide tuition assistance, a monthly stipend, and other required education fees for students pursing education/training that would lead to an appointment in a healthcare profession. This program will help VA meet future need for health care professionals by obligating scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure/certification.

Extending this program for an additional five years would allow VA to offer additional scholarships to satisfy recruitment and retention needs for critical health care providers. The regulation development process is lengthy, involving legal review and public comment, and VHA anticipates that final HPSP regulations will be published by early 2014. If HPSP expires in December 2014, the program would be in operation for less than one academic year.

VA estimates that this bill would cost $850,000 in FY 2014 and $23.73 million over five years.

S. 851, CAREGIVERS EXPANSION AND IMPROVEMENT ACT OF 2013

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law (P.L.) 111–163 (the Act), signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits under the Act were authorized only for qualified family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers, include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not eligible for TRICARE and not entitled to care or services under a health-plan contract.

S. 851, the Caregivers Expansion and Improvement Act of 2013, would remove "on or after September 11, 2001" from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand eligibility under such program to Veterans of all eras who otherwise meet the applicable eligibility criteria.

Recently, VA sent a report to the Committees on Veterans' Affairs of the Senate and House of Representatives (House) (required by Section 101(d) of the Act) on the feasibility and advisability of such an expansion, as would be effected by S. 851. In that report, VA noted that expanding the Program of Comprehensive Assistance for Family Caregivers would allow equitable access to seriously injured Veterans from all eras (who otherwise meet the program's eligibility criteria) and their approved family caregivers. VA also noted that families across every generation have been caregivers who have sacrificed much for their Veteran and this Nation.

In the report, VA noted difficulties with making reliable projections of the cost impact of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a range of $1.8 billion to $3.8 billion in FY 2014.

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. This is especially true as VA presses to buttress mental health services and ensure the fullest possible access to care in rural areas. VA is also mindful as we look ahead to the allocations for the Veterans Benefits and Services functions in the Senate-passed and House-passed FY 2014 budget resolutions (S. Con. Res. 8 and H. Con. Res. 25, respectively).

We wish to make it very clear that VA believes an expansion of those benefits that are limited by era of service would result in equitable access to the Program of Comprehensive Assistance for Family Caregivers for long-deserving caregivers of those who have sacrificed greatly for our Nation. However, VA cannot endorse this measure before further engaging with Congress on these top-line fiscal constraints, within the context of all of VA health care programs. VA welcomes further discussion of these issues with the Committee.

S. 852, VETERANS HEALTH PROMOTION ACT OF 2013

Section 2 of S. 852, the Veterans Health Promotion Act of 2013 would require VA, acting through the Director of the Office of Patient Centered Care for Cultural Transformation (OPCC&CT), to operate at least one center of innovation for complementary and alternative medicine (CAM) in health research, education and clinical activities in each VISN.

Section 3 of the bill would require VA to establish a 3-year pilot program through OPCC&CT to assess the feasibility and advisability of establishing CAM centers within VA medical centers to promote the use and integration of such services for mental health diagnoses and pain management. The pilot would operate in no fewer than 15 separate medical centers and would provide voluntary CAM services to Veterans with a mental health condition diagnosed by a VA clinician or a pain condition for which the Veteran has received a pain management plan from a VA clinician. Section 3 would also impose quarterly and final reporting requirements.

VA supports sections 2 and 3 of S. 852. CAM practices already are widespread within VA, although with significant variation. According to the National Institute of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM), defining CAM is difficult. Thus, VA recommends using the term "Integrative Health" (IH) instead. In addition, because IH impacts the entire spectrum of healthcare and involves practitioners across healthcare professions and all points of care, VA recommends that the legislation not limit the provision of care to clinicians who provide IH services exclusively.

VA supports an integrated implementation of sections 2 and 3 that could build on the existing infrastructure within VHA and OPCC&CT that could include: (1) Expanding the capacity of existing VHA OPCC&CT Centers of Innovation to serve as National Integrative Health Centers of Innovation to develop and implement innovative clinical activities and systems of care, serve as regional learning centers, and work collaboratively with the identified pilot sites; (2) Creating additional sites of innovation (i.e., one in each VISN) that could develop specific models for the delivery of Integrative Health, including CAM; (3) Expanding the OPCC&CT Field Implementation Teams and educational initiatives to include IH and IH coaching to support the implementation of these sites/pilot projects; (4) Creating a national strategy and to address any barriers to implementation identified through the pilot and Centers of Innovation; and (5) Developing an evaluation strategy to assess impact.

These pilots would also operate in conjunction with existing initiatives, including the Mental Health Innovations Committee, the VA/DOD Health Executive Council's Pain Management Work Group, VHA's National Pain Office, and IH pilot projects

being undertaken at three Polytrauma Centers by OPCC&CT and the Physical Medicine and Rehabilitation Service National Program Office. Building on these pilots, VA recommends the legislation specify a total of "up to five" pilot projects at Designated Polytrauma Centers rather than five. The funding source for this proposed legislation is unclear, and implementation of sections 2 and 3 would be problematic without additional funding.

Section 4 of S. 852 would require VA to carry out a 3-year pilot program through the award of grants to public or private nonprofit entities to assess the feasibility and advisability of using wellness programs to complement the provision of mental health care to veterans and family members eligible for counseling under 38 U.S.C. § 1712A(a)(1)(C). Grantees would be required to periodically report to the Secretary, and VA in turn would report to Congress every 180 days during the pilot period.

VA supports section 4 but recommends that contracts be used instead of grants, because of the limited ability to fund grants within existing VA funding authority. In addition, VA uses the term "well-being" instead of wellness because well-being is a broader concept that incorporates whole person health, inclusive of mind, body and spirit.

As a component of the pilots identified in section 3 of S. 852, VA would pilot at up to five sites the use of wellness programs as a complementary approach to mental health care. This would be accomplished by training peers, volunteers, and patient advocates as IH coaches who will link Veterans to community organizations that can provide support focused on the Veterans' health and well-being, including self-development and spirituality, concepts that until recently were not associated with traditional medical care in the United States.

Section 5 of S. 852 would require VA to carry out a 2-year pilot program through the National Center for Preventive Health to assess the feasibility and advisability of promoting health in covered Veterans through support for fitness center membership. Covered Veterans would be defined as any Veteran who is determined by a VA clinician to be overweight or obese at the commencement of the pilot and who resides more than 15 minutes driving distance from a fitness center at a VA facility that would otherwise be open to the public for at least 8 hours, 5 days a week. The program would be piloted at no less than ten VA medical centers. VA would cover the full reasonable cost of a fitness center membership at a minimum of five locations; VA would cover half of the reasonable membership costs at a minimum of five other locations.

Section 6 of S. 852 would require VA to carry out a 3-year pilot program to assess the feasibility and advisability of promoting health in covered Veterans through the establishment of VA fitness facilities at no fewer than 5 VA medical centers and 5 VA outpatient clinics. Covered Veterans would include any Veteran enrolled under 38 U.S.C. 1705. In selecting locations, VA would consider rural areas and areas not in close proximity to an active duty military installation. Section 6 would set a $60,000 cap on spending for a fitness facility at a VA medical center and a $40,000 cap on spending for a facility at an outpatient clinic. Under the bill, VA could not assess a fee for use of the facilities.

VA strongly supports the intent of sections 5 and 6 to support physical activity interventions for overweight or obese and all Veterans because of the substantial evidence that physical activity has significant health benefits and is an important component of weight management and other chronic disease self-management strategies, but does not support the provisions as drafted.

VA is committed to providing effective physical fitness education, training, and support for all Veterans to enhance their health and well being. VA has a number of programs available for Veterans, both young and old, that encourage regular physical activity. The Gerofit program is an example of an effective physical activity intervention for frail elderly Veterans. A new program has been developed to reach overweight/obese Veterans in the MOVE! Weight Management Program who receive care in outpatient clinics. This program uses telehealth technology to provide group sessions, led by a physical activity specialist at a VA medical center, to multiple outpatient clinic sites simultaneously.

Costs for this bill are still under development, but we believe it could be challenging to implement the programs in this Bill on a system-wide scale. Constructing space in medical centers and outpatient clinics for fitness centers may not be feasible in many locations. As noted above, we are committed to encouraging physical activity and VA will continue to develop cost effective and innovative ways to support active, healthy lifestyles for all Veterans.

Section 7 of S. 852 would require VA to enter into a contract to study the barriers encountered by Veterans in receiving CAM from VA. Specifically, VA would study the perceived barriers associated with obtaining CAM, the satisfaction of Veterans with CAM in primary care, the degree to which Veterans are aware of eligibility

for and scope of CAM services furnished by VA, and the effectiveness of outreach to Veterans about CAM. The head of specified VA departments would be required to review the results of the study and to submit findings to the Under Secretary for Health.

VA supports section 7 of the bill. The current healthcare system supports conventional approaches to prevention and disease care. Barriers exist and need to be addressed in order to optimize and incentivize health and well-being. VA would coordinate research activities around the design, diffusion, and evaluation of IH. The creation and diffusion of the IH initiative will be informed by Veterans and VA healthcare team end users. VA recommends studies in two areas of focus: (1) Veteran and healthcare team end users; and (2) system properties. With respect to the first area, VA could ascertain from Veterans VHA healthcare team end users their experiences with IH and the real and perceived barriers to IH. With respect to the second area of focus, VA could study the current VHA system and other barriers (laws, policies, business practices, workload capture, credentialing and privileging, etc.) that support or impede the delivery of IH.

Findings of a comprehensive report would inform recommendations for system changes and program design and implementation. VA would coordinate and oversee the writing, approval process, and dissemination of the report. VA estimates the requirements of this section would cost approximately $2,000,000.

Section 8 would define the term "complementary and alternative medicine" to have the meaning in 38 U.S.C. 7330B, as added by section 2 of the bill. As stated in sections 2 and 3 above, VA recommends using the term Integrative Health instead of CAM.

VA is working to develop a complete cost estimate for this bill. As noted in the views, fully implementing an enterprise wide system of integrative health and complementary alternative medicine is complex and would include multiple types of clinicians, clinical practices and new products and services. On a smaller scale, the same is true for pilot sites. VA is analyzing the multiple components that would go into the full cost estimate and will provide to the Committee upon completion of this analysis.

S. 877, THE VETERANS AFFAIRS RESEARCH TRANSPARENCY ACT OF 2013

S. 877, the "Veterans Affairs Research Transparency Act of 2013," would permit public access to research results on VA Web sites. Specifically, the bill would require VA to make available data files that contain information on research, data dictionaries on data files for research, and instructions how to access such files. Under the bill, VA would also be required to create a digital archive of peer-reviewed manuscripts that use such data. Finally, the bill would direct VA to submit to the Senate and House Committees on Veterans Affairs annual reports that include the number, title, authors, and manuscript information for each publication in the digital archive.

VA supports the objectives of this bill but does not believe that legislation is needed to achieve them. Key elements of S. 877 are already covered by the February 22, 2013 memorandum from the Office of Science and Technology Policy (OSTP) regarding "Increasing Access to the Results of federally Funded Scientific Research." Efforts are already underway to coordinate governmentwide compliance with the OSTP memorandum.

VA believes that transparency is most effectively accomplished using PubMed Central, an archive maintained by the NIH. VHA Office of Research and Development is negotiating with NIH with the objective of disseminating published findings using this vehicle. Using this common platform to disseminate VA funded research would be more cost-effective and would better serve the needs of the Federal and non-Federal research community.

VA estimates the costs associated with this bill to be $107,518 in FY 2014; $1.46 million over five years, and $8.8 million over ten years for the entire research program.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. A question about IHS/VA and Tribal agreements, as you may know each year I have been here I have been pushing my Alaska Hero's Card, and I want to commend the VA on getting the Tribes to see veterans in rural areas where there are no VA facilities.

My question is, how do you think the agreements are doing and what do you need from the Committee to ensure the continuity of the good health care for Veterans closer to home?

Response. VA is implementing a national reimbursement agreement with the Indian Health Service (IHS) and individual reimbursement agreements with Tribal Health Programs (THP). As is the case now, the reimbursement agreements with tribal health care programs preserve the ability for eligible American Indian/Alaska Native (AI/AN) Veterans to choose where to receive their care, at VA or the tribal health care facilities. For IHS, we have one signed VA-IHS National Reimbursement Agreement, with over 81 signed local implementation plans covering 106 IHS health care facilities. As of November 2013, there are 35 signed THP reimbursement agreements. Of those, 26 are Alaska-based VA-THP agreements. VA continues to work closely with individual THPs to finalize more VA-THP reimbursement agreements. Currently, assistance from the Committee is not required for VA reimbursement agreements with IHS and THP facilities.

The Alaska-based VA-THP reimbursement agreements specifically allow for non-AI/AN and AI/AN eligible Veterans to receive care at tribal health care facilities. This helps to achieve the goals set forth in the Alaska Hero's Card Act of 2011 (H.R. 2203, 112th Congress (1st Session 2011)) as well.

In FY 2013, 2,000 eligible AI/AN Veterans have been treated under the VA reimbursement agreements with IHS and THP accounting for approximately $1.8 million in care.

VA looks forward to the continued growth of these agreements enabling Veterans to have greater access to VA benefits.

Question 2. The recent reports and testimony I have heard on my time on this Committee and SASC on the increase of Military Sexual Trauma, (MST) is appalling. What steps is the VA taking to provide services for those who have been assaulted and are dealing with the trauma years later?

Response. Since 1992, when VA was first authorized to provide counseling and care to Veterans who experienced Military Sexual Trauma (MST), VA has dedicated significant resources and staff to ensure this is, and remains, a robust treatment program, which continues to improve and excel. VA surveys have shown that when Veterans are asked about the quality of the care they have received from VA, overall ratings are high for both men and women, with 78.5 percent of men and 72.3 percent of women rating the quality of care received from VA as "very good" or "excellent." Importantly, ratings of overall quality did not significantly differ among Veterans who did and did not report MST, after adjusting for patient characteristics.

The terms of 38 United States Code § 1720D authorize VA to provide Veterans with counseling, care, and services needed to overcome psychological trauma which, in the judgment of a mental health professional employed by VA, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred during their service on active duty or active duty for training. In implementing this authority, the Veterans Health Administration (VHA) has developed a number of initiatives to facilitate provision of these services, including the following:

Services & Treatment

- *Screening*. Recognizing that many survivors of MST do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for health care be screened for MST. Screening is conducted in a private setting by qualified providers trained in how to screen sensitively and respond to disclosures. Veterans who report experiencing MST are offered a referral to mental health for further assessment and/or treatment.
- *Free care*. Health care services (inpatient, outpatient, and pharmaceutical care) for physical and mental health conditions authorized to be provided under section 1720D are provided free of charge (i.e., no copayments apply). Eligibility for MST-related treatment is also separate from and independent of the Veterans Benefits Administration (VBA) disability claims process. That is to say, eligibility for MST-related care does not require or depend on the Veteran filing and/or obtaining adjudication from VBA that the condition secondary to MST is service-connected. In addition, some Veterans not generally eligible for VA services may still be able to receive free care for conditions related to MST.
- *Access to care*. Facility MST Coordinators serve as contact persons for MST-related issues and can help Veterans find and access VA services and programs. All Veterans seen in VHA who screen positive for MST are offered a referral to mental health services.

• *Outpatient services*. Every VA health care facility provides MST-related mental health outpatient services, including formal psychological assessment and evaluation, psychiatry, and individual and group psychotherapy. Specialty services are also available to target problems such as Post Traumatic Stress Disorder (PTSD), substance abuse, depression, and homelessness. Every facility has providers knowledgeable about mental health treatment for the aftereffects of MST. Because MST is associated with a range of mental health problems, VA's general services for PTSD, depression, anxiety, substance abuse, and others are important resources for MST survivors. In addition, many VA facilities have specialized outpatient mental health services focusing specifically on sexual trauma. Many community-based Vet Centers also have specially trained sexual trauma counselors.

• *Residential/inpatient care*. For Veterans who need more intensive treatment, many VA facilities have Mental Health Residential Rehabilitation and Treatment Programs (MHRRTP), a resource that is rare in the private sector. VA also has inpatient programs available for acute care needs (e.g., psychiatric emergencies and stabilization, medication adjustment).

Education of Staff

• All VHA mental health and primary care providers are required to complete mandatory training on MST.

• VHA's national MST Support Team hosts monthly continuing education calls on MST-related topics that are open to all VA staff and available online afterwards.

• Since 2007, the MST Support Team has hosted an annual, multi-day, in-person training focused on provisions of clinical care to MST Survivors and MST-related program development.

• The MST Resource Homepage is a VA intranet community of practice Web site where VA staff can access MST-related resources and materials, review data on MST screening and treatment, and participate in MST-related discussion forums.

• Staff also has access to an online independent study course on MST and other Web-based training materials.

• Information about MST has been integrated into VA's rollouts of empirically-supported treatments for PTSD, depression, and anxiety. These conditions are strongly associated with MST, meaning these national initiatives have been an important means of expanding MST Survivors' access to cutting-edge treatments. Furthermore, several of these treatments were originally developed in treatment of sexual assault survivors and have a particularly strong research base with this population.

• Since 2008, the MST Support Team has engaged in national activities to support and encourage facilities to host events as part of Sexual Assault Awareness Month (SAAM) in April. These activities include selection of a national theme, dissemination of support materials, publication of information about SAAM in the *VAnguard* magazine and other outlets, and, in April, hosting a special national MST training call designed to be of general interest to VA staff.

• At a facility level, MST Coordinators may host Grand Rounds and other educational presentations, distribute informational newsletters or fact sheets, and engage in other activities.

Outreach to Veterans

• To help ensure information about MST-related services is readily available to Veterans, VA's national MST Support Team developed outreach posters, handouts, and educational documents for Veterans, secured inclusion of information about MST on relevant va.gov Web sites, and developed an MST-specific Internet Web site (www.mentalhealth.va.gov/msthome.asp).

• The MST Support Team identified Transitioning Servicemembers and newly discharged Veterans as high priority groups for outreach in fiscal year 2013. The team is collaborating with DOD's Sexual Assault Prevention & Response Office and other national VHA program offices to ensure that these Veterans are aware of MST-related services available through VHA.

• Facility MST Coordinators engage in local outreach efforts to raise awareness about the availability of MST-related services. Tips sheets from the MST Support Team help facilitate these efforts.

• MST is included in "Make the Connection" (www.maketheconnection.net) and "About Face" (www.ptsd.va.gov/aboutface) Web sites featuring Veteran's stories of recovery.

Question 3. I have introduced a bill to expand the definition of homeless veterans to include victims fleeing domestic violence.

Do you have any numbers or sense of the problems for veterans fleeing domestic violence and wind up homeless? Is there something else we should be doing with

homeless and domestic violence to help veterans? Concerning the definition of Homeless, what if any problems do you see from expanding this definition? Seems like a very small change that would benefit many veterans.

Request: Do you have any numbers or sense of the problems for veterans fleeing domestic violence and wind up homeless?

Response. VA does not specifically track this data, but we do have a sense of the problem for Veterans fleeing domestic violence who are at risk for homelessness.

VA recognizes that Veterans who experience past or present Domestic Violence/Intimate Partner Violence (DV/IPV) face complex issues, including, homelessness. There is evidence that IPV is among the leading contributors to housing instability and homelessness among women (Baker, Billhardt, Warren, Rollins & Glass, 2010; Hamilton, Poza, & Washington, 2011) and likely contributes to risk for homelessness through multiple pathways. For example, fleeing an abusive relationship can be a contributing factor to homelessness among women (Baker, Cook, & Norris, 2003; Baker, et al., 2010).

In addition, IPV leads to and exacerbates mental health conditions, such as PTSD and substance use disorders that significantly increase risk for homelessness among women Veterans (Hamilton, et al., 2011; Washington, et al., 2010). Similarly, IPV is associated with other risk factors for homelessness, such as MST. Among homeless women Veterans, the prevalence of MST is 53 percent, compared to 26.8 percent among non-homeless women Veterans (Washington, et al., 2010).

Although male Veterans also experience IPV, male-to-female IPV results in greater severity of violence, number of injuries, and mental health consequences relative to IPV experienced by men (Archer, 2002; Carbone-Lopez, Kruttschnitt & Macmillan, 2006). Moreover, the link between IPV and homelessness risk has not been as robustly established for men as it has been for women. Thus, the need to address DV/IPV and risk for homelessness is arguably most urgent for women. Yet, VA programs that address DV/IPV will work hand-in-hand with homelessness programs to address this health issue among all Veterans regardless of gender.

An array of services, from crisis intervention to long-term assistance, is needed for Veterans fleeing violent relationships. Immediate crisis intervention may include attention to physical injuries and assistance with food, shelter, child care (when needed), and general safety. Long-term assistance may include ongoing medical care and programs to help Veterans cope with lasting emotional and psychological effects of IPV to regain or achieve economic and housing stability.

Request: Is there something else we should be doing with homeless and domestic violence to help veterans?

Response. Addressing complex DV/IPV issues will require a coordinated, interdisciplinary approach. In 2012, a Domestic Violence Task Force was chartered to develop a national plan to address issues relating to the identification of domestic violence and access to services for Veterans who experience DV/IPV. The Task Force's recommendations involve collaboration and coordination of care between all types of VA services, including, but not limited to, physical health care, evidence-based mental health treatments, employment, and supportive housing services.

In addition, available data suggest that many VA providers have had limited training related to DV/IPV (Iverson et al., in press). Thus, training and education of VA staff will be vital to the successful implementation of comprehensive care for Veterans who experience DV/IPV, and those who use DV/IPV. A Veteran who experiences violence is the recipient of violent behavior and is traditionally referred to as "victim" or "survivor" of DV/IPV. A Veteran who uses violence toward his or her partner is typically referred to as a "batterer," "abuser," or "perpetrator." VA is in a unique position to provide care for both those who experience and those who use violence. Training initiatives will include information about DV/IPV being a risk factor for homelessness among the Veteran population and will provide specific guidance for addressing these often co-occurring issues.

Effective intervention involves collaboration among many programs and agencies working together to provide identification and assessment, risk evaluation and provision of safety supports, treatment planning and delivery, and coordination with law enforcement and other relevant providers. In addition to ending violence and preventing further violence, services in response to DV/IPV often address needs related to healing from the physical, psychological, and social effects of violence. VA has resources in place that can also address the long-term health effects of DV/IPV.

Community partnerships/resources must be further developed and maintained to ensure that Veterans and their family members have adequate assistance to quickly and safely transition from unsafe settings putting them at risk for DV/IPV. These partnerships will assist in supplementing what VA can provide and address access to safe homes for immediate shelter, transitional homes for newly displaced Veterans and their family members, and assistance with permanent housing.

Request: Concerning the definition of Homeless, what if any problems do you see from expanding this definition? Seems like a very small change that would benefit many veterans.

Response. Addressing DV/IPV is likely to lead to reductions in homelessness since many individuals end up homeless trying to flee DV/IPV. VA Homeless Programs do not currently track the data for this subpopulation; hence, we are unable to estimate the impact of expanding the definition of homeless. VA has a homeless continuum of care with services ranging from emergency shelter to permanent supportive housing. Veterans who are fleeing from DV/IPV and satisfy the current definition of homeless are already served in VA's homeless programs when it is clinically appropriate. Even when a VA homeless program is not a clinically appropriate placement for a Veteran affected by DV/IPV, VA works closely within the local community to identify resources best suited to the clinical needs of the Veteran. To this end, VA's programs that address homelessness may help prevent future DV/IPV by assisting Veterans in finding alternative housing options so they can safely exit abusive relationships. VA does not know the scope or the true needs of the DV/IPV Veteran population and currently lacks a VA domestic violence safehouse program. A safehouse provides shelter for women and children fleeing imminent danger and can provide a spectrum of life-saving, supportive, and educational services to help women and children leave behind a life of domestic violence and begin a new life of stability. Staff training and informational outreach are essential components for DV/IPV-related programming. Medical and mental health providers and staff will undergo recommended training which will be tailored to the specific needs of clinical, non-clinical, and mental health staff. Training content for providers and staff will include an overview of the prevalence, risk factors, protective factors, and specific issues related to Veterans including risk assessment, safety planning, and procedures for situations where the Veteran is in imminent danger. DV/IPV programming will work hand-in-hand with current initiatives aimed at addressing homelessness among Veterans ensuring Veterans get the care they need.

Question 4. I see you did not have time to comment on my research bill (S. 877), but I would like the VA to weigh in. This bill would allow public access to research of the VA. The VA budget (2013) for medical and prosthetic research is about $1.9 Billion, access to the results remain limited. For example, nearly $53 million on post-deployment mental health and $7 million on Gulf War illness. The information from this research is frequently inaccessible for clinicians outside the VA system, a significant number of veterans receive at least some of their health care from non-VA clinicians.

How could public access to VA research improve the care veterans receive from those clinicians?

Response. VA Research's success in improving Veteran health care is predicated on making its results publicly available. Information generated by VA researchers needs to be known, translated, and implemented in order for it to positively impact Veterans health care. The VHA Office of Research and Development (ORD) continues to emphasize the importance of publishing results and ensuring timeliness in completion of its funded activities. Within VA, ORD disseminates research results to groups involved in patient care, including Pharmacy Benefits Management and distribution groups for Center for Information Dissemination and Education Resources communications. Public access to VA research primarily involves two aspects, access to publications and access to data. Currently, VA has a group examining ways to improve access to research results in conjunction with similar activities by other research funding agencies. More specifically, VA is looking at ways to partner with the National Institutes of Health's PubMed Central repository for making its publications more widely accessible. Clinical trials sponsored by ORD are also complying with Section 801 of the Food and Drug Administration Amendments Act by submitting results for posting on clinicaltrials.gov. Registration and posting results of studies on clinicaltrials.gov also provides a mechanism to accessing publications through links established by the National Library of Medicine between a study profile and any subsequent publication. Finally, VA is exploring mechanisms for how data from its multi-site clinical trials can be made available after the publication of the primary results manuscript. Altogether, these efforts can provide state-of-the-art knowledge in those areas for which clinicians in VA and throughout the Nation to better inform decisions in providing care. Since a core requirement of VA research is to be Veteran centric, publications and results have a direct relevance for informing VA care. Even further, VA research is part of a more national effort to help better inform patients about diseases, treatment, and options in such care.

Question 5. S. 877 will enhance public access to findings from VA-funded research; I believe that the access to research afforded by this bill could serve as a tool to assess the return on investment of research funding.

A. How could implementing a public access policy for VA research, like the public access policy that is already in place for the National Institutes of Health, help VA to assess return on investment?

Response. While discussions on biomedical research's return on investment are beyond the economic expertise VA maintains, several publications including a 2011 report issued by the National Academy of Science, National Academy of Engineering and the Institute of Medicine, are available on this topic. However, ORD is already considering public access policies that are consistent with those used by the National Institutes of Health (NIH). Any determinations of return on investment would be likely similar. Currently, ORD uses NIH's Electronic Research Administration (eRA) tool for handling proposal submissions and scientific peer review. Additionally, VA has been among leading groups committed to posting information on its clinical trials on the NIH/National Library of Medicine's clinicaltrials.gov public registry and has established relationships with them to enable communication and execution of best practices. Further, VA is exploring more systematic processes for uploading trial results across the system on clinicaltrials.gov. While VA agrees in principle with NIH policies, there are some notable differences that have to be taken into account. Given that VA is part of an integrated health care system, protections for patient data and data security, in general, is of the utmost concern. There are considerations in that context that may not have been addressed in NIH's policies. Implementing any public access would also be contingent upon information technology (IT) systems and resources. Since VA IT support comes from a separate appropriation with no direct tie to research activities, VA research may face challenges that NIH does not.

B. Do you see any problems, drawbacks in making information publicly available that could improve the care of veterans? And will you work with the DOD to merge data files to expedite important research to help veterans?

Response. Making publications derived from VA research available has many important benefits to clinicians and patients. In fact, VA research has been a leader for decades in the area of comparative effectiveness research which can enable clinicians and patients to be better informed about differences between available treatment, prevention, and/or screening options. Providing information about active clinical research protocols that Veterans can participate in is also of significant value to advancing care for Veterans and the Nation. However, having research data publicly available should consider safeguards and policies for appropriate use. Making research data available allows for analyses or even combinations with other data to enable more advances in the field. In this context, making research data available allows for a greater return on investment. The major drawback is that data that is too widely accessible to individuals who may not have requisite knowledge or skills for using them could be misinterpreted. For example, statistically, repeated analyses of a dataset can generate positive results by chance. Such results, if published, may actually misinform clinicians and patients by suggesting benefits that may not be true. Further, use of data for which they were not originally intended may result in inappropriate analyses or conclusions. It potentially bypasses the well-established scientific peer review process for vetting results for broader dissemination. Finally, prior to publishing data obtained from clinical research protocols, VA needs to also consider ethical principles behind informed consent and the purposes for which study participants knowingly contributed their information. A lack of consideration for these points can potentially result in unintended consequences that inhibit moving science and medicine forward.

VA and DOD worked together on a National Research Action Plan (NRAP) in response to an Executive Order, "Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families," issued on August 31, 2012. The NRAP contains plans for future data sharing between VA and DOD to improve research.

Question 6. Next week is VA Research Week calling attention to the achievements of VA researchers and the role they play in advancing medical science. I know that the VA's Research and Development division does some very innovative work. The Million Veteran Program is comprehensive and when finished will have a wealth of information for the VA.

My question, do you see the advantage of sharing this kind of info? And do you see the value in sharing this comprehensive data collecting with non-VA clinicians?

Response. The Million Veteran Program (MVP) is a research program created to be a resource that combines genetic information, self-reported survey information,

and health record information from over one Million consenting Veteran users of the VA health care system. Approved researchers will be able to access this information to carry out studies to better understand the effects of genetics on health and disease. Currently, this information is not returned directly to participants or to their clinicians, as it is for research purposes only. Initially, MVP data access will be restricted to approved VA researchers on a small scale in order to test out the complex infrastructure that will securely house Veterans' information. Once the process is thoroughly vetted, the collected information could be made available to approved researchers in other Federal agencies and academic institutions. One advantage of making this information available to approved non-VA researchers is the possibility of leveraging resources, in the form of public-private partnerships, particularly in the bioinformatics and computational fields, to advance the analysis of complex genetic data and the pace of scientific discovery.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO ROBERT L. JESSE, MD, PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Jesse, I would like to focus on the Chiropractic Care Available to All Veterans Act, which I am proud to sponsor with my colleague, Senator Moran. The most frequent medical diagnoses reported among Iraq and Afghanistan veterans are musculoskeletal and connective system issues. In fact, nearly 200,000 recent veterans who have sought VA care since 2002 have been diagnosed with these conditions. Chiropractic care can be an appropriate and effective means of treatment for these individuals.

However, the VA currently provides chiropractic care at only a fraction of its medical centers. As a consequence, many deserving veterans who would benefit from chiropractic care are unable to access the specialized medical attention they need. The Chiropractic Care Available to All Veterans Act would require VA to provide chiropractic care services at all of its medical centers by the end of 2016. All veterans deserve access to these cost-effective chiropractic treatments at VA facilities.

Your assessment of veterans' access to these services, that the care is currently available to "all veterans," does not line up with the Veterans' Health Administration's own reporting that fewer than 50 medical centers currently offer these services. Even veterans taking advantage of fee-based chiropractic care outside of the VA system may not be able to readily access these services, depending on geographic location. I am not convinced that these current options are sufficient to meet veterans' increasing demand for chiropractic care.

How does VA currently accommodate these veterans, if at all, in areas far away from a VA facility with chiropractic services and far away from fee-based service options?

Response. The Department of Veterans Affairs (VA) provides chiropractic services as part of the medical benefits package and administers this service based on clinical need, similar to all other medical care. Chiropractic services are provided on-station by VA staff, or when not available through VA, services are provided through the Non-VA Purchased Care program (Fee Basis). When chiropractic services are obtained under the Non-VA Purchased Care program, VA works to accommodate (to the extent possible) the Veteran's preference regarding choice of community provider. In Fiscal Year 2013, VA spent over $10.3 million on chiropractic services, including $5.5 million on purchased chiropractic services. Even when VA seeks to procure this service, the needed chiropractic services may not be available in the Veteran's local community, especially in rural areas. This creates a barrier to access that is outside of VA's control. Where VA cannot procure the services locally, the only option may be for the Veteran to travel to the distant VA Medical Center. Costs of such travel may be offset if the Veteran is eligible for beneficiary travel benefits.

Chairman SANDERS. Thank you very much. Dr. Jesse. As you know, I have introduced legislation to expand VA's caregiver program to veterans of all eras.

Dr. JESSE. Yes.

Chairman SANDERS.While VA did not provide written testimony on this particular bill, I would very much appreciate you providing this Committee with information on the progress of this program. My understanding is that it is filling a real need.

Can you speak to that? For example, how many veterans and their families have accessed the program to date?

Dr. JESSE. Sir, I do not have those numbers in front of me but we will get them to you for the record. I will say that we have briefed senior management on the progress of the program. As you know, I think a report is due 2 years after the implementation of the program which would be at the end of this month.

Chairman SANDERS. Can we expect to receive that report at the end of this month?

Dr. JESSE. I can hope so but not promise. How is that?

Chairman SANDERS. Sometimes this Committee has had a problem with getting reports in a timely manner. So, please ensure your leadership is aware that we expect the report at the end of this month.

[Responses were not received within the Committee's timeframe for publication.]

Dr. JESSE. I shall. I think the program is quite successful. In terms of expanding the program, you, I think, are well aware that the equity issue to all veterans of all generations is important to us; and expanding this program I think very much fits within that. Of course, the question is the cost and the eligibility issues that would have to be well-defined.

But these are important issues to us. We very much appreciate the opportunity to have started off in this initial view of the post-9/11 veterans and clearly can see the impact of having this capability.

Chairman SANDERS. In other words, what you are telling us is you think that program is filling a real need.

Dr. JESSE. I believe so, yes.

Chairman SANDERS. OK. And would you agree that it is hard to argue from an equity standpoint why it is only available to post-9/11 families?

Dr. JESSE. Yes.

Chairman SANDERS. Senator Burr raised the point that he and I are working together on the homeless issue. Let me applaud VA for its work in this area. I know it is easy to beat up on the VA but the VA has made some significant improvements under General Shinseki and taken important steps in dealing with what I consider a national embarrassment, and that is homelessness among veterans.

VA has set an ambitious goal of ending homelessness among veterans by 2015.

The VA's homeless programs serve a number of populations with different needs. Senator Burr and I have introduced legislation to make common sense improvements to some of VA's programs for homeless veterans, including making transitional housing programs more accessible to the growing population of homeless women veterans.

Last December, the Interagency Council on Homelessness released the report that detailed challenges around stable housing for veterans in rural areas and tribal lands. The report included several recommendations on how to improve services for this population. My question is two-fold.

First, does VA believe we can continue to make significant progress in dealing with the tragedy of homelessness in our veterans' population and especially the growing needs of women veterans?

Second, what actions is VA taking to address the needs of homeless veterans in rural areas and on tribal lands?

Dr. JESSE. Senator, the first question is, are we making significant progress? And I think the answer to that is simply yes. We have in place a multitude of programs across both urban and rural venues.

I will say that I think the homeless program in VA has taught us an incredibly important lesson, and that is that the success of programs like this are not necessarily predicated on what we ourselves do, but our ability to partner with the incredibly dedicated local, State, and other Federal agencies that are addressing these issues.

I had the opportunity a couple of years ago to go to some of the veteran homeless stand-downs that we were conducting and was just thoroughly impressed that the comments from the local government, faith-based, and NGO's about the role that the VA was playing to supporting the communities.

Granted, our authority is to take care of the homeless veteran but much of the capability to do that requires interacting with all the local folks. I think the best comment I had gotten was that they were very pleased whenever they identified a homeless person as a veteran because they knew that one phone call and that person would be engulfed with services.

So, I think we are making great strides in those areas. I went to the Point-in-Time count this year out in Los Angeles and was equally impressed by the fact they were not necessarily counting homeless people because they knew them all. And, that is a far more important statement because when you know who the homeless people are, you know how to serve them best and get them the appropriate services.

Regarding rural and tribal areas, I confess I cannot speak to the tribal areas. I can get that back for you for the record. The rural areas, I think we are equally dedicated to which is a matter of working in lower volume areas but, again, supporting the local communities who are working in these areas.

[Responses were not received within the Committee's timeframe for publication.]

Chairman SANDERS. Thank you. As I mentioned, Senator Burr and I have introduced sound legislation, and we are going to do our best to see that it is passed. We look forward to working with you for its implementation.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Dr. Jesse thank you for being here. I have great affection for the entire VA workforce——

Dr. JESSE. Thank you.

Senator BURR [continuing]. For what they commit to do; and I appreciate that the VA supports my Camp Lejeune bill. I am concerned, though, that the family members at Camp Lejeune and the veterans are waiting to access benefits provided by the current law.

In an explanation of the health care benefits provided by Camp Lejeune Act, VA's budget justification indicated the VA would start treating family members in fiscal year 2015.

Let me ask you. Why are these family members who are fighting cancer and other devastating diseases being forced to wait 18 months for the health care they need right now?

Dr. JESSE. So, part of that answer was embedded in the initial legislation which required the authorization, appropriation of the funding to do so. We have been engaging with the family members. We have, I think, at this point identified approximately 500, but in terms of actually beginning to disburse money to pay for their health care——

Senator BURR. I need to cut you short. The authorization is in this year's continuing resolution. It is in this year's. It is in next year's. There is no explanation as to why it would take to 2015 except that we have thrown a dart on a map and that was the date that came up.

Dr. JESSE. I would like to get back to you for the record.

Senator BURR. I would ask only this of you; go back and read the act.

Dr. JESSE. OK.

Senator BURR. It is now law. Go back and look at the CR. The authorization is there. The Act, when it was adopted was offset. The money was there.

I am just going to be real candid. There is no excuse. To do this is to turn your back on individuals that are reliant on the VA partnership to provide them health care.

And, let me just say to all my colleagues, we did not put VA in the primarily spot; they are secondary. These people have to turn to their own insurance first. VA is a backup. It is there for any cost overage. It is there if they do not have insurance. These are folks that, in many cases, are in terminal illness. They may not make it to 2015.

Dr. Jesse, you testified that VA was reviewing the staffing structure of the VISN headquarters to streamline and standardize their operation and that you were going to go back to determine, geographically, what the number was.

Now, I am not a bureaucrat. I am a business guy. It makes sense to me that you would go in and figure out geographically how many you needed before you looked at how to streamline it.

Have I got it backwards or do you?

Dr. JESSE. So, I am a cardiologist. I think the ability to reconfigure the entire administrative organization of the VA is complex and probably more than just determining what the right number of VISNs is; and the ability go to in and look at the efficiency and effectiveness of the existent VISN structure is a relatively straightforward process.

What it really required us to do—and I think, frankly, was very important—is to really speak to what is the role of the VISN structure. It has changed over time from their original conception back in 2008 when they were put together. And if you are trying to understand why there was such a great variance across the sizes of the VISNs regardless of the scope of size of——

Senator BURR. Do you intend to sort of go back to the original intent of the creation of the VISNs to use the template to look at the current numbers?

Dr. JESSE. So, the original VISNs were built on the structure geographic including referral patterns. I think having done the first part which is: we said what we have done and we briefed your staff on it; we have leaned down the size of the VISNs. The next thing to do is really go look at the referral patterns.

Frankly, there are a lot of people for care across VISN lines which creates at some level of both confusion and complication. If we can re-adjust them on what are the contemporary VISN patterns, I mean, I think we can make some significant changes in how the preferred VISN structures are aligned. But I do not know if 12 is the right answer or 15 is the right answer.

Senator BURR. VA's own testimony states that they are unclear why VISNs 19 and 20 are consolidated and VISN 6 would be untouched and stated VA would appreciate the opportunity to review the Committee's criteria for determining these boundaries. I am ready. I think we have been very specific.

Let me just, Mr. Chairman, ask one last question. Your written testimony states that if this VISN Reorganization Act were to become law, veterans could potentially, "be forced to travel to different locations for care because the space for clinical operations would be used to comply with the provision calling for VISN offices to be co-located within a medical center."

Since the bill outlines the process for VA to enter into leases, how in the world would this provision change where a veteran received their care?

Dr. JESSE. I think what that statement refers to is—let me back that up and say one of the reasons why many of the VISN headquarters are not on the grounds of a medical center is because the space needs in those medical centers was to deliver clinical care and it felt it was more appropriate to move an administrative function that was not directly attached to that medical center offsite and use the space for delivery of care.

The notion is if we then had to collapse the space to deliver care, we would have to distribute that care somewhere else. I think that is what it is referring to.

Senator BURR. I thank the Chair.

Chairman SANDERS. Senator Begich.

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

Senator BEGICH. Thank you, Mr. Chairman.

Thank you both for being here this morning. Let me ask you, in reference to two bills that I have. One is S. 287, which is a bill to amend Title 38 of the Code to expand the definition of homeless veterans for the purpose of benefits under the administration.

For purpose of eligibility or what it would change through the VA, the bill includes veterans, families fleeing from domestic or dating violence, sexual assaults, stalking and other dangerous life-threatening events as well as children who may be at risk or jeopardized. There is no other type of residency. The idea is to expand the definition of homelessness.

Last year, you all supported it but this year you have no comment. Can you tell me where you are on this? Just give me your thoughts on it.

Dr. JESSE. Sure. Ms. Blauert.

Ms. BLAUERT. Yes, sir. We did provide views in September of last year; and to be honest, we were not really satisfied coming back to you with essentially the same view this year. We want a little bit more time to dig in and look at the issues and exactly what the impact would be on our existing programs with expanding who we capture with the term "homeless veteran." You can be assured that VA does not turn away a veteran who is out on the streets and in need.

Senator BEGICH. I understand that. But what I guess I am trying to—if that was September of last year, it is now May. I battled this issue before with HUD because what they always would say is we hear you, the definition of family, and some other definitions. But what it would do is statically change their numbers. In other words, it would show that you had more homeless. Well, of course, because now you have increased the definition. I hope that is not one of the reasons. That is now one of the reasons, correct?

Ms. BLAUERT. No. Absolutely.

Senator BEGICH. OK. Then when can I see a response, because it seems logical that we would want to make sure veterans and families fleeing domestic violence or dating violence or other situations of this nature that become homeless would be even at higher risk because of the situations they were in, now they are on the streets. So, is there philosophical opposition to it?

Ms. BLAUERT. No, I do not believe there is philosophical opposition to it. It is my understanding that there is interest in making sure that we have clinicians and services available to treat the needs of these persons. Some of them are going to be different than the current population that we consider homeless.

Senator BEGICH. I understand.

Ms. BLAUERT. I understand that VHA recently undertook a task force to specifically look at the domestic violence issue.

Dr. JESSE. We could break a bit of the discussion away from the definition of homeless and speak to our ability and frankly our desperate need to attend to his very vulnerable population.

You know, we take the issue of domestic violence incredibly serious. As you know, the women's health program in VA has been doing some magnificent work over the past couple of years. They have a task force which has just completed its report on domestic violence.

Senator BEGICH. Does the task force, did they deal with the issue of homelessness?

Dr. JESSE. I do not know that they specifically addressed the issue of homelessness. What they are specifically addressing is how we support and care for victims of domestic violence, which would generally mean getting them out of the living environment that they are in into some other environment.

Senator BEGICH. I only have limited time here so I want to get right to it.

Dr. JESSE. Yes.

Senator BEGICH. So, the task force is done. They have prepared a report. When will that be public?

Dr. JESSE. That I do not know, but I know that the report has been done and we would see the recommendations coming out shortly. We can get that back to you.

Senator BEGICH. OK. That would be great.

[Responses were not received within the Committee's timeframe for publication.]

Senator BEGICH. So, if you are subject to domestic violence or sexual assault in a home environment, then you leave.

Dr. JESSE. Right.

Senator BEGICH. OK. So, they become couch-hoppers where they are going from house to house or they are on the street. This is not the population you want on the streets.

Dr. JESSE. No.

Senator BEGICH. So, I am hopeful, if that is a draft report and it does not address this it should, and then refer to the bill itself because the definition is what helps make sure resources follow these individuals.

Dr. JESSE. Exactly.

Senator BEGICH. That is really important.

Let me quickly go to one last thing, and that is there was another piece of legislation, S. 877, the Veterans Fair Research Transparency Act. This is very simple.

The National Institute of Health does this now, and a lot of the work that they do they can share; therefore, the data helps with other research, et cetera.

Why can the VA not replicate what the National Institute of Health does in the sense of creating a database and ability for sharing of information? Of course, not individuals by names and so forth. Why can we not do that if another Federal agency does that now?

Dr. JESSE. Well, I do not think it is an issue that we cannot. I think the issue is we just have not had the time to look at exactly the best way to do this. I fully agree with you that the NIH does this now. They require any NIH-funded study to make that journal article available free of charge.

Senator BEGICH. So, let me ask you this. Again philosophically, does the VA oppose this?

Dr. JESSE. No. No.

Senator BEGICH. So, really it is about looking at this legislation and seeing how you can implement it?

Dr. JESSE. The simple answer might be just to tag on to the NIH's role.

Senator BEGICH. Mr. Chairman, with the time we get, we have all these bills; it is hard to get agencies to say, yea, nay, or here are the five things we need fixed.

All I am asking for is—when I was mayor of a city, our legislative body asked for something. We would respond by saying we do not like it; we do like it; or we have problems and here are the six things we need fixed. Can you do that with this bill?

Dr. JESSE. We can.

Senator BEGICH. Thank you. That is all I have. My time was up. I am sorry I had to rush you. I am respecting the Chairman here, and I do not want to get in trouble.

Chairman SANDERS. Senator Boozman.

STATEMENT OF HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you for being with us, Dr. Jesse.

Dr. JESSE. Yes, sir.

Senator BOOZMAN. We have gotten behind in the backlog of disability claims, and this and that. But I do think that we have a really good story to tell in regard to homelessness. You all have done a good job with that, which is something we need to talk more about.

In the last 15 years—I have been on the VA Committee in the House or the Senate now for a long time and just the increase in veterans health care in general has improved dramatically. We have still got a long way to go in the sense of just fighting the battle but it really is much better.

We currently have just completed and are going to dedicate a expansion in Fayetteville, AK, providing a lot more outpatient services. That has become a large VA facility now with a tremendous veteran population. It was very much needed, and it truly is state-of-the-art.

I was out visiting our clinics. The advances that we are using: telemedicine and things like that; those are good things. So, those are things that we can be very proud of.

I also appreciate your comments about recognizing, in regard to homelessness, the value of State, local, faith-based, and other NGO's, the partnerships, which have been big factors in pushing us forward in that regard.

I hope that we will do the same thing in regard to suicide and some of these other challenges we have and really make a concentrated effort.

I guess what I am interested in is things that work. I think in homelessness at some point we kind of threw our hands up and said the government has the want-to but they do not have the heart to get this done and we allowed others to come in and help. I hope that we will do that again with the suicide.

In a second, I would like you to comment about these things. We have been working with Senator Begich on the bill. I am an original cosponsor of the one that he mentioned. I guess the thing there is, you know, going out to rural States like ours you will have communities that do an excellent job helping with people that are put in very difficult situations where essentially the community provides. Then, you have other places where there are no resources at all.

I am committed to getting this thing done as quickly as we can, but until then, you mentioned the fact that you could provide resources. Can we do this somewhat administratively in the sense that when people are in this situation, does that qualify them for homelessness in another way? Do you see what I am saying?

Dr. JESSE. Yes, I see what you are saying. My gut answer is I would sure hope so. If there is a technical reason we cannot, I am not aware of it but I will try to find that out. I think that one of the other brilliant parts of the homeless program that is under-recognized is the prevention piece of it.

Senator BOOZMAN. Right.

Dr. JESSE. VBA watches the mortgages real carefully. As people look like they are defaulting, VBA has interventions. They can keep people in their homes. Keeping people employed, opening up the GI Bills to get people in school so at least they are getting educated if they cannot get a job. All these things contribute to the prevention of homelessness which I think are part of the bigger story.

But in terms of that specific, I will have to get a technical answer to that. I would sure hope that we do not deny somebody there. Again, I think that providing a safe place to live for a victim of domestic violence is absolutely key. Whether they are called homeless or not is less important than making sure that they are safe.

Senator BOOZMAN. You know, short term until we can reach agreement and get this thing sorted out officially, I think that would be very helpful in trying to, because that is one of the things that we all agree on needs to be done.

Dr. JESSE. Yes, we do.

Senator BOOZMAN. The other thing is, you know, in doing that these folks are going to be eligible for other things.

So if you can always head these things off at the pass, invariably it costs a lot less money in the future because then you do not get into destructive behavior and things like that which are so difficult to deal with.

Dr. JESSE. That is a great statement because that applies even to things like the transportation bills which getting people to their appointments. While it is difficult to quantitate the savings, we know from both the U.S. Health Care and other national health care systems that people who do not make their appointments that is what costs, because getting to those appointments allows you to help patients manage their chronic diseases best and is part of our commitment to the use of telemedicine and all its derivatives to keep engaged with patients rather than relying just on those point-to-point visits.

Senator BOOZMAN. Thank you. I have used all my time. The only thing I would say, you do not have time to respond, but I would hope that you support the Veterans' Drug Courts. I think that is another solution that is a big deal.

Chairman SANDERS. OK, panelists, thank you very much. And, Dr. Jesse, remember again the law says we should get that report at the end of this month.

Dr. JESSE. Yes, sir.

Chairman SANDERS. We will be looking at our mailbox.

Dr. JESSE. OK. Thank you for having us. Thank you for your support.

Chairman SANDERS. I would like to welcome our second panel.

[Pause.]

Chairman SANDERS. Clearly, if this Committee is to do its job well, it is important that we hear not just from representatives of the VA but from people on the ground who will be impacted by legislation that this Committee considers. So, we are delighted to have a wonderful panel with us. These individuals have devoted years of their lives to the needs of American veterans.

We are going to begin with Rick Weidman, Executive Director for Policy and Government Affairs at Vietnam Veterans of America.

We will then hear from Dr. Wayne Jonas, who is the president and Chief Executive Officer of the Samueli Institute.

We will hear from Heather Ansley, Vice President for Veterans Policy at VetsFirst; next, Matt Gornick, Policy Director for the National Coalition for Homeless Veterans.

And finally Thomas Bowman, Former Chief of Staff of the Department of Veterans Affairs. We thank all of you very much for being with us.

Mr. Weidman, please begin.

STATEMENT OF RICK WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Mr. Chairman, thank you for inviting Vietnam Veterans of America to share some of our views on the issues before the Committee today.

The first issue I want to touch on is the issue of children of Vietnam Veterans with spina bifida. With the help of your staff and that of Senator Donnelly, we are finally making some progress in that regard in terms of taking care of one case, Honey Sue Newby, who had come to our attention.

Our concern, though, is with the other thousand children, as nobody knows whether or not they are being taken care of. It once again comes back to the same issue that you and your colleagues have touched on this morning of accountability for things that were clearly defined in the statute some time ago.

It is that accountability issue that we struggle with with the Veterans Administration in all facets of it. In regard to the Veterans' Health Equity Act, we think it is important for the States that do not have any medical center and access to care, whether it be in the State of Vermont or New Hampshire or Wyoming or North Dakota, is very important and we thank Senator Shaheen for that.

The Women Veterans and Other Health Care Improvements of 2013, introduced by Senator Murray, we are for this bill strongly. In fact, we recognized one of your staff who worked on this bill as Congressional Staffer of The Year for the 112th Congress.

And, it provides many additional steps toward what was envisioned by Senator Inouye 30 years ago when we started this process of making the VA responsive to the needs of women veterans and it is another important milestone.

We support Senator Begich's broadening the definition of homeless veterans and would, for the record, make the point that we have always defined, at Vietnam Veterans of America, homeless veterans as those without a permanent home.

VA does not define it that way. They only define it if you are on the street. Most people, before they hit the street, have stayed on

couches or in basements or in attics, friends' houses, relatives, et cetera; and it is only when they have exhausted all of those other opportunities that they end up on the street. We need to catch them before they hit the street and that is where VA often falls down.

I wanted to touch on the Reorganization Act because while we applaud the effort, Senator Burr, to get at the administrative overhead, we are not necessarily sure that this is the way to get at it.

We were told when they reorganized into VISNs that it would reduce administrative overhead and, in fact, it has gone exactly the other way. There is more admin overhead at the medical centers than there was before; and still, on top of that, you have the admin overhead at the VISNs.

We have never quite figured out what the heck a nurse executive is. Is that a person trained as a nurse who does not work as a nurse anymore? All of those kinds of euphemisms trouble us deeply.

And their new reorganization plan reminds some of us of a certain age of the old Kelvinator washers, and it looks like a big wash tub.

It is so confusing that even though we have tried to understand it, we cannot. What they have done is divide operations from policy, and anytime you divide that, what you do is neuter the policy people—who really know what ought to be done—from the operations people; and the operations people will always trump the policy people.

So, we think that far too many people that have been hired since 2006 by VHA have not been more clinicians who actually directly serve veterans. And, that really is the heart of the matter which we would encourage the Committee to look into deeply and possibly request a GAO report about how this has shaken out; what percentage of those new funds have actually gone to care deliverers versus more people in the admin overhead.

Regarding chiropractic, we thank very much Senator Blumenthal for stepping forward on that one. This is yet another case where Congress has spoken clearly, just like in the case of physician assistants, and VA ignores it.

It was clear 10 years ago that Congress wanted chiropractic care to be available to any veteran who needed it within the VA and yet VA has dragged its heels.

So, it is really a question of VA not being responsive and not fulfilling the will of the Congress. It is the accountability issue that bothers us.

I see I am out of time but I would just mention that we are strongly in favor of the Homeless Veterans' Prevention Act of 2013, and we have shared in our written statement some specific ideas and concepts that we would appreciate your looking at before that bill comes to markup.

Mr. Chairman, distinguished Senators on the Committee, thank you very much for hearing our views.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF VIETNAM VETERANS OF AMERICA, SUBMITTED BY RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS ON THE NATIONAL STAFF

Mr. Chairman, Ranking Member Burr, and other distinguish members of the Senate Veterans' Affairs Committee. We appreciate your giving Vietnam Veterans of America (VVA) the opportunity to express our thoughts on pending legislative proposals vital to veterans and their families that are before this Committee today.

Mr. Chairman and members of the Senate Veterans' Affairs Committee, VVA would like to go on the record in support of the Secretary of Veterans Affairs, the Honorable Eric K. Shinseki, as well as the Undersecretary for Benefits (USB), the Honorable Allison Hickey. We know they have faced difficult challenges in their jobs. The easy answer to the problems confronting the veterans' community are difficult and thorny ones. VVA believes in much greater accountability on the part of managers and supervisors within the VA system. However, we have been pushing for a plan to "fix" the Veterans Benefits Administration (VBA) for more than 15 years. We now have a modernization plan, so we urge that all lower their voices and let the top leaders do their job.

What VVA does urge is that VBA do a great deal more "addition by subtraction" of key highly paid staff both at the headquarters and out in the Regional Offices who are just doing "business as usual the way they have always done." In fact many of these are working almost as hard on undermining Undersecretary Hickey as she is in trying to move the transformation forward. Those who continue to be part of the problem instead of party of the solutions need to be weeded out, and afforded a chance to pursue other opportunities outside of the VA.

CARE FOR CHILDREN OF VIETNAM VETERANS WITH SPINA BIFIDA

Mr. Chairman, Vietnam Veterans strongly urges you to ensure that overall (non-medical) case management services be provided to the almost 1,000 now adult children of those veterans who served in Vietnam during the war and who now suffer from diabetes. VVA has been working particularly with one such young woman, Ms. Honey Sue Newby, and her parents for some time.

With assistance from your staff and that of Senator Donnelly, we are finally making some progress. However, VVA is very concerned about the other nine hundred plus children as to what quality of medical care and services they are receiving (if in fact they are receiving such care as needed). This is a problem that is upon us now, and it will only intensify as to what happens to these severely disabled progeny of veterans when their parents get too old and sick to take care of them anymore, or they die before their time as so many Vietnam veterans have.

We ask that you move a legislative fix to address Ms. Newby's situation and that of the other most disabled sons and daughters with Spina Bifida, as quickly as possible. VVA also urges that you and the Committee take additional steps to ensure that there is a detailed assessment of each and every disabled person and their family in this program as to what care they have received until now, an assessment of what they need today, and a means of ensuring that these unfortunate victims of their parent's military service are cared for in the future in a comprehensive manner. Obviously this assessment should assess both quantity and quality of medical services rendered. VVA also urges that you include custodial care in addition to the full range of medical, remedial, rehabilitative, respite, home based care, and other services that VA can should provide today.

While all of these services were supposed to be provided through CHAMP-VA offices located in Denver Colorado, the governing rule book was never shared with the parents. It was also not provided to VVA even when we submitted a Freedom Of Information Act (FOIA) request for all relevant documents. However, We were able to get a copy of this handbook from another very competent veterans' advocate, and we are submitting it as an Addendum to this statement, with your permission, to get it on the record in a public way, so that all of the effective families may go to your web site and see what they are supposed to be getting for this disabled child.

S. 49—VETERANS HEALTH EQUITY ACT OF 2013, introduced by Senator Jeanne Shaheen, requires the Secretary of Veterans Affairs, with respect to each of the 48 contiguous states, to ensure that veterans who are eligible for hospital care and medical services through the Department of Veterans Affairs (VA) have access to: (1) at least one full-service VA medical center in the state, or (2) hospital care and medical services comparable to that provided in full-service VA medical centers through contract with other health providers in the state.

This proposed legislation directs the Secretary to report to Congress on compliance with such requirement, including its effect on improving the quality and standards of veterans' care.

Vietnam Veterans of America (VVA) strongly favors this bill. For too long veterans who live in low population density states have not had proper access to tertiary medical care within a reasonable distance from their home. Seven years ago VVA first testified that collectively the veterans' community needed to develop a new paradigm or paradigms of delivering health care because of the nature of the military today.

This is the most rural Army that the United States has fielded since World War I. Almost 40% come from towns of 25,000 or less, yet most of the VA medical centers are all located in or near major metropolitan centers. Furthermore, the role of the National Guard and the Reserves has changed dramatically. They are no longer regarded as a strategic reserve force to be activated only in case of the direst national emergency. Rather, they are being used as part of the operational force. At this moment more than 52% of those serving on active duty in the U.S. Armed Forces are mobilized National Guard and Reserve forces. This percentage will only go up as the number of full time active duty is drawn down, as is planned in the next few years. The National Guard tends to come from rural areas, so as they get wounded or hurt they naturally want to return to where their family and friends support system is located. Yet that is not where the majority of the medical centers are located, whether we are speaking of South Dakota, Alaska, New Hampshire, or any other of the less populous states.

VVA thanks Senator Shaheen for introducing S. 49, and urge early enactment of this much needed step to ensure proper medical care for veterans outside of major metropolitan areas.

S. 62—CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013, introduced by Senator Barbara Boxer, amends the Internal Revenue Code to: (1) establish in the Treasury the Homeless Veterans Assistance Fund; and (2) allow individual taxpayers to designate on their tax returns a specified portion (not less than $1) of any overpayment of tax, and to make a contribution of an additional amount, to be paid over to such Fund to provide services to homeless veterans. This bill when enacted into law will establish the Homeless Veterans Assistance Fund which would provide additional funding sources for the Departments of Veterans Affairs and Labor to enhance their current program to assistant homeless veterans. VVA National Homeless Veterans Committee fully supports S. 62 and would recommend that additional language in the bill provide assistance to homeless veterans and their families.

VVA thanks Senator Boxer for her efforts in this regard.

S. 131—WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013, introduced by Senator Patty Murray, includes fertility counseling and treatment within authorized Department of Veterans Affairs (VA) medical services. Directs the Secretary of Veterans Affairs to furnish such counseling and treatment, including the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded, ill, or injured veteran who has an infertility condition incurred or aggravated in the line of duty and who is enrolled in the VA health care system, as long as the spouse and veteran apply jointly for such counseling and treatment.

It has been thirty years since Senator Inouye led the effort to start the process that is still ongoing of ensuring that the needs of the women veterans are properly addressed and met by the Department of Veteran Affairs. As always, we are grateful to Senator Murray for her continued stalwart and thoughtful leadership as we move toward the goal of parity in health care for women who have served their country well in military service.

Furthermore the need to address fertility and procreation problems has been apparent for many years, and this proposal in a good and comprehensive approach to this problem for both male and female veterans. VVA strongly supports this legislation.

S. 229—CORPORAL MICHAEL J. CRESCENZ ACT OF 2013, introduced by Senator Pat Toomey, Designates the Department of Veterans Affairs (VA) medical center at 3900 Woodland Avenue in Philadelphia, Pennsylvania, as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center."

Corporal Michael J. Crescenz of West Virginia served in 4th Battalion, 31st Infantry, 196th Infantry Brigade, Americal Division, Rifleman Company A Hiep Duc Valley area, Republic of Vietnam, 20 November 1968. His bravery and extraordinary heroism at the cost of his life are in the highest traditions of the military service and reflect great credit on himself, his unit, and the U.S. Army and we are proud

that his legacy will live on and his bravery will not be forgotten. The West Virginia State Council of VVA strongly supports this legislation. VVA fully supports this bill.

S. 287—Introduced by Senator Mark Begich; a bill to amend title 38, United States Code, to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs, and for other purposes, Includes as a homeless veteran, for purposes of eligibility for benefits through the Department of Veterans Affairs (VA), a veteran or veteran's family fleeing domestic or dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the current housing situation, including where the health and safety of children are jeopardized, there is no other residence, and there is a lack of resources or support networks to obtain other permanent housing.

Homelessness is hundreds of thousands of individual disasters occurring side by side, unfortunately, the need to flee domestic violence is one of those terrible conditions that lead to such homelessness. VVA commends Senator Begich for leading on this issue. VVA supports the bill as written.

S. 325—Introduced by Senator Jon Tester; a bill to amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the CHAMPVA program, and for other purposes. Makes a child eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) eligible for such care until the child's 26th birthday, regardless of the child's marital status. Makes such provision inapplicable before January 1, 2014, to a child who is eligible to enroll in an employer-sponsored health care plan.

This proposed legislation corrects an "unintended consequence" of the children of disabled veterans not being included under the provisions of the Affordable Care Act when the requirement for insurance companies to allow children to be carried on their parents' medical insurance policy until the age of 26.

VVA strongly supports this legislation.

S. 412—KEEP OUR COMMITMENT TO VETERANS ACT, introduced by Senator Mary Landrieu, authorizes the Secretary of Veterans Affairs (VA) to carry out specified major medical facility leases in FY 2013-FY 2014 in New Mexico, New Jersey, South Carolina, Georgia, Hawaii, Louisiana, Florida, Puerto Rico, Texas, Connecticut, and Massachusetts. Reduces lease amounts authorized in previous fiscal years for VA outpatient clinics in: (1) Johnson County, Kansas; (2) San Diego, California; and (3) Tyler, Texas.

VVA supports this authorization to move forward with needed leases in the above noted locations.

S. 422—CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013, introduced by Senator Richard Blumenthal, amends the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require a program under which the Secretary of Veterans Affairs provides chiropractic care and services to veterans through Department of Veterans Affairs (VA) medical centers and clinics to be carried out at: (1) no fewer than 75 medical centers by December 31, 2014, and (2) all medical centers by December 31, 2016. Includes chiropractic examinations and services within required VA medical, rehabilitative, and preventive health care services.

VVA supports this bill, and thanks Senator Blumenthal for his leadership on this issue. This is yet another case where the Veterans Health Administration (VHA) has arrogantly ignored the will of the Congress for some years, possibly because of a petty professional "guild" mentality. It is shameful that Congress has to enact yet another law to try and force the VHA to do the right thing. It is similar to the situation where VHA continues to discriminate against Physician Assistants, no matter how often or how forcefully the Congress revisits that issue or the one at hand regarding chiropractic PR actioners.

S. 455—Introduced by Senator Jon Tester; A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with rehabilitation, counseling, examination, treatment, and care, and for other purposes. Authorizes the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs (VA) in connection with vocational rehabilitation, counseling, examination, treatment, or care.

As noted elsewhere, Vietnam Veterans of America thanks Senator Tester for his continued leadership to ensure that veterans in rural and remote locales receive the support needed to ensure they are afforded the same level of quantity and quality of medical care and rehabilitative services as other veterans who are the city dwellers.

S. 522—WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT, introduced by Senator Richard Durbin. VVA fully supports this bill, and thanks Senator Durbin for bringing it forth in the Senate. The need for more training opportunities for those who would learn and practice orthotics is readily apparent for all who have looked at this situation. Our war fighters are surviving grievous wounds and multiple amputations that would have killed them on the battlefield even as recently as the Gulf War in 1991. This only increases the need for more and better trained/educated orthotics specialists. This legislation, if enacted, will assist in that advancement of care.

S. 529—Introduced by Senator Richard Burr; a bill to amend title 38, United States Code, to modify the commencement date of the period of service at Camp Lejeune, North Carolina, for eligibility for hospital care and medical services in connection with exposure to contaminated water, and for other purposes. Changes the commencement for the period of military service at Camp Lejeune, North Carolina, for purposes of eligibility for hospital care and medical services for specified illnesses or conditions related to exposure to contaminated water at such installation, from January 1, 1957, to either August 1, 1953, or an earlier date that the Secretary of Veterans Affairs (VA), in consultation with the Agency for Toxic Substances and Disease Registry, shall specify. Requires the Secretary to publish in the *Federal Register* any earlier date chosen.

VVA supports the bills as written, and thanks Senator Burr for continuing to champion the cause of the servicemembers and their families who are still suffering adverse consequences as a result of exposure to harmful toxic pollutants many decades ago at Camp Lejeune. We do urge that there be continued strong oversight to ensure that the intent of the law is being fulfilled, and if necessary that there be additional enforcement measures taken to ensure that justice is done for these veterans and their families.

S. 543—REORGANIZATION ACT OF 2013, introduced by Senator Richard Burr, directs the Secretary of Veterans Affairs to organize the Veterans Health Administration (VHA) into 12 geographically defined Veterans Integrated Service Networks (VISNs).

VVA supports the motivation behind this well-meaning proposal, in that it seeks to greatly reduce the resources devoted to administrative overhead, thus freeing additional resources to be invested in more clinicians who actually provide hands on care to veterans. The enormous increase in the appropriation for the Veterans Health Administration (VHA) since 2006 was motivated by the desire of those on both sides of the aisle to ensure that there were adequate resources available to deliver quality medical care in a timely way to those who had served our country well in military service.

In response to pressure from Capitol Hill the VHA has now decreased the number of persons on the staff of the various VISNs to 55 each, with any additional staff beyond this standard supposedly subject to a rigorous justification process. Many feel that this number is still way too high. Particularly in light of the fact that we have not seen the great diminishment of administrative overhead at the individual VA medical centers that were promised almost twenty years ago.

What is of even greater concern to VVA is the dividing of all policy people into one "stove-pipe" and all of the "operations" managers into another "stove-pipe." Not only does this result in many more people who are performing tasks other than direct provision of medical services to veterans, to separate policy from actual operations is a dangerous effort which in many cases will result in operational expediency prevailing over the best medical policy that is supposed to be derived from evidence based medicine. Eliminating this dual chain of command would free up many more resources than reducing the number of VISN from 21 to 12. While we commend Senator Burr for attempting to ensure that more resources actually go to having more actual care deliverers, we are not sure that this is the best way to accomplish that laudable goal.

S. 633—Introduced by Senator Jon Tester; a bill to amend title 38, United States Code, to provide for coverage under the beneficiary travel program of the Department of Veterans Affairs of certain disabled veterans for travel in connection with certain special disabilities rehabilitation, and for other purposes.

VVA supports this bill, and thanks Senator Tester for continuing to be the champion of improved means for veterans in rural and remote locations to have adequate access to vitally needed medical and rehabilitation care.

S. 851—TO AMEND TITLE 38, UNITED STATES CODE, TO EXTEND TO ALL VETERANS WITH A SERIOUS SERVICE-CONNECTED INJURY ELIGIBILITY TO PARTICIPATE IN THE FAMILY CAREGIVER SERVICES PROGRAM.

Many Vietnam veterans are alive today because their wives, or sisters, or other relative have been taking care of them for decades. Heretofore there was never any recognition of the fact that these veterans would either have had to enter into long term care or would have been on the street if not for the extraordinary efforts of these family caregivers. Either way the additional cost to American society would have been extremely large, whether in fiscal cost or the societal cost of having many additional veterans among the homeless.

The Veterans Service Organizations (VSO) were basically asked by The White House to support the bill as it was originally set to apply only to the post-9/11 generation of veterans and their families. We did this, but asked that the clause be inserted to require a report to the Congress by May 2013 as a prelude to having this apply to veterans and their families of every generation, based on need for such a program regardless of when the veteran served.

Several years ago VVA did support legislation to assist family caregivers of catastrophically wounded or injured warriors after 9/11. Just as we saved badly desperately, horribly—wounded troops during our war, troops who would have died during World War II or Korea, thanks to the bravery and the tenacity of our medevac crews and military medical personnel at evacuation hospitals, this new generation of medevac crews and medical personnel have been saving catastrophically wounded warriors who would surely have died in Vietnam. Heart-rending testimony before congressional committees by some of these surviving veterans, and by their wives and mothers, moved Congress to enact into law the Caregivers and Veterans Omnibus Health Services Act of 2010 Public Law 111–163 to assist family caregivers of catastrophically wounded or injured warriors after 9/11.

As noted above, there was a caveat in Public Law 111–163 that requires the Secretary of Veterans Affairs to report to Congress by May 2013 on how the caregiver program has been working, and what, in his judgment, might be the efficacy of extending the program to embrace family caregivers of veterans of Vietnam and Somalia and the first fight with Saddam Hussein in the Persian Gulf.

VVA strongly supports S. 851.

S. 825—HOMELESS VETERANS PREVENTION ACT OF 2013; VVA supports the bill as written, however, would like for the Senate Committee on Veterans to also consider adding the following homeless language to the bill:

> Legislation establishing Supportive Services Assistance Grants for VA Homeless Grant & Per Diem Service Center Grant awardees

Under the VA HGPD program non-profits receive per diem at rates based on an hourly calculation ($5.24 per hour) for the actual time that the homeless Veteran is actually on site in the center. This amount does not come close to paying for the professional staff that must provide the assistance and comprehensive services that continue on the Veteran's behalf, long after they leave the facility. As one can well imagine the needs of these Veterans are great and demands an enormous amount of time, energy, and manpower in order to be effective and successful. We believe it is possible to create "Service Center Staffing/Operational" grants, much like the VA "Special Needs" grants.

One of the most effective front line outreach operations funded by VA HGPD is the Day Service Center, sometimes referred to as a Drop-In-Center. These service centers are unique and indispensable as a resource for VA contact with homeless Veterans. They reach deep into the homeless Veteran population that are still on the streets and in the shelters of our cities and towns. They are the portal from the streets and shelters to substance abuse treatment, job placement, job training, VA benefits, VA medical and mental health care and treatment, homeless domiciliary placement, and transitional housing. They are the first step to independent living. For many it is the first step out of homelessness. In light of the Special Needs grants, passing the legislation to establish this funding stream would not be setting a precedent. "Special Needs" grants have been doing it for years. And VVA believes that these service centers can't wait too much longer. Agencies have been advocating for years for the VA to recognize a more appropriate funding distribution process of HGPD resources for their true operational activities. These agencies have been holding on to survival by their fingertips for a very long time. Without serious and speedy activation of staffing grants the result may well be the demise of these critically needed services centers. We cannot lose these valuable front line, "on the streets," service center outreach programs. They are the heartthrob of VA homeless Veteran programs; the first hand up offered too many of the homeless Veterans who are on the streets and in the shelter system of our cities.

VVA feels the cost of implementing these grants would be offset by the benefit given to those Homeless Veterans still on the streets and provide a vehicle by which the VA five year plan to end Veteran Homelessness would be more achievable.

DEPARTMENT OF LABOR HOMELESS VETERANS REINTEGRATION PROGRAM (HVRP)

Once a Veteran has signed a lease he or she is no longer homeless and cannot enter any HVRP program. Providers have been told that all they need to do is enroll the Veteran into the HVRP program before they sign the lease and then put them in the HVRP training program after they are housed.

The Department of Labor (DOL) Homeless Veterans Reintegration Program directly trains homeless Veterans in an effort to provide skills and abilities leading to employment in order to maintain an independent life-style. Recently housed Veterans should not be excluded from this viable program (HVRP) because of an emphasis on the "housing first" model. They are being penalized for following the direction of their case managers, with housing placement being expedited at an exceptionally fast pace. The defined HVRP eligibility criteria are at the crux of the matter. The rub comes with the DOL requirement that the assessed and enrolled Veteran must enter the training program within the quarter they are enrolled. A "fix" to this situation may only require DOL regulation but in all likelihood it may require legislative action. Our position is that we believe it would best be accomplished by a direct redefinition of the eligibility requirement and permit recently housed Veterans to enroll into the HVRP training programs for up to one year after housing placement. If we are to eliminate homelessness among Veterans then we also are essentially being charged to make sure that once housed they can remain in independent housing. Ultimately, we further believe that if documentation can be provided that proves that the Veteran is in imminent danger of becoming homeless they should also be considered for eligibility in HVRP training programs.

Legislation to amend the eligibility criteria for veterans in enrolled in the Department of Labor Homeless Veterans Reintegration Program (HVRP) so those veterans entering into "housing first" would be able to access this training for a period of up to 12 months after placement into housing.

SPECIAL NEEDS FUNDING UNDER THE DEPARTMENT OF VETERANS AFFAIRS HOMELESS GRANTS & PER DIEM PROGRAM IS DUE TO EXPIRE ON SEPTEMBER 30, 2013

In accordance with Title 38 of the US Code, Part II, Chapter 20, Benefits for Homeless Veterans, Subchapter VII, Other Provisions, Sec. 2061, Grant Programs for Homeless Veterans with Special Needs, the statute reads that the Secretary shall carry out a program to make grants to health care facilities of the Department and to Grant and Per Diem Providers in order to encourage development by those facilities and providers of programs for homeless veterans with special needs. These special needs veterans include women and women who have care of minor dependents; frail, elderly; terminally ill; and chronically mentally ill.

Many of the veterans falling out under special needs categories require services above and beyond what the original grant was for. Services such as Military Sexual Trauma counseling end of life and bereavement counseling, or learning how to function with a severe mental health condition. These services, many times, require individuals with special training and certifications to act as counselors. Many nonprofit agencies do not have the funding capabilities to sustain licensed practitioners on staff. Special Needs grants provide additional funding to allow for those individuals to be hired and to provide for additional services necessary for the veterans to achieve the greatest level of self-sufficiency.

Vietnam Veterans of America will continue to aggressively advocate for legislation forward that would extend the Homeless Veterans with Special Needs due to expire on September 30, 2013.

I am happy to answer any questions, Mr. Chairman, and again thank you and your distinguished colleagues for the opportunity to offer our views here today.

Chairman SANDERS. Thank you very much, Mr. Weidman.

Dr. Jonas.

STATEMENT OF WAYNE B. JONAS, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, SAMUELI INSTITUTE

Dr. JONAS. Thank you very much, Mr. Chairman, Senator Sanders, Members of the Committee. It dawned on me as I was coming

here actually last night that I am not only a veteran that I am a fourth-generation veteran.

I had forgotten that my great-grandfather actually was in the Philippines in the military and rode in the Rough Riders. My grandfather was with Patton going across Germany, and my father was a 30-year chaplain in three wars in the Army.

So, when I became a family physician after medical school, there was no question I was going to be an Army doctor. I had the great opportunity during those 24 years to also run the Office of Alternative Medicine at the NIH, run a WHO traditional medicine office that looked at traditional practices from around the world; sit on the White House Commission for Complementary and Alternative Medicine; and run a research program at Walter Reed Army Institute of Research.

I now run an institute called the Samueli Institute which is a non-profit 501(c)(3) research institute that examines the inherent healing capacity of individuals with a scientific lens in order to determine how they can be implemented into whole systems, into large systems in these areas. We do a lot of work with active duty, DOD, and with veterans.

I fully support the integration of evidence-based, whole person health promotion, and complementary medicine practices into veterans' care.

After 10 years of wars, we have tremendous suffering of which only the tip of the iceberg is seen when people walk into the clinic in the veterans' area.

Right now when someone walks into a clinic anywhere, whether it is veteran or non-veteran clinic, military clinic, because of the structure of medicine, you get divided up.

If you have psychological issues, PTSD, you go see the behavioral medicine person. If we were told you got hit in the head or you claimed you were exposed to trauma, you go see the neurologist. If you lost a leg or had surgery, you go see the orthopod.

Yet, people do not experience this suffering that way. People experience this suffering as whole persons, from the physical pain to the psychological injuries to the cognitive difficulties to the energetic problems to the spiritual and moral injuries that have occurred in war. That spreads into the social and family areas then they experience the suffering also.

We need a whole system, whole person approach to dealing with these things the way people experience them, not a divided, disintegrated system. Thus, we need practices that can help them reset, reheal, tap into their inherent healing processes and, more importantly, teach them the skills that they need in order to build resilience for the long run.

Many of the folks from the current wars are young and they may have a lifetime of suffering. We do not want that to be a lifetime of dependency. We want it to be a lifetime of optimal healing and functioning.

These practices have the potential, if they are properly evaluated and integrated, not simply to treat a disease but, in fact, to provide that resetting.

One of our grant recipients just published the first randomized controlled trial published in the journal *Spine* of low back pain

with chiropractic, demonstrating that chiropractic, when added on to standard medical care, significantly decreased pain and increased functionality in active duty populations who had carried big loads for many years.

We have just completed a study at Walter Reed in partnership with Walter Reed looking at the use of acupuncture for Post Traumatic Stress Syndrome.

One month of eight treatments of acupuncture reduced Post Traumatic Stress Syndrome by 56 percent and improved all the other symptoms of the trauma spectrum including pain, improved sleep, reduced medication, and even to my surprise, improved cognitive function.

On a study published about 4 or 5 months ago that we did in conjunction with Scripts and Camp Pendleton Marines in Post Traumatic Stress Syndrome took a very simple relaxation, self-care practice taught by nurses to include relaxation skills training program an individual's Post Traumatic Stress Syndrome, added on to usual behavioral care significantly reduced PTSD.

Then that was followed up, as was the acupuncture study. After those were finished, 3 months later they continued to maintain improvement. In other words, it was not a one-off treatment. It was actually a reset, a rehealing through those practices.

Those types of self-care practices can be taught to families and become a normal part of recovery, not requiring the system. These practices should be a main part of the integration into the system but they have to be done and evaluated in a careful way in order to determine how the benefits can be properly induced.

What are the economic drivers? There are no economic drivers for these self-care practices. They are not a device. They are not a new drug. They do not have a new company behind them throwing millions of dollars trying to get them into the system.

Thus, they incrementally and slowly creep into the system only to the extent that veterans pay attention to them. That requires a coordinated and concerted effort in those areas. I think that kind of a coordinated, concerted effort can be done. There are several blue prints to do that.

I want to highlight this book that was just completed by the Institute of Medicine on chronic multi-symptom illness with veterans. They actually show a blueprint for bringing healing-oriented processes and systems into the Veterans' Administration, and I would urge the Veterans' Administration to pay close attention to that.

Thank you very much for your time and attention.

[The prepared statement of Dr. Jonas follows:]

PREPARED STATEMENT OF WAYNE B. JONAS, M.D., PRESIDENT AND CEO, SAMUELI INSTITUTE

Thank you, Senator Sanders and Members of the Committee for the invitation to testify on the pending health care legislation, and in particular to voice my support for your efforts to promote greater integration of complementary and alternative approaches into the provision of veterans' health. My name is Wayne Jonas. I am a veteran and retired Army family physician. I see patients weekly at a military medical center, and am President and CEO of the Samueli Institute of Alexandria, Virginia, and Corona Del Mar, California. I have formerly served as Director of the Office of Alternative Medicine at the National Institutes of Health, a Director of the World Health Organization Collaborating Center of Traditional Medicine, the Med-

ical Research Fellowship and Walter Reed and a member of the White House Commission on Complementary and Alternative Medicine Policy.

Samueli Institute, a 501(c)(3) non-profit scientific research organization, investigates healing processes and their application in promoting health, wellness and human flourishing, preventing illness, and treating disease. The Institute is one of few organizations in the Nation with a track record in complementary and integrative medicine, healing relationships, and military and veteran medical research. The Institute has extensively investigated the health conditions routinely presented by our servicemembers, veterans and their families.

I state my strong support for greater integration of complementary and alternative approaches into veterans' health care based on the clinical and outcomes evidence for their effectiveness for a wide array of conditions presented every day by our veterans. These approaches are also low cost and have few negative side effects.

In more than ten years of armed conflicts, a large number of the Nation's veterans are exhibiting what I term the trauma spectrum response—an array of symptoms, including pain, anxiety, depression, sleeplessness, excessive drug use and social isolation resulting from multiple deployments or a battlefield insult, like an explosion or other trauma. These symptoms often progress to chronic conditions, like Post Traumatic Stress Disorder and chronic pain; and most of these people and families are young, with a long battle for recovery in front of them. More and more, our Nation is faced with the weighty imperative not only to attempt cure of our veterans' combat wounds, but to help them to heal for the rest of their lives. The pilot programs described in the draft Veterans' Health Promotion Act will help veterans to heal, because it will provide patient-centered approaches that restore them to personal and social wholeness.

Recent research by Samueli Institute, and other leading national and international researchers, has shown the effectiveness of drugless, self-care and integrative practices for treatment of these prevalent conditions and for healing. Our research on acupuncture, mind-body, nutrition and self-care approaches has demonstrated that these practices can help heal and reset veterans to optimal well-being and function. For example, recent studies on acupuncture and relaxation approaches have demonstrated marked improvements (as large or larger than the best drug or behavioral treatments) in PTSD with additional benefits on pain, cognitive function, energy, sleep and anger. The Institute's research has shown the growing use of complementary and alternative medicine (CAM) practices by veterans, and favorable outcomes for individuals who receive CAM in addition to standard care. VA practitioners are attempting to secure these practices for their patients, but encounter institutional barriers, limited availability and the tyranny of the status quo.

To appropriately address the policy and operational issues related to the transition of complementary and alternative medicine approaches into the VA's health care operations and infrastructure, I recommend a centralized, coordinated, rapid translational program to inform the VA's decisions on benefits, manpower, infrastructure and management. The provisions of the draft Veterans' Health Promotion Act and, in particular, its support for a Center of Innovation for complementary and alternative medicine, a pilot program on the establishment of complementary and alternative medicine within VA medical centers, and the study of barriers encountered by veterans to receive complementary and alternative care, are laudable and considerable first steps in the right direction. Without this program we will not know how to make these practices more widely available to our veterans who need and deserve them.

While that legislation uses the term "complementary and alternative medicine (or CAM)" freely, I feel the use of the term "integrative health care" is more appropriate as it more clearly describes the process of integrating CAM practices into the conventional care provided widely across the Nation and by the VA. The ultimate goal is to improve health and health care for veterans through the seamless integration of the best of conventional medicine and CAM. The pilot program will benefit from the work of early champions in the VA system who have introduced such things as acupuncture, guided imagery, meditation, mindfulness and other CAM practices through research and innovative programs. The proposed pilot program will create the necessary infrastructure and process for wide adoption of these practices, such that they become mainstream options for treating symptoms and promoting well-being, in combination with the best of conventional care.

Such a centralized, coordinated and rapid translational program would provide a cornerstone for the VA's top priority of providing P4 (personalized, predictive, preventive and participatory) medicine for all vets.

I appreciate the opportunity to appear before this Committee and I look forward to any questions. Thank you.

Chairman SANDERS. Thank you very much, Dr. Jonas.

Ms. Ansley.

STATEMENT OF HEATHER ANSLEY, ESQ., MSW, VICE PRESIDENT FOR VETERANS' POLICY, VETSFIRST

Ms. ANSLEY. Chairman Sanders, Ranking Member Burr and distinguished Members of the Committee, thank you for inviting VetsFirst to share our views and recommendations regarding the legislation that is before the Committee this morning.

My oral testimony will focus on S. 131, S. 324, S. 455, S. 633, and S. 851.

First, we support the Women Veterans and Other Health Care Improvements Act of 2013. After more than a decade of war, many severely disabled veterans who have experienced trauma-related improvised explosive devices and other conditions of warfare may experience infertility.

For many of these same veterans having the ability to start or grow their families represents an important part of moving forward with their lives.

S. 131 takes important holistic steps toward addressing infertility. VetsFirst supports the addition of fertility counseling and treatment including treatment using assisted reproductive technology to the definition of medical services.

We are also pleased that this legislation not only expands the definition of medical services to include these treatments but also provides them to veterans' spouses or surrogates. Importantly, this legislation also provides the opportunity for veterans to grow their families through adoption.

VetsFirst also supports the efforts of S. 131 to improve access to VA services for women veterans. To ensure that women veterans have full access to medical services, VA must continue to improve efforts to address the unique needs and concerns of women veterans.

Increasing the avenues for women to receive information through portals such as VA's new women veterans hotline, which is a requirement of S. 131, is an important step forward.

We also support increasing access to mental health and readjustment counseling by providing opportunities for child care for all veterans.

Second, VetsFirst supports S. 325, which would increase the maximum age for children eligible for medical care under the CHAMPVA program. Children who are CHAMPVA beneficiaries typically lose their coverage at age 18 unless they are full time students in which case they can maintain their benefits to age 23.

The Affordable Care Act or the ACA allows children to remain on a parent's health insurance until age 26. However, TRICARE and CHAMPVA beneficiaries were not covered by this provision. TRICARE has since been brought into alignment with the ACA but CHAMPVA has not. S. 325 would correct this injustice by allowing those beneficiaries to receive health care benefits until age 26.

Third, we support S. 455 which would provide VA with the authority to provide transportation for veterans who need assistance to and from VA facilities. Lack of transportation options remains a barrier for some veterans who need to travel to VA facilities for

health care services. For many veterans riding with family members and friends, using public transportation, or driving themselves allows them to travel to a VA facility when needed.

For veterans who do not have a network of friends and family, they are not able to drive. They do not live near public transportation. They have to seek other options.

In January 2013, the President signed the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012, which authorized VA to transport individuals to and from VA facilities for these purposes. This authority will expire in 2014. We support S. 455, which would extend it to ensure most importantly that no veteran is left without the ability to access critical VA services.

Fourth, VetsFirst supports S. 633, which provides beneficiary travel benefits for all veterans who have spinal cord injuries, vision impairments, and multiple amputations, and need to travel to receive inpatient rehabilitation services.

For those veterans who need these services but are not eligible for travel benefits, the ability to pay for travel, which may include traveling a great distance, can be very burdensome, so every effort must be made to reduce the barriers that limit access to these services, primarily because without those, that assistance, a veteran can lose their independence and may end up in a higher cost care somewhere.

Last, VetsFirst supports the Caregiver Expansion and Promotion Act of 2013. Many families of disabled veterans play a crucial role in providing needed services and supports that allow veterans to return to and remain in their homes.

Spouses and family members, however, often must leave the work force to assist their husbands, wives, adult children in their efforts to rehabilitate and reintegrate into their communities. That sacrifice may include lost income and other benefits, including health insurance. S. 851 would extend enhanced caregiver benefits originally provided to family caregivers of post-9/11 veterans with serious injuries to caregivers of veterans of all eras who have serious service-connected disabilities.

Many of these caregivers have sacrificed for decades in order to be able to provide assistance to their veterans and gladly have done so.

But we would hope that this would be an opportunity to recognize their significant contributions that they have made for, in several cases, many years to keep those veterans independent, working, and living in their communities.

Again, thank you for the opportunity to share VetsFirst's views of the legislation today. This concludes my testimony.

[The prepared statement of Ms. Ansley follows:]

PREPARED STATEMENT OF VETSFIRST, A PROGRAM OF UNITED SPINAL ASSOCIATION, SUBMITTED BY HEATHER L. ANSLEY, ESQ., MSW, VICE PRESIDENT OF VETERANS POLICY

Chairman Sanders, Ranking Member Burr, and other distinguished Members of the Committee, thank you for the opportunity to testify regarding VetsFirst's views on the bills under consideration today.

VetsFirst, a program of United Spinal Association, represents the culmination of over 60 years of service to veterans and their families. We provide representation for veterans, their dependents and survivors in their pursuit of Department of Veterans Affairs (VA) benefits and health care before VA and in the Federal courts.

Today, we are not only a VA-recognized national veterans service organization, but also a leader in advocacy for all people with disabilities.

WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013 (S. 131)

After more than a decade of war, many severely disabled veterans who have experienced trauma related to improvised explosive devices and other conditions of warfare may experience infertility. For many veterans, the ability to start or grow their families represents an important part of moving forward with their lives. Unfortunately, the current services available from VA in many cases do not reflect the needs of these veterans and their families.

Presently, VA provides male veterans who have spinal cord injuries with fertility services for retrieving, storing, and preparing sperm for use for assisted reproductive technology. These services are available to male veterans who are service-connected and also for those who have access to VA health care but whose disabilities are not related to their military service. Although VA provides these services for male veterans who have spinal cord injuries, there is no provision to provide the assisted reproductive technologies needed for fertilization.

The Women Veterans and Other Health Care Improvements Act takes important steps toward assisting veterans, their spouses, and surrogates in holistically addressing infertility. VetsFirst supports the addition of fertility counseling and treatment, including treatment using assisted reproductive technology to the definition of medical services. We are also pleased that this legislation not only expands the definition of medical services to include these treatments, but also provides them to veterans' spouses or surrogates. We are disappointed, however, that these services are not required for veterans who are not service-connected.

This legislation also provides the opportunity for veterans who are severely wounded, ill, or injured to grow their families through adoption. VA's assistance would be available for the adoption of up to three children or one cycle of in vitro fertilization, whichever is of lesser cost. VetsFirst believes that providing the option for disabled veterans to adopt is a critical recognition of the many paths to parenthood.

This legislation also requires VA to facilitate collaborative research with the Department of Defense and the National Institutes of Health which will help VA to address the long-term reproductive health needs of veterans. This research will be critical in addressing the unique infertility issues of veterans with combat-related injuries. We are also pleased that the legislation requires that the research be disseminated within the Veterans Health Administration to guide treatment practices.

VetsFirst also supports efforts in this legislation to improve access to VA services for women veterans. Women make up an increasing percentage of the veteran population. By 2040, VA projects that women will make up nearly 18 percent of the veteran population. As of 2012, 360,000 women veterans were using VA health care. VA must continue to improve efforts to address the unique needs and concerns of women veterans.

As part of these efforts, VA recently launched the Women Veterans hotline. The purpose of the hotline is to provide a single portal for women veterans to receive information about VA benefits and services. The call center staff will work collaboratively with other VA hotlines, including VA's crisis line. The Women Veterans and Other Health Care Improvements Act would complement and build upon these efforts by ensuring that the Women Veterans hotline is able to connect women veterans with needed services not provided by VA.

One of the services that many veterans, women and men, need to be able to fully access VA health care and readjustment counseling is affordable, convenient childcare. This legislation also provides veterans who are the primary caretaker of their children the opportunity to receive childcare assistance from VA when receiving mental health care services, readjustment counseling, or other intensive health services. This assistance may include stipends for licensed childcare services and VA provision of childcare services.

VetsFirst supports the Women Veterans and Other Health Care Improvements Act. This comprehensive legislation is needed to ensure that veterans are able to begin or expand their families and receive the health care assistance they need following their military service.

TO INCREASE THE MAXIMUM AGE FOR CHILDREN ELIGIBLE FOR MEDICAL UNDER THE CHAMPVA PROGRAM (S. 325)

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a robust health care program for the spouses and dependent children of veterans who are permanently and totally disabled, died while on active

duty, or died due to a service-connected disability. For the families of these veterans, CHAMPVA provides critical physical and mental health care benefits. Children who are CHAMPVA beneficiaries typically lose coverage at age 18 unless they are full-time students, in which case they maintain benefits until age 23.

The Affordable Care Act (ACA) allows children to remain on a parent's health insurance until age 26. However, TRICARE and CHAMPVA child beneficiaries were not covered by this provision. The National Defense Authorization Act (NDAA) for FY 2011 brought TRICARE into alignment with the ACA provision by extending coverage to age 26 for TRICARE beneficiaries. CHAMPVA child beneficiaries, however, were not included in the NDAA.

Consequently, CHAMPVA child beneficiaries are prohibited from receiving benefits provided to other adult children in our Nation. S. 325 will correct this injustice by allowing child beneficiaries to continue to receive health care benefits under the CHAMPVA program until age 26. This legislation will ensure parity for the children of permanently and totally disabled veterans and those who died in service to our Nation.

VetsFirst supports S. 325 because it will ensure that the children of men and women who have sacrificed greatly for our Nation are able to finish educational opportunities and begin careers without having to forgo access to critical health care benefits. We urge swift passage of this critical legislation.

TO AUTHORIZE VA TO TRANSPORT INDIVIDUALS TO AND FROM VA FACILITIES IN CONNECTION WITH REHABILITATION, COUNSELING, EXAMINATION, TREATMENT, AND CARE (S. 455)

Lack of transportation options can present significant barriers to disabled veterans in their efforts to actively participate in their communities. VetsFirst has been an active supporter of efforts to make public transportation, taxis, and other modes of transportation more accessible to wheelchair users and other people with disabilities. We also support and promote travel training to help people who have acquired disabilities learn how to navigate their community's transportation options.

Despite these efforts, transportation remains a barrier for some veterans who need to travel to VA medical services for health care. For many veterans, riding with family members and friends, using public transportation, or driving themselves allows them to travel to VA facilities when needed. For veterans who do not have a network of family and friends who can drive them to appointments, or who live in areas without public transportation or widespread assistance from volunteer organizations, they must seek other options.

To address unmet needs, VA launched the Veterans Transportation Service (VTS) initiative in 2010. The VTS initiative provides funding for mobility managers, transportation coordinators, and vehicles at local VA facilities. Although volunteer drivers are an integral part of transporting many disabled veterans to and from VA facilities, the need for drivers is greater than the number of volunteers. In addition, some veterans who need transportation have significant medical needs or are unable to ambulate, and volunteer drivers may be hesitant to transport these veterans.

In January 2013, the President signed the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012 (Public Law 112–260). Section 202 of this legislation authorized VA to transport individuals to and from VA facilities for vocational rehabilitation, counseling, and for the purpose of examination, treatment, or care. This authority will expire in 2014.

S. 455 will extend VA's authority to ensure that no veteran is left without the ability to access critical VA services. VetsFirst supports this legislation and urges swift passage.

TO PROVIDE COVERAGE UNDER VA'S BENEFICIARY TRAVEL PROGRAM FOR THE TRAVEL OF CERTAIN DISABLED VETERANS FOR CERTAIN SPECIAL DISABILITIES REHABILITATION (S. 633)

Veterans who have spinal cord injuries or disorders, vision impairments, or double or multiple amputations require access to rehabilitation services that allow them to live as independently as possible with their disabilities. For those veterans who need these services but who are not eligible for travel benefits, the ability to pay for travel to these rehabilitation programs can be very burdensome. In addition, few of these services are available locally, particularly to veterans who live in rural areas.

All disabled veterans who need to travel to receive in-patient care at special disabilities rehabilitation programs should be eligible to receive travel benefits from VA. Every effort must be made to reduce barriers that limit access to these services. The long-term savings of ensuring that these veterans are able to maintain their

health and function significantly outweighs the short-term costs associated with this legislation.

VetsFirst supports S. 633 because it will improve access to rehabilitation services for all veterans who have spinal cord injuries or disorders, vision impairments, or double or multiple amputations.

CAREGIVER EXPANSION PROMOTION ACT OF 2013 (S. 851)

Many families of disabled veterans play a crucial role in providing needed services and supports that allow veterans to return to, and remain in, their homes. The sacrifice of family caregivers not only supports veterans, but also VA's mission. Spouses and family members often must leave the workforce to assist their husbands, wives, and adult children in their efforts to rehabilitate and reintegrate into their communities. The sacrifice of these caregivers, however, may result in lost income and other benefits, including health insurance.

Although the commitment of the caregivers of our Nation's veterans has been evident for many decades, a study released in November 2010 by the National Alliance for Caregiving provides statistical evidence supporting the depth of the commitment that these caregivers have made to our veterans. For instance, the study report titled, "Caregivers of Veterans-Serving on the Homefront," noted that 70 percent of caregivers for our Nation's veterans are spouses. For all populations, only 6 percent of caregivers are spouses. Clearly, immediate family members have an important role in caregiving for our Nation's veterans.

An even higher number of caregivers, 80 percent, live with the veteran for whom they are providing care. Nationwide, only 23 percent of caregivers of all adults live with the care receiver. Consequently, 68 percent of caregivers of veterans report a high level of emotional stress due to caregiving which is more than double the level of stress endured by caregivers of all adults.

The lifelong commitment made by caregivers of our Nation's veterans is clearly represented by the 26 percent of parents who are providing care for their sons and daughters who are veterans of the wars in Iraq and Afghanistan. The long-term caregiving relationship of our Nation's veterans with disabilities and their caregivers exceeds that of other caregiving relationships. According to the National Alliance for Caregiving, 30 percent of caregivers of veterans from all eras give care for 10 years or longer, as opposed to only 15 percent of caregivers nationwide.

In May 2010, the President signed the VetsFirst supported Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163), to provide critical supports for caregivers of veterans with disabilities. Caregivers for all eligible veterans who are enrolled in the VA's health care system are to have access to education sessions, support services, counseling, mental health services, and respite care. The law also provides certain caregivers of veterans who have a serious injury, such as a Traumatic Brain Injury, that was incurred or aggravated in the line of duty on or after September 11, 2001, with a monthly stipend and access to medical care.

The expansive services provided through Title I of Public Law 111–163 provided hope for many caregivers who as the National Alliance for Caregiving study demonstrates provide care for a longer period of time and have a higher stress level than other types of caregivers. In order to receive assistance under the program of comprehensive assistance for family caregivers, a caregiver must be providing care to an "eligible veteran." According to 38 U.S.C. § 1720G(a)(2),

> [A]n eligible veteran is any individual who (A) is a veteran or member of the Armed Forces undergoing medical discharge from the Armed Forces; (B) 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 September 11, 2001; and (C) is in need of personal care services because of (i) an inability to perform one or more 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 considers appropriate.

Under the comprehensive program, family caregivers are eligible to receive training, technical support, counseling, and lodging and subsistence. For the family caregiver who is chosen as the primary provider of personal care services additional benefits are available. These benefits include mental health services, respite care of not less than 30 days annually, medical care, and a monthly personal caregiver stipend. As identified by the National Alliance for Caregiving, these benefits are desperately needed by the caregivers of disabled veterans.

Public Law 111–163 requires VA to submit a report to Congress regarding the feasibility of expanding comprehensive caregiver benefits for veterans who have a serious service-connected injury that was incurred or aggravated before September 11, 2001. To date, VA has not released this report.

The Caregiver Expansion and Improvement Act of 2013 (S. 851) would build on Public Law 111–163 by extending these enhanced caregiver benefits to the caregivers of veterans of all eras who have serious service-connected disabilities. Many of these caregivers have sacrificed for decades to serve their seriously injured disabled veterans. We must recognize the significant contributions made by these caregivers by ensuring that they have full access to all VA caregiver benefits. The determination for which caregivers receive comprehensive caregiver benefits should be based on a veteran's level of need, particularly as those with serious injuries, including spinal cord injuries, age.

VetsFirst strongly supports the expansion of comprehensive caregiver assistance to family caregivers of all veterans with a serious service-connected disability. We urge swift pass of S. 851.

TO PROVIDE FOR CERTAIN REQUIREMENTS RELATING TO THE IMMUNIZATION OF VETERANS (DRAFT)

For veterans who have spinal cord injuries and disorders or other significant disabilities, contracting influenza or pneumonia can lead to severe, debilitating health problems, or even death. Since focusing on the need for veterans with spinal cord injuries and disorders to receive influenza vaccinations due to their high-risk of influenza related complications, VA has seen an increase in the vaccination rate for these veterans from 28 percent in 2000 to 79 percent in 2010. Similarly, VA saw an increase in vaccination rates for pneumococcal pneumonia from 40 percent in 2000 to 94 percent in 2010.

Receiving every recommended immunization as suggested is critical for all veterans. This draft legislation would ensure that veterans have access to immunizations against infectious diseases in accordance with the recommended adult immunization schedule. The legislation requires VA to include information about immunizations in VA's annual report to Congress on preventive health. Importantly, this legislation also requires VA to develop and implement quality measures and metrics, including targets for compliance, to ensure that recommended immunizations are delivered in accordance with the schedule.

VetsFirst fully supports legislation to establish requirements for immunizations and metrics for their delivery. Veterans, particularly those who are at high-risk for contracting diseases that vaccines can prevent, must receive those immunizations. As efforts to address influenza and pneumonia have proven, concerted efforts to increase immunizations can increase the number of veterans who are offered and accept those vaccines.

Thank you for the opportunity to testify concerning VetsFirst's views on these important pieces of legislation. We remain committed to working in partnership to ensure that all veterans are able to reintegrate in to their communities and remain valued, contributing members of society.

Chairman SANDERS. Thank you very much, Ms. Ansley.

Mr. Gornick.

STATEMENT OF MATT GORNICK, POLICY DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS

Mr. GORNICK. Chairman Bernard Sanders, Ranking Member Richard Burr, and distinguished Members of the Senate Committee on Veterans' Affairs, I am honored to appear before this Committee as the policy director of the National Coalition for Homeless Veterans.

On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your steadfast commitment to serving our Nation's most vulnerable heroes.

My testimony today will focus on three bills currently before this Committee: S. 62, the Check the Box for Homeless Veterans Act of 2013; S. 287, a bill to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary

of Veterans Affairs; and S. 825, the Homeless Veterans Prevention Act of 2013.

Since their inception, Federal assistance programs for homeless veterans have received overwhelming bipartisan support from Congress. While critical, some of these investments have been modest in consideration of the full range of problems associated with veteran homelessness.

Sen. Barbara Boxer's Check the Box for Homeless Veterans Act would help address some of the shortfalls by establishing a national Homeless Veterans Assistance Fund, supported through designated tax overpayments and other direct contributions.

This fund would be used for two purposes: one, to develop and implement new and innovative strategies to prevent and end veteran homelessness; and two, to provide services through any homeless veteran program administered by the VA, HUD, and Labor.

This fund's primary purpose should be to help close gaps in service delivery systems for veterans. It would be counterproductive to reduce appropriations for homeless veteran assistance simply due to this fund's establishment.

The next bill I would like to discuss is S. 287. Over the past few years, VA's homeless programs have evolved to accommodate the growing number of homeless women veterans and single veterans with dependent children.

Unfortunately, the Department still defines homeless veteran based on an incomplete citation of the McKinney-Vento Homeless Assistance Act. The full definition of "homeless" under this act includes individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in their housing situation.

Senator Mark Begich's S. 287 serves a straightforward purpose: to include this provision in VA's definition of a homeless veteran.

Although some veterans who meet this expanded definition may already qualify for VA homeless assistance due to the nature of their circumstances, we must ensure that they are not denied the help that they need.

The last bill that I would like to discuss is Chairman Sanders and Ranking Member Burr's S. 825, the Homeless Veterans Prevention Act of 2013.

The breadth of this bill is a testament to this Committee's leadership in the effort to prevent and end veteran homelessness. Among its many important provisions, S. 825 would reauthorize competitive grant programs for community- and faith-based veteran service providers.

These programs include the Grant and Per Diem Program, Homeless Veterans' Reintegration Program, and Supportive Services for Veteran Families Program.

NCHV concurs with VA in its fiscal year 2014 Budget Proposal on the following items, which are not reflected in this bill. The Grand Per Diem Program should be permanently authorized at $250 million. This program has the capacity to serve 30,000 homeless veterans each year and is vital to VA's mission to end veteran homelessness.

The Supportive Services for Veteran Families Program should be permanently authorized at $300 million. This program will serve as the foundation of VA's strategy to prevent veteran homelessness well beyond 2015.

Last, the Grant Program for Homeless Veterans with Special Needs should also be permanently authorized. Therefore, NCHV recommends that the Homeless Veterans Prevention Act be amended to accommodate these proposals. Without these extensions, VA cannot adequately plan for these programs' future.

Additionally, while this bill would provide increased per diem payments for service providers implementing a Transition-in-Place housing model, the need to reform the per diem payment method remains.

This Committee helped pass legislation that became Public Law 112–154, which requires VA to study all matters relating to the per diem payment method, including anticipated changes in the cost of providing services to homeless veterans.

VA must report to Congress on its findings less than 3 months from today. Anything short of a proposal to thoroughly modernize this outdated reimbursement policy from a flat per diem rate to a flexible, cost-of-services payment method should be deemed insufficient.

In closing, thank you for the opportunity to present this testimony. It is a privilege to work with this Committee to ensure that every veteran in crisis has reasonable access to the support services they earned through their service to our country.

Thank you.

[The prepared statement of Mr. Gornick follows:]

PREPARED STATEMENT OF MATT GORNICK, NCHV POLICY DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Bernie Sanders, Ranking Member Richard Burr, and distinguished members of the Senate Committee on Veterans' Affairs: I am honored to appear before this Committee as the policy director of the National Coalition for Homeless Veterans (NCHV). On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your steadfast commitment to serving our Nation's most vulnerable heroes.

This testimony will focus on our support for three bills currently before this Committee:

- S. 62, the "Check the Box for Homeless Veterans Act of 2013;"
- S. 287, a bill "to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs;" and
- S. 825, the "Homeless Veterans Prevention Act of 2013."

Additionally, this testimony will recommend ways to improve effective service delivery to homeless veterans.

BACKGROUND

For decades, the veteran service provider community represented by NCHV has worked arduously toward the goal of ending veteran homelessness. The announcement of Secretary of Veterans Affairs Eric Shinseki's Five-Year Plan to End Veteran Homelessness in November 2009—fully incorporated into the "Federal Strategic Plan to Prevent and End Homelessness"—demonstrated the Federal Government's solidarity in making that goal a reality.

Congress has seen the promise of this plan and, through fiscal year (FY) 2013, has increased funding for successful community-based programs to end veteran homelessness. These investments have fueled consistent decreases in the number of homeless veterans on a given night—down 17.2% since 2009, according to the latest Point-in-Time Report from the U.S. Department of Housing and Urban Development (HUD).

As the maturity date of the Five-Year Plan approaches, NCHV maintains that our Nation is on a path to ensure that no veterans, regardless of their personal haunts and challenges, are ever left to fend for themselves on the streets.

The legislation currently before this Committee would help keep our Nation on this path.

S. 62, "CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013"

Since their inception, Federal assistance programs for homeless veterans have received overwhelming bipartisan support from Congress. While critical, some of these investments have been modest in consideration of the full range of problems associated with veteran homelessness.

Sen. Barbara Boxer's S. 62 would help address some of the shortfalls by establishing a national Homeless Veterans Assistance Fund, supported through designated tax overpayments and other direct contributions. The fund would be used for two purposes:

1. To develop and implement new and innovative strategies to prevent and end veteran homelessness; and
2. To provide services through any homeless veteran program administered by the Department of Veterans Affairs (VA), the Department of Labor-Veterans' Employment and Training Service (DOL-VETS), and HUD.

This fund's primary purpose should be to help close gaps in service delivery systems for veterans. It would be counterproductive to reduce appropriations for homeless veteran assistance programs simply due to this fund's establishment.

The Homeless Veterans Assistance Fund should help organizations that cannot compete for Federal grants under limited programs—such as those in highly rural areas—provide support to veterans in crisis. The fund should also support nontraditional, high-demand activities such as:

- Contracting with veteran service providers to administer case management for veterans in permanent supportive housing in underserved communities.
- Providing child care assistance for veterans in employment assistance programs.
- Helping veterans make security deposits and pay utility hook-up fees for housing placements.

All of the above activities are already authorized in some form. By focusing on these areas of service delivery, S. 62 would serve a vital role in both eliminating and preventing veteran homelessness.

S. 287, A BILL "TO EXPAND THE DEFINITION OF HOMELESS VETERAN FOR PURPOSES OF BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS"

Over the past few years, VA's homeless programs—such as the Supportive Services for Veteran Families (SSVF) and HUD-VA Supportive Housing (HUD-VASH) Programs—have evolved to accommodate the growing number of homeless women veterans and single veterans with dependent children. Unfortunately, the department still defines "homeless veteran" based on an incomplete citation of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302(a)). The full definition of "homeless" under this act includes the following provision:

> "Any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing."

Sen. Mark Begich's S. 287 serves a straightforward purpose: to include this provision in VA's definition of "homeless veteran."

Although some veterans who meet this expanded definition may already qualify for VA homeless assistance due to the nature of their circumstances, we must ensure that we do not deny any of these veteran families the help that they need.

S. 825, "HOMELESS VETERANS PREVENTION ACT OF 2013"

The breadth of this bill is a testament to this Committee's leadership in the effort to prevent and end veteran homelessness. Introduced by Chairman Bernie Sanders and Ranking Member Richard Burr, S. 825 would—among many important provisions—reauthorize competitive grant programs for community- and faith-based veteran service providers. These programs include the Grant and Per Diem (GPD) Program, Homeless Veterans' Reintegration Program (HVRP), and SSVF Program.

Along with the continued buildup of the HUD-VASH Program, expansion of these programs has contributed to the steady reduction in veteran homelessness over recent years.

NCHV concurs with VA in its FY 2014 Budget Proposal on the following items, which are not reflected in this legislation:

• The GPD Program should be permanently authorized at $250 million. As currently written, S. 825 would allow the program's authorization to drop to $150 million after FY 2014.

• The SSVF Program should be permanently authorized at $300 million. As currently written, S. 825 would allow the program's authority to expire after FY 2014. This program will serve as the foundation of VA's strategy to prevent veteran homelessness well beyond 2015, and its permanent authorization is critical to sustain the national priority to end veteran homelessness.

• The grant program for homeless veterans with special needs should be permanently authorized. As currently written, S. 825 would allow the program's authority to expire after FY 2014.

Therefore, NCHV recommends that S. 825 be amended to accommodate these proposals. Without these extensions, the Department of Veterans Affairs cannot adequately plan for these programs' future.

Additionally, while this bill would provide increased per diem payments for service providers implementing a "Transition in Place" housing model, the need to reform the per diem payment method remains. This Committee helped pass legislation that became Public Law 112–154, which requires VA to:

> "Complete a study of all matters relating to the method used by the Secretary to make per diem payments under section 2012(a) of title 38, United States Code, including changes anticipated by the Secretary in the cost of furnishing services to homeless veterans and accounting for costs of providing such services in various geographic areas."

The law requires VA to report to Congress on its findings no later Aug. 6, 2013. Anything less than a proposal to thoroughly modernize this outdated reimbursement policy—from a flat per diem rate to a flexible, cost-of-services payment method—should be deemed insufficient.

IN SUMMATION

Thank you for the opportunity to present this testimony for today's hearing. It is a privilege to work with the Senate Committee on Veterans' Affairs to ensure that every veteran in crisis has reasonable access to the support services they have earned through their service to our country.

Chairman SANDERS. Thank you very much, Mr. Gornick.

Mr. Bowman.

STATEMENT OF THOMAS BOWMAN, FORMER CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. BOWMAN. Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee, it is a pleasure to be here and offer my comments on S. 543, the VISN Reorganization Act of 2013.

I believe the proposed legislation is both timely and necessary to ensure that the VA with predictable regularity, reviews, reorganizes or right sizes, as appropriate, its VISN organizational structure and operation to more efficiently and effectively oversee and manage the budgetary and planning responsibilities for the respective networks.

At the outset, I believe it important to state that I receive all my health care through the VA at the Bay Pines VA Medical Center in St. Petersburg, FL. Although I have many other health care options available to me, I choose the VA because I believe in its mission and its people.

My comments have been influenced most particularly by my last 3-1/2 years experience as an employee of VA, day to day, as the senior advisor to the VISN 8 network director.

There has been no serious review or right-sizing of the VISN geographic boundaries in approximately 18 years until prompted by the proposed legislation.

The legislation reduces the number of VISNs from 21 to 12 by combining existing geographic boundaries and eliminating excess VISN headquarters, and assisting the transfer or reassignment of affected personnel to nearby VA medical centers or other VA facilities. Many could fill existing vacancies at these facilities based upon their exceptional skill sets.

With the closure of 9 VISN headquarters under the reorganization, the funding saved could be provided to other VA medical centers to support their clinical needs, other capital asset upgrades, and maintenance, as needed.

I have provided the Committee a map reflecting the proposed realigned boundaries. The map also reflects the current location of existing VA medical centers, community-based outpatient clinics and VISN headquarters.

The geographic combinations result in a re-balancing across VA of the aggregate number of today's veteran beneficiaries under one VISN director instead of two or possibly, in one case, three separate VISN headquarters.

Some might argue that despite smaller unique or enrolled patient numbers, you need to separate VISNs because of the challenge presented by the number of VA medical centers or the expansion of geographic areas that the combinations would entail.

VA medical centers are not all the same complexity level or size. The same management process and procedures for budgeting and planning can be applied by a VISN director whether the number of medical centers is 8, 14, or in the largest proposed VISN combination—VISNs 1, 2 and 3—would be 20.

The management tools, reports, information technology capability, tele and video communications venues, and site visits available to a VISN director and staff are significant and effective, if appropriately utilized.

It should be noted that the realignment of the VISN geographic boundaries would not adversely impact individual veteran patient referral patterns as they exist today. They would continue as before.

Patients would still be cared for by their VA medical center staff or wherever they may be referred for care. The VISN headquarters does not currently, nor under the proposed restructuring, provide direct patient care.

What would change is that the VA medical center directors in realigned VISNs would have a new VISN director to which they will be accountable, and a new boss.

The proposed legislation states, in essence, that a VISN headquarters is to be located on the grounds of a VA medical center. At the same time, however, it provides that the Secretary can justify keeping the VISN headquarters in a leased location off campus by justifying his decision in a report to appropriate Congressional oversight committees.

The Secretary, in providing that report, then is offering his justification for keeping a lease that may be in existence or to possibly move into an offsite location.

In the absence of an unanticipated exigent circumstance—natural disaster or other unforeseen emergencies—there is very little justification for not being able to balance the VISN books at the end of the fiscal year.

VISNs begin to plan for the closure of their books, and VA Central office is generally well aware of any deficiencies well in advance of the end of the fiscal year. VA Central Office has the ability to transfer reserve funds held at their level to cover the deficiencies in VISN accounts in advance of the end of the fiscal year where and when they propose to do so.

In addition, the Under Secretary for Health has a number of means and methods by which to hold VISN directors accountable for year-end budget deficiencies.

Mr. Chairman, this concludes my comments; I offer others in my written statement.

[The prepared statement of Mr. Bowman follows:]

PREPARED STATEMENT OF THOMAS G. BOWMAN, J.D., COLONEL USMC (RET.), FORMER CHIEF OF STAFF, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Sanders, Ranking Member Burr, Distinguished Members of the Senate Committee on Veterans Affairs, Thank you for the opportunity to appear before you and offer my comments on S. 543, "VISN Reorganization Act of 2013." I believe the proposed legislation is both timely and necessary to ensure that the Department of Veterans Affairs with predictable regularity, reviews, reorganizes or right sizes, as appropriate, its VISN organizational structure and operation to more efficiently and effectively oversee and manage the budgetary and planning responsibilities for veteran healthcare in the respective networks.

By way of personal background, I retired from the Marine Corps in September 1999 after 30 years having served as both an infantry officer and Judge Advocate; my last assignment as the Senior Military Assistant to the Under Secretary of Defense for Personnel and Readiness. Upon retirement, I joined the Committee on Government Reform and Oversight, U.S. House of Representatives as a Senior Counsel and served there until February 2002 when I joined the Department of Veterans Affairs. I served in various positions at VA headquarters which included Acting Assistant Secretary for Public and Intergovernmental Affairs, Deputy Chief of Staff and Chief of Staff. I departed VA Central Office in January 2009 and assumed the position of Senior Advisor to the Director of the VA Sunshine Healthcare Network (VISN 8) in St. Petersburg, Florida. I retired from the VA in June 2012.

In 1995, Dr. Kenneth Kizer, then the Under Secretary for Health for VA implemented a plan for the reorganization of both the field operations and its central office management. It was called Vision for Change: A Plan to Restructure the Veterans Health Administration, March 17, 1995. Under the plan the basic budgetary and planning unit of healthcare delivery in the field was moved from individual medical centers into integrated service networks providing care for veteran beneficiaries in pre-determined geographic areas. Dr. Kizer stated:

> "These network service areas and their veteran populations are defined on the basis of VHA's natural referral patterns; aggregate numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and to a lesser extent, political jurisdictional boundaries such as states."

VISN GEOGRAPHIC BOUNDARIES

Although 22 VISN's were part of the original implementation plan, two of the smallest VISN's were combined to better justify and accommodate staffing, funding and patient population leaving 21 VISN's to initiate Dr. Kizer's plan. The VISN staffing level was to be 10 FTE. There has been no serious review and right sizing of the VISN geographic boundaries in approximately 18 years until prompted by the proposed legislation.

The proposed legislation reduces the number of VISN's from 21 to 12 by combining existing geographic boundaries and eliminating excess VISN headquarters, and assisting the transfer or reassignment of affected personnel to nearby VA medical centers, or other VA facilities. Many could fill existing vacancies at these facilities based upon their exceptional skillsets. With the closure of 9 VISN headquarters under the reorganization, the funding saved could be provided to other VA medical centers to support clinical needs and other capital asset upgrade and maintenance, as needed. Attached is a map reflecting the proposed realigned boundaries identifying affected VISN's. The map also reflects the current location of existing VA medical centers, community based outpatient clinics (CBOC) and VISN headquarters locations.

The geographic combinations result, across the VA, in a re-balancing and closer standardization of the aggregate number of today's veteran beneficiaries under the budgetary and planning management of one VISN director instead of spread across two or, in one case, three separate VISN headquarters with its associated staff. In essence, the combining of the selected VISN's is analogous to what Dr. Kizer found appropriate to do for roughly similar reasons in the very beginning when he combined two VISNs.

By way of an example below, I am using approximate 2011 VA data for VHA unique patient/veteran enrollee numbers. Combining VISN 1 (232,490/353,911), VISN 2 (129,815/140,415) and VISN 3 (167,172/183,382) would result in approximately 529,477/677,708 total unique patients/veteran enrollees would result in one VISN director and associated staff managing them, instead of the VISN headquarters budget and FTE overhead of three VISN. Those numbers compare more favorably to what one VISN, VISN 8, had as numbers for the same categories at the same time—505,133/714,755. Another example is combining VISN 17 (261,560/394,110) and VISN 18 (240,044/363,209) would result in one VISN director managing 501,604/757,319. A further example is combining VISN's 19 and 20. VISN 19 (170,608/261,736) combined with VISN 20 (243,872/375,968) results in 414,480/637,704 total unique patients/veteran enrollees; numbers still smaller than those of VISN 8.

Some might argue that despite smaller unique and enrollee patient numbers, you need separate VISN's because of the challenge presented by the number of VA medical centers or the expansion of geographic areas that the combinations would entail. VA medical centers are not all the same complexity level or size. The same management process and procedures for budgeting and planning can be applied whether the number of medical centers is 8, 14, or in the largest proposed VISN (combining VISN's 1, 2 and 3) would be 20. The management tools, reports, IT and tele and video communications venues available to a VISN director and staff are significant and effective, if utilized appropriately. Much of the intended mission of the VISN operation is accomplished through data analysis and "dashboards" All too often in recent years the immediate response to any additional tasking or expansion of responsibility at the VISN headquarters level has is a request for more FTE instead of working with what staff already exist. Doing so underestimates the fact that current VISN staff are individually and collectively more capable of assuming more responsibilities if asked, especially in the restricted budget environment that VA will be challenged with in future years.

It is important to note that the realignment of the VISN geographic boundaries would not adversely impact individual veteran patient referral patterns. They would continue as before. Patients would still be cared for by their VA Medical Center staff, or wherever they may be referred for care. The VISN headquarters does not currently, nor under the proposed restructuring, provide direct patient healthcare. What would change is that VA Medical Center directors in realigned VISN's would have a new VISN director to which they will be accountable * * * a new boss.

VISN STAFFING

The current review by VHA into the VISN headquarters FTE staffing numbers seems to be consistent in its results (55–65 FTE) with VISN staffing levels recommended by the proposed legislation—not more than 65 FTE. However, the current VHA review was done assuming 21 VISN's. I believe the review started with approximately 1720 adjusted VISN FTE staff, and VHA is in the process of reducing VISN staffing to a total of 1230 FTE, a reduction of approximately 490 FTE. With the proposed realignment, VISN staffing could be further reduced by approximately 520 FTE. The budgetary savings and FTE benefit could be moved to support operations at the VA medical centers.

In conjunction with the reorganization of the number of VISN's, I would strongly urge that the position of VISN Deputy Director be upgraded to SES level at all

VISN headquarters. VA medical centers are healthcare systems and each health system has a director that is an SES. They are accountable to the VISN director (an SES) in the chain of command. As the term Deputy Director is currently applied, it is a misnomer. If a VISN director retires; is replaced for cause; or, absent for a significant period of time, VA has to identify an SES level individual to replace him or her for the duration of the absence or vacancy. Usually that replacement is through detailing a current sitting medical center director within the VISN, or seeking someone from another VISN to assume the director responsibilities until a replacement is appointed. At the present time, that recruitment and appointment process can be rather time consuming.

An SES Deputy Director can immediately assume the Acting Director role with current understanding of the VISN issues; no "learning curve" would be necessary. Medical center directors will be more inclined to see the SES Deputy Director as more of a "peer" and interact with that person more completely and confidentially on business and other related issues that they usually reserve for conversations with the VISN director. Additionally, upgrading the position can be an excellent succession planning venue for potential medical center director candidates allowing them to gain significant experience and insight into executive planning and decisionmaking. SES allocations for these positions can possibly come from SES positions that become available through the VISN consolidations if retirements occur or from those currently available within VA Central Office.

LOCATION OF VISN HEADQUARTERS

The proposed legislation states, in essence, that a VISN headquarters is to be located on the grounds of a VA medical center. At the same time, however, it provides that the Secretary can justify keeping the VISN headquarters in a leased location off campus by justifying his decision in a report to appropriate Congressional oversight committees. The preference for colocation upon a VA medical center campus is in keeping with what Dr. Kizer recommended. Colocation on a VA medical center campus provides for veteran and medical center situational awareness for the VISN staff by witnessing their budget policy and planning being implemented at the operational level. If the Secretary ultimately directs the movement on campus, there would possibly be some associated costs, but that would be the decision of the Secretary.

VISN BALANCED BUDGET

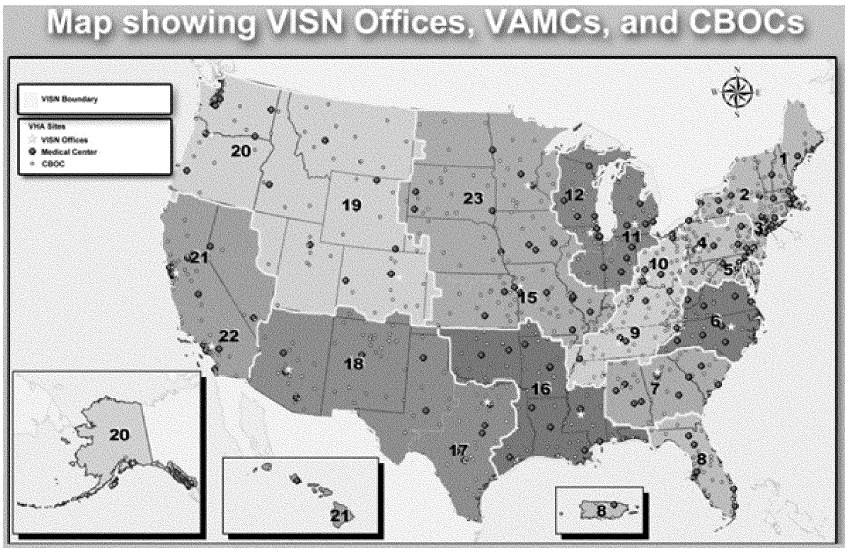
In the absence of an unanticipated exigent circumstance (natural disaster, or other unforeseen emergencies), there is very little justification for not being able to balance at the end of the fiscal year. VISN's begin to plan for the closure of their books, and VA Central office is generally well aware of any deficiencies in advance of the end of the fiscal year. VA Central Office has the ability to transfer reserved funds held at their level to cover the deficiencies in VISN accounts in advance of the end of the fiscal year where and when they want to do so. In addition, the Under Secretary for Health has a number of manner, means and methods of holding VISN directors accountable for year-end budget deficiencies.

TRIENNIAL REVIEW OF VISN STRUCTURE

A review and report to Congress every three years will provide appropriate "checks and balances" for VA leadership as it plans and programs for VISN field operations; preclude unnecessary FTE increases; and, facilitate and enhance appropriate Congressional oversight of VISN operations.

Mr. Chairman, this concludes my statement. I am pleased to answer any questions that you or other Members may have.

[Included in Mr. Bowman's testimony:]



Chairman SANDERS. Mr. Bowman, thank you very much. Each of you provided excellent testimony. You all have made an important contributions to the discussion on how we should go forward.

Dr. Jonas, let me start with you. As you may know, your statement is fairly revolutionary. As I understand it, what you are suggesting is that complementary or alternative medicine should be integrated into our health care system. What you are suggesting is that if we move aggressively in areas like meditation, acupuncture, chiropractic care, and other areas, we can ease the suffering of veterans and we can save the system substantial sums of money.

Is my characterization correct? If so, what would you suggest that we do with VA to increase access to these therapies? How aggressive should we be? The VA has already made efforts in all of these areas and may even be ahead of the curve compared to the private sector.

Dr. JONAS. I think your characterization could be correct provided these practices are integrated in the proper way. They are not simply tagged on as if they were another treatment system for another condition and a specialty is created.

So, my first suggestion is that the VA—and they have made a lot of progress in these areas—get outside help. And what I mean by that is that by definition, these things are not part of the mainstream system. That is why they are called complementary and alternative medicine. They are outside of the way things normally are done.

That means the skills in terms of the delivery of them are not things that are normally part of the educational part of practitioners that are in the VA. They are integrated into medical records, for example. They are not part of the benefits system. They are not tightly linked to the priorities such as the personalized person-centered care center.

So, we will go into a patient-centered medical home. In the VA version, it is a pact, and we will look for whether these practices are even on the radar screen; and in most cases they are not or they are on the side. They are not fully integrated.

We will go into the distribution system for primary care enhancements, for example, called the Scan System. That infrastructure is there to do it but you do not see integrative practices as part of that.

There needs to be a retraining program and an evaluation and quality assurance program that is coordinated with current existing practices so that they are systemically designed and evaluated as they are put in to the system.

Chairman SANDERS. Are there any health care systems in this country which are doing a better job than the VA that we can learn from?

Dr. JONAS. In this area there are, and I suggest the VA really look at some of those care systems that have demonstrated improvements in pain, improvements in function, and reduction of costs in those areas.

There are a number of them. The Allina System up in Minnesota, for example, has a wonderful inpatient example of how to integrate complementary practices into mainstream in a systematic way.

Chairman SANDERS. And the results have been positive?

Dr. JONAS. Very positive, yes, reductions in pain, anxiety, cost, length of stay in the hospital, this type of thing.

There are some examples within the VA also but they tend to be champion driven meaning that if you have a passionate person who is organized in the VA, it is done. Salt Lake City had a wonderful one, for example, that showed, documented, and published major improvements in outcomes, reductions in costs, including impact on homelessness and that type of thing through a whole-person integrated practice.

But when the medical director of that VA retired and left, it largely went away. It was not embedded into the system, into the benefits, or into the training and education of the entire system.

So, these are the kinds of things that need to be coordinated.

Chairman SANDERS. My impression is that people are gravitating more to these type of procedures. My impression also, having visited a number of VA centers, is that many veterans look forward to and want to access these types of alternative treatments. Is that accurate?

Dr. JONAS. That is absolutely right. Surveys done on the DOD side, and also on the VA side, show that the use of these practices tends to be even higher in those populations than they are out in the civilian population, especially for stress-related pain and those types of conditions, mental health conditions.

Chairman SANDERS. All of us are wrestling the epidemic of PTSD.

Dr. JONAS. Right.

Chairman SANDERS. It is a huge problem. You touched on it in your testimony. You think there are treatments, complementary and alternative treatments, that can help?

Dr. JONAS. Well, I mentioned two. One is a relaxation treatment that we tested out at Camp Pendleton which was delivered by nurses. It induced a deep relaxation. It actually involved training skills; in other words, training veterans and their families how to do that. We are doing another one of those programs down at Fort Hood and at some VAs that show improvements in that.

Those are the kinds of practices. They are skill-based training. They are not treatments per se. They are not something where you have a pill or you have even a needle or a manipulation where you require a professional. It is self-care practice.

Chairman SANDERS. You have done that within the DOD. Am I correct that there is no reason why that could not be done within VA, as well?

Dr. JONAS. There are mind, body, and relaxation practices going on in the DOD. Few of them have been evaluated. There have been some that have had impact in those areas.

They need to be designed with experts from the outside that get involved, subject matter experts, and done in coordination with the VA practitioners so they learn how to actually deliver them because they are the implementation experts.

So, that is why a team approach is required in those areas.

Chairman SANDERS. Thank you very much. My time has expired.

Senator Burr.

Senator BURR. Mr. Chairman, thank you, and to the panel. I found it to be fascinating. I will probably need another round just to let you know now because I want to cover as much ground as I can today.

Tom, thank you for being here and retirement looks like it is treating you well.

The VISN Reorganization Act would create regional support centers, and they were set up to measure the efficiency and the effectiveness of the VISNs.

Now, the VA has testified that these centers would likely increase staffing, are not the best functions to be moved to a regional level, and could produce conflicting oversight programs.

Let me ask you. Do you believe that this function could be carried out without additional staff?

Mr. BOWMAN. Senator, I do. And, by way of background, the functions that have been identified in the legislation—finance, compliance, outreach, women veterans, homelessness, and could be others. In each VISN, there are individuals that are responsible for those tasks and responsibilities of analysis and oversight of what is occurring in the medical centers within the respective VISN.

If you were to move forward with the regional support centers, what you are doing is taking what would be a number of personnel. Now, it could be a one, two, or three personnel office that would be looking at a larger number of VA medical centers. It would not be an expansion or an explosion of additional FTE.

And in fact, in the legislation, the approach that is taken is that you would attempt to move individuals who had those responsibilities in VISNs where there were a closure of the VISN headquarters and move them into the regional support center.

An important point to remember is that at the VISN level, the individuals who are conducting those responsibilities, those anal-

ysis and assessment responsibilities are accountable to the VISN director.

If their functions are moved to a regional support center and they are looking at more VISNs, you gain the ability to assess good practices, good implementation across a larger number of headquarters.

I am aware that there has been some comments about a confusion in the chain of command. So, if you create a regional support center, do you now blur the chain of command, the answer is no, because as the legislation is discussed, the regional support center would be looking at a predetermined number of VISNs as determined by the Under Secretary or the Secretary.

Then, they would take a look at whether or not they are performing, those medical centers are performing. If they are not performing, the VISN director is going to be made aware of it by reports and information that would come down from VA central office. The regional support centers would be a field entity where accountability by the VISNs can be taken to the VISN level of accountability back up to VA central office.

Senator BURR. So, to some degree, some VISNs or some directors might look at this as a threat because there would actually be data that they could not influence what it said that makes its way to central office.

Mr. BOWMAN. Yes, there would be a concern there.

Senator BURR. You know, Tom, I noticed in your written testimony you mentioned the lack of succession planning, and specifically you state that VISN deputy directors should be at the SES level to match the VA medical center directors.

I am wondering. Can you expand on that to some degree?

Mr. BOWMAN. At the present time, the way VISNs are constructed and the way medical centers are constructed, you have an SES as a VISN director and you have an SES as a medical center director. At the present time and by exception in one case, VISN 8, the deputy network director is not an SES.

Now, from an operational standpoint that I witnessed for 3-1/2 years is that when a deputy director is not a VISN, if there is a gap or an absence on the part of the VISN director, either they were relieved for cause or they retire or for some other reason are going to be gone for a long period of time, VA has to pull in either an existing medical center director to act temporarily as the VISN director. This means he or she is no longer managing the business of the medical center from which they came or they are going to be the VISN director until the personnel process of replacing the VISN director occurs. And, as we know, that is not a very quick process.

The other point is that if you have the deputy network director as an SES, it becomes a position that career employees—as they advance in their rank within the VHA structure—it will be a position that they look to compete for because of the advantage of experience to be gained.

It becomes part of a succession planning venue because, if you have individuals who have served as deputy network directors, they then become good candidates to be looking at or to be considered for medical center directors because they have gained the ad-

vantage of the experience and background of what a VISN operation is like as they oversee medical centers.

It would, at the same time, allow the medical center directors to feel more comfortable in bringing to the attention of a deputy network director issues sensitive in nature, whether they be business or personal as it relates to happenings within the VISN much more so than somebody who is not at the SES level.

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

Chairman SANDERS. Thank you, Mr. Bowman.

Senator Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman.

Rick, you mentioned and Dr. Jesse alluded to it earlier of the sense of having HUD look at in preventing—sometimes we do not talk about the prevention of homelessness which again are very, you know, are so beneficial.

I think you make an interesting point if you have the—it might be an intervention there. If that does not resolve it, then the next step is that you are sleeping on somebody's couch. That is another opportunity to intervene before the bad things happen where you are physically out on the street.

So, I think you make a really good point there. Perhaps, you know, there is something that we can do to figure out how we can do that step. I certainly would like to work with you in that regard.

I just want to thank all of you. We really can be proud of a lot of things that have happened in the last several years and your advocacy in different ways really has made a huge difference, working with the VA. And so, we really do appreciate it.

The other thing is you mentioned spina bifida and that is something that I would like to look at.

The Vietnam era is my era. I can recall somebody that was just a wonderful employee whose husband died very, very young that was up to his eyebrows in Agent Orange. They had two children who had multiple problems, you know, as a result of this.

So, we all know of those kind of stories. But like I said, I would like to be involved in that and I will get with you on that.

Mr. Bowman, I think you have got some great ideas. I appreciate your service and have enjoyed working with you now for the last several years.

And again, you know, we have got a great story to tell in regard to making changes. I guess good ideas were there for quite a while. I am sure that you are frustrated in the sense of getting some of those ideas done then, as we all are.

I have been on the Committee for a long time. We have all been working in these areas. What is your recommendation? How do we actually get those good ideas that you had implemented?

What is the next step in actually getting some of this stuff done in regard to perhaps looking at reorganization, looking at, I guess—what I would like to know is how do we get that done?

And then the other question is what is the low hanging fruit out there that you think that the Committee, the VSOs, the nonprofits, what are some of the low hanging fruit that we can get at to help VA? I think a lot of this stuff, probably the vast majority VA wants to be helped to implement.

What are the things we need to address that we could actually get done fairly quickly?

Mr. BOWMAN. Well, sir, in the area of veterans' health and the operation at the field level, I think the one thing that needs to occur to be able to kind of pave the way for ideas to be immediately identified as beneficial is that the more opportunity that senior officials in the VA central office have to go into the field and spend time in the field, a 2-day visit down to a particular medical center is not going to gain a senior official an opportunity to fully understand or grasp what may be an issue. They can get that based upon a briefing in their office.

When senior officials come down, they are going to then be able to see what is being commented upon as needs. I believe that the collaboration and close coordination with veteran service organizes and their state-level entities is exceptionally important because of lot of the day-to-day adjustments and practice of outreach, of information flow is accomplished by and through and with the veteran service organizations and what I saw in my 3-1/2 years down at the VISN 8 area was the community- and faith-based organizations were more interested in what was happening through the process of conveyance of information.

The low hanging fruit I believe——

Senator BOOZMAN. So, in regard to the other, some of that is just the tyranny of the urgent that you are dealing with that prevents you from—it is interesting. I think, you know, the advice that you are giving is good advice for us.

I mean, we are in the same position as senior officials in having oversight and getting out in the field, you know, spending time. We just simply do not do enough of that, yet I am not being critical. We are the people who are actually interested in spending a lot of time but I think that is good advice for all of us.

Mr. BOWMAN. The follow-up comment is that with my time in central office and then down in the field in VISN 8 that the impact of a visit by a senior official or a Member of Congress on the morale of the employees at the operational level in the medical center is tremendous—oftentimes it may go overlooked—because the mere fact you have taken the time to go down there sends a very clear signal that you are interested and that you are aware.

And then, what will happen is I think there is doing to be an exchange of information through staff because they believe, I mean, if you were to come down an say, what do you need here?

Intuitively and institutionally, it will either find its way into the vapor, you know, the higher it goes up through the chain of command, now some of it has to go up through the chain of command and should because senior officials within the VA chain of command should be made aware.

However, if a Members of Congress comes down and talks to a medical center director and says, is there anything that I can do for you; and if that medical center director has already, you know, expressed that, I believe there should be the latitude, the internal belief that he could be candid with the Member of Congress.

That is not the feeling, and I think that the morale out there in tough times can be significantly enhanced by very small events and that is by "small" I mean it could be 1 or 2 days but the fact that

you have oversight individuals, whether they be senior officials at the headquarters level but especially Members of Congress.

Senator BOOZMAN. Thank you.

Chairman SANDERS. Thank you, Senator Boozman.

Senator Boozman, at one of our recent hearings, you raised an issue that I want to pick up on now with Dr. Jonas. I think you raised a concern that many of us have heard about, which is the over medication of many of our veterans. We have heard that time and time again. Dr. Jonas, let me ask you about that issue. Is it fair to assume that by increasing the availability of complementary and alternative medicine we could address, at least to some degree, the problem of over medication?

Dr. JONAS. Overmedication is a large problem. We spend less than .01 percent of our research budget on pain treatments, for example, that are not some type of intervention or medication aspect, the vast majority of that. We wonder why that is the tool that the physicians have to use to do that.

Sir, I know you saw *Escape Fire*. I would recommend it to the rest of you. There was a servicemember there who gets the typical kinds of medical treatment for multiple problems. Each of these practitioners that I mentioned that you go to has their own special medication that they treat for sleep, for anxiety, for depression, for pain, et cetera.

Part of the trauma spectrum is medication addiction used for treating pain and these other aspects. So, many of these things, in fact, can substitute for that and can lower that. In fact, some of the demonstration projects that I mentioned to you have all demonstrated that as ways of substituting for medications in many of these areas.

Chairman SANDERS. Thank you very much.

Rick, we have introduced legislation to expand the Caregivers Expansion and Improvement Act. I think you heard from the VA today that the program has been a success with the families of post-9/11 veterans.

Is there any reason, in your judgment, why we should not expand the program to Vietnam-era veterans, their families, as well as those veterans from other eras?

Mr. WEIDMAN. Senator, when the bill was first advanced in the Congress, people asked, what is your contribution in getting this law enacted? I said, our contribution at Vietnam Veterans of America is we are going to be quiet.

In other words, our folks, a lot of our members who are alive today because their spouse has been taking care of them for 40 years and without any assistance from the government and saving the government over that period of time billions of dollars that otherwise would have had to go into custodial care or long-term care of one form or another.

We had always hoped that, and the White House at that point assured us, that they would follow on with expanding it to all generations based on medical needs or life situation needs. Yet, that has not happened from there. We are very pleased that it is coming from the Committee and we are strongly in favor of expanding it to every generation.

Chairman SANDERS. Thank you.

Mr. WEIDMAN. May I say one thing, sir?

Chairman SANDERS. Sure.

Mr. WEIDMAN. Senator Boozman, you asked the question about what can VA do that is low hanging fruit? What VA can do is implement the executive order that was issued on January 21, 2009, having to do with open government, transparency, and participation of stakeholders.

It is not followed anywhere in VHA. They give lip service to it. They have a quarterly meeting, as an example, at the VISN level that is mostly what we used to call a "dog and pony show" where they fill the air with talk for 2 hours and 45 minutes of a 3-hour session. Then, you have 15 minutes to ask questions and then everybody has got to go.

That is not participation in our view and it is not either the letter or the spirit of that executive order. Might I suggest, Mr. Chairman and Ranking Member, that you even consider taking that and enacting that into statute so it will live beyond this presidency.

Chairman SANDERS. Mr. Bowman, as I understand the essence of your testimony, regarding Senator Burr's legislation is that we should not support bureaucracy but put our resources into providing care to veterans. That is certainly a noble goal, one which I support.

How many years have you worked with the VA?

Mr. BOWMAN. Almost 11 before I retired.

Chairman SANDERS. OK. And you worked at the national level and the local level.?

Mr. BOWMAN. Yes, sir.

Chairman SANDERS. You began your testimony by saying to get your health care the VA. Overall, understanding that every health care system has its share of problems, including VA, does VA do a fairly good job for our veterans, do you think, in terms of providing quality health care?

Mr. BOWMAN. In the delivery of health care to veterans at the medical center level, I would say yes, they do. My concern would be, as I look at my experience in VISN 8, is that there are more veterans out there who belong in the VA system and they are not there because of an outreach deficiency.

Chairman SANDERS. Let me pick up on that point. You know, we had a hearing just on that issue.

Mr. BOWMAN. Yes, sir.

Chairman SANDERS. So, what you are telling me, and excuse me. VISN 8 is where?

Mr. BOWMAN. VISN 8 is essentially of all Florida except for a little chunk of the panhandle.

Chairman SANDERS. OK. And a lot of veterans live there?

Mr. BOWMAN. Yes, sir.

Chairman SANDERS. So, what you are telling this Committee is there are veterans who are eligible for and need care who do not know how to access the system?

Mr. BOWMAN. Yes, sir; and I know it may sound strange with all of the publicity that has been——

Chairman SANDERS. No, it does not sound strange to me. All of us here, no matter what our political views may be, share one understanding.

You do not get elected unless you figure out how to communicate with the people in your State, right? And sometimes bureaucracies do not do that. What I am hearing you say just confirms why we held that hearing.

Mr. BOWMAN. Yes, sir.

Chairman SANDERS. I want to see every veteran in this country who is entitled to benefits to get them or at least know about them. You agree with that?

Mr. BOWMAN. Yes, sir.

Chairman SANDERS. You are telling me that this is a problem in Florida?

Mr. BOWMAN. I believe it is a problem in the Florida area, and from my time in Washington, I believe that it is a problem across the country that there needs to be more aggressive outreach.

Chairman SANDERS. Good. I very much share that concern.

Senator Burr.

Senator BURR. Dr. Jonas, you mentioned that there is recent research that has shown the effectiveness of complementary and alternative medicines. In standard research studies, they include experimental groups and control groups. Did any of that research that was done adopt this standard of two different groups?

Dr. JONAS. Yes, sir, all the studies that I mentioned in my testimony were done in what is called randomized controlled trials which is not only two different groups but they are equally distributed into the comparison and the control group so that they start at the same level when they are looking for comparative benefits, yes.

Senator BURR. If there is an executive summary to that research out there, I hope you will provide it for the Committee. If it is in your testimony I apologize, or is it in the book?

Dr. JONAS. So, we just supplied the IOM. I was on the Committee for the IOM, and we just supplied them with a comprehensive analysis of complementary medicine and guidelines and what are called "meta analysis" which is where you look at these kinds of studies and look for the quality and the quantity of them into this book. So, they are available, especially Chapter 6, which really talks about that.

Senator BURR. In your professional opinion, is the reluctance to utilize more alternative treatment unique to the VA or is it across medicine as a whole?

Dr. JONAS. This is across medicine as a whole. This is not unique at all to the VA. In fact, as Senator Sanders said, the VA tends to be ahead of the curve in the use of these compared to a civilian population where these things do not get paid for.

Senator BURR. So, is this an ignorance of understanding that your research is out there or a disregard for its conclusion?

Dr. JONAS. It is partly ignorance and it is partly the squeaky wheel. When you have billions and billions of dollars dumped into technologies that are then advertised and pushed on the system—and I get them in my medical bag as a primary care practitioner and I have .01 percent of the research dollars going into my medical bag—going into drugless approaches like this, it is no wonder I cannot find them in the bag. They are buried underneath other types of things.

There is actually no economic driver to deliver these low-cost self-care types of practices. That is a large part of it. So, I never learned about them. I did not learn about nutrition, for example, in my medical school, and yet I know it is a very important part of brain function, of cardiovascular disease, hypertension, you know, depression, et cetera.

Senator BURR. So, when you talked earlier about evidence-based, you would not be highlighting that VA or the health care system in this country should adopt anything that there is not clinical reason to implement.

Dr. JONAS. Absolutely. This has to be evidence-based. If we do not do this, then we end up doing things that not only are wrong but they may actually harm people. So, it has to be that way.

Senator BURR. Good. Mr. Gornick, in your testimony, you talked about shortfalls that exist that would be solved by establishing a national assistance fund. Detail for me, if you would, what these shortfalls are that exist?

Mr. GORNICK. Thank you for that question.

Some of the different things that I laid out in my written testimony include providing child care assistance for veterans in employment assistance programs, and helping veterans make security deposits and pay utility hook-up fees for housing placements.

The latter could be addressed by the SSVF program, but generally with a limited amount of funds; that is not where the dollars go.

For a veteran that receives a HUD-VASH voucher, for instance, that veteran now has a rental subsidy indefinitely so long as Congress provides funding for that. But that does not pay for the bed. That does not pay for the couch. That does not pay for the down payment that he or she needs to make on an apartment. Therefore, that veteran could continue being homeless without these additional forms of help.

Senator BURR. So, we have a lot of different pieces out here. We are hopeful because we say we have got a homelessness program and they all come together to fill the need of an individual, whatever that gap is.

But what you are saying is there is still—if everything came together perfectly—there are still some shortfalls out there that are relatively inexpensive but that blow up the whole model if we do not address them. Is that an accurate statement?

Mr. GORNICK. Undoubtedly.

Senator BURR. Well, you know, Dr. Jonas talked about a holistic approach and I think I share this with the Chair. We do have a lot of programs, and I think we have got a passionate commitment on the part of the Secretary and Members and everybody within the VA to end homelessness for veterans.

What we do not do is a good job of holding accountable and verifying that all these pieces come together. I think there is a tendency that when the roof goes over somebody's head, we walk away and we sleep well that night because we know that they are no longer under a bridge.

I would suggest to you that our goal should not be to end there. It is to make sure that the complementary, wraparound, holistic

services come to that veteran so that the mental health treatment is there, substance abuse treatment is there.

Our goal cannot be temporary relief from veterans' homelessness. It has to be constructed for permanent transition. So, Mr. Gornick, I hope if there are more gaps than what you have listed in your testimony, you will provide those to the Committee so that we can begin to work with VA to see if there are ways to fill them.

I thank all of you.

Chairman SANDERS. Thank you very much Senator Burr. And let me thank all of our witnesses. I have enjoyed your testimony very much and I thank you for being here. We will continue our discussion of pending legislation with a new panel next week.

Again, thank you all very much. This hearing is adjourned.

[Whereupon, at 11:53 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BARBARA BOXER, U.S. SENATOR FROM CALIFORNIA

S. 62, THE CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013

Chairman Sanders, Ranking Member Burr: Thank you for considering S. 62, the Check the Box for Homeless Veterans Act of 2013 at today's hearing.

I am so grateful to you both for your longstanding commitment to our Nation's veterans and particularly for your tireless efforts to eliminate the epidemic of veteran homelessness.

Ending veteran homelessness is one of the most critical challenges facing our Nation today. It is also an issue that brings Americans together because we all agree it is simply unacceptable that more than 60,000 veterans are homeless on any given night.

I strongly believe that if we work together as a Nation, we can end veteran homelessness once and for all. And I know so many Americans are looking for ways to give back to our veterans who have sacrificed so much for us.

That is why I introduced S. 62, the Check the Box for Homeless Veterans Act of 2013. This straightforward bill would create a "check-off box" on the annual Federal tax return form and allow taxpayers to make a voluntary contribution in the amount of their choice to support programs that prevent and combat veteran homelessness.

Taxpayer contributions would be deposited and safeguarded in a new Homeless Veterans Assistance Fund established in the U.S. Treasury. These funds would be available to the VA—in consultation with the Departments of Labor and Housing and Urban Development—solely to provide services to homeless veterans, including developing and implementing new and innovative strategies to end veteran homelessness. My bill would also authorize the transfer of funds between these three agencies to support programs that assist homeless veterans.

To ensure transparency and accountability in how these taxpayer dollars are spent, my bill requires the President's annual budget submission to include proposed uses of funds from the Homeless Veterans Assistance Fund. Additionally, my bill stipulates that Congress must be notified 60 days in advance of any expenditure of such funds.

The Check the Box for Homeless Veterans Act of 2013 would provide additional necessary resources to help end the cycle of homelessness for men and women like Air Force veteran Mike Hofler. After completing his military service, Mike struggled with Post-Traumatic Stress and hit rock bottom when he was hospitalized in a VA mental health unit.

The VA eventually referred Mike to the non-profit organization Swords to Plowshares, where he got the support he needed to get his life back on track. Within months, Mike found his own apartment and began pursuing his bachelor's degree in social work. Today, Mike is a recent graduate of the Columbia University School of Social Work's Master of Science program and is working with returning veterans in New York.

I am proud that this bill has strong support from our military and veteran communities and has been endorsed by the National Coalition for Homeless Veterans, the American Legion, the Veterans of Foreign Wars, AMVETS Department of California, the Center for American Homeless Veterans, the California Association of Veteran Service Agencies, and Swords to Plowshares.

According to the National Coalition for Homeless Veterans, "The simple act of checking a box would enable taxpayers to prevent and end homelessness for those who have served this country in a way increasingly few Americans ever will. By supplementing proven Federal programs, the 'Check the Box for Homeless Veterans Act' will have a strong and lasting impact in communities nationwide."

I look forward to working with my colleagues to see this important legislation enacted into law.

PREPARED STATEMENT OF HON. JOE DONNELLY, U.S. SENATOR FROM INDIANA

S. 832, IMPROVING THE LIVES OF CHILDREN WITH SPINA BIFIDA ACT OF 2013

Chairman Sanders, Ranking Member Burr, Members of the Committee, Thank you for the opportunity to submit a statement on behalf of S. 832, the Improving the Lives of Children with Spina Bifida Act of 2013. This bill requires the Secretary of Veterans Affairs to carry out pilot programs on furnishing case management services and assisted living for children of Vietnam veterans and certain Korea service veterans suffering from spina bifida.

Currently, the Department of Veterans Affairs (VA) provides monetary allowances, vocational training and rehabilitation, and VA-financed health care benefits to certain Korea and Vietnam veterans' birth children who have been diagnosed with spina bifida. As of 2008, Public Law 110–387, Section 408, outlined changes to the program, providing comprehensive health care for spina bifida beneficiaries.

I first became aware of this program from a constituent whose step-daughter suffers from spina bifida, and is a beneficiary of the VA program. My constituent has worked for years to get the comprehensive care services needed for his step-daughter and family, and has struggled every step of the way. For several months, I have been working in coordination with the Committee, the Vietnam Veterans of America, and the VA to resolve his concerns, and I appreciate the Committee's support during this process. We are beginning to make progress in the VA's compliance with providing the services required by law.

Earlier this year, the Committee conducted oversight activities on implementation of the VA's spina bifida program, its outreach to spina bifida beneficiaries, and options for improving the program. My office was briefed on the conversations, and two key conclusions emerged: (1) spina bifida patients are in need of comprehensive case management to coordinate services, provide follow-up and follow-through support, and help patients work in their home to resolve problems. Case management is allowed for in the existing law, but has not been utilized; and (2) as spina bifida beneficiaries and their caretakers age, beneficiaries will need lifelong management of their health issues. Assisted living facilities may enable these beneficiaries to maintain their independence, and may be a better option than nursing home care.

Based on these conclusions, I worked with the Committee to develop S. 832 calling for two pilot programs to address case management and assisted living care. A key component of the pilot programs is a requirement for the VA to inform all covered individuals of the services available under the pilot programs. This can help narrow the gap between the number of eligible beneficiaries, and those actually utilizing the services provided by the VA. Additionally, this bill relies on funding already appropriated or otherwise made available within the spina bifida program to furnish case management and nursing home care. We are not seeking to increase the benefits provided to spina bifida beneficiaries, but rather to improve their access to care and VA implementation of the services required under the law.

I believe this bill can make a meaningful difference in the lives of spina bifida children, and encourage VA to live up to its obligations under the law. I am grateful for the support of the Committee in developing this legislation, as well as for the support of Vietnam Veterans of America and Veterans of Foreign Wars.

Thank you for your consideration of the bill, and for your support.

PREPARED STATEMENT OF THE AMERICAN LEGION

S. 49, VETERANS HEALTH EQUITY ACT OF 2013

To require the Secretary of Veterans Affairs, with respect to each of the 48 contiguous states, to ensure that veterans who are eligible for hospital care and medical services through the Department of Veterans Affairs (VA) have access to: (1) at least one full-service VA medical center in the state, or (2) hospital care and medical services comparable to that provided in full-service VA medical centers through contract with other health providers in the state; and directs the Secretary to report to Congress on compliance with such requirement, including its effect on improving the quality and standards of veterans' care.

The American Legion has no position on this bill.

S. 62, CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013

To offer taxpayers the opportunity to help keep those who have served our country off the streets by making a voluntary contribution on their annual Federal income tax return to support programs that prevent and combat veteran homelessness.

On any given night in January 2013 over 60,000 veterans were homeless in the United States. As such, The American Legion strongly believes, in accordance with Resolution No. 306, *Funding for Homeless Veterans*, passed at National Convention 2012, that homeless veteran programs should be granted sufficient funding to provide supportive services such as, but not limited to, outreach, healthcare, rehabilitation, case management, personal financial planning, transportation, vocational counseling, employment and training, and education.

Resolution 306 states that The American Legion "seek[s] and support[s] any legislative or administrative proposal that will provide medical, rehabilitative and employment assistance to homeless veterans and their families." This bill would help do that by establishing a Homeless Veterans Assistance Fund in the Treasury Department which would supplement proven Federal programs for homeless and at-risk veterans and their families. Additionally, this bill would provide funding for innovative and relevant programs/services that would improve and expand services available to homeless veterans. The Department of Veterans Affairs (VA) Five-Year Plan to eliminate veteran homelessness by 2015 is past the halfway mark. By helping to provide the necessary resources to reach this obtainable, and worthy, goal, this Nation can finally end the scourge of veteran homelessness.

The American Legion supports this bill.

S. 229, CORPORAL MICHAEL J. CRESCENZ ACT OF 2013

To designate the Department of Veterans Affairs (VA) medical center at 3900 Woodland Avenue in Philadelphia, Pennsylvania, as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center."

The American Legion has no position on this bill.

S. 287, A BILL TO AMEND TITLE 38 UNITED STATES CODE, TO EXPAND THE DEFINITION OF HOMELESS VETERAN FOR PURPOSES OF BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES

To include as a homeless veteran, for purposes of eligibility for benefits through the Department of Veterans Affairs (VA), a veteran or veteran's family fleeing domestic or dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the current housing situation, including where the health and safety of children are jeopardized, there is no other residence, and there is a lack of resources or support networks to obtain other permanent housing.

The Department of Veterans Affairs (VA) currently defines "homeless veteran" based on an incomplete citation of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302 (a)). The full definition of "homeless" under this act includes the following:

> "Any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing."

The expansion of the "homeless veteran" definition proposed by S. 287 would align VA and HUD, making their partnership at the state level more efficient. The bill would include as homeless veterans those getting emergency shelter or other services as a result of their being victims of domestic violence.

According to Resolution No. 306 Funding for Homeless Veterans, passed at the 2012 National Convention, The American Legion is committed to assisting homeless veterans and their families, continues to support the efforts of public and private sector agencies and organizations with the resources necessary to aid homeless veterans and their families; and, supports any legislative or administrative proposal that will provide medical, rehabilitative, and employment assistance to homeless veterans and their families.

The American Legion supports this bill.

S. 325, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO INCREASE THE MAXIMUM AGE FOR CHILDREN ELIGIBLE FOR MEDICAL CARE UNDER THE CHAMPVA PROGRAM, AND FOR OTHER PURPOSES

To make a child eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) eligible for such care until the child's 26th birthday, regardless of the child's marital status, and to make such provision inapplicable before January 1, 2014, to a child who is eligible to enroll in an employer-sponsored health care plan.

The American Legion has no position on this bill.

S. 412, KEEP OUR COMMITMENT TO VETERANS ACT

To authorize the Secretary of Veterans Affairs (VA) to carry out specified major medical facility leases in FY 2013–2014 in New Mexico, New Jersey, South Carolina, Georgia, Hawaii, Louisiana, Florida, Puerto Rico, Texas, Connecticut, and Massachusetts, and to reduce lease amounts authorized in previous fiscal years for VA outpatient clinics in: (1) Johnson County, Kansas; (2) San Diego, California; and (3) Tyler, Texas.

The American Legion has no position on this bill.

S. 422, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

To amend the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require a program under which the Secretary of Veterans Affairs provides chiropractic care and services to veterans through Department of Veterans Affairs (VA) medical centers and clinics to be carried out at: (1) no fewer than 75 medical centers by December 31, 2014, and (2) all medical centers by December 31, 2016, and to include chiropractic examinations and services within required VA medical, rehabilitative, and preventive health care services.

The American Legion has no position on this bill.

S. 455, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO AUTHORIZE THE SECRETARY OF VETERANS AFFAIRS TO TRANSPORT INDIVIDUALS TO AND FROM FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS IN CONNECTION WITH REHABILITATION COUNSELING, EXAMINATION, TREATMENT, AND CARE, AND FOR OTHER PURPOSES

To authorize the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs (VA) in connection with vocational rehabilitation, counseling, examination, treatment, or care.

The American Legion's Resolution No. 294, *Department of Veterans Affairs Rural Healthcare Program,* passed at the 2012 National Convention, states that one out of every three veterans that receive their health care at VA facilities live in rural communities and that veterans residing in these areas have been underserved due to a lack of access to health care, which can be attributed to greater travel barriers and a lack of public transportation in these areas.

During The American Legion's 2012 System Worth Saving site visits, which focused on Rural Veterans Health Care, it was recommended to the Undersecretary of VHA for the Department of Veterans Affairs and the Office of Rural Health that VA medical centers fully implement a Veterans Transportation Service (VTS) Department to coordinate all veteran transportation programs for the hospital, i.e. staff to conduct transportation catchment area analysis, VTS program initiatives, volunteer transportation drivers/scheduling and beneficiary travel programs.

The American Legion believes that the provisions in this bill would be extremely beneficial to veterans who reside in rural and/or highly rural areas of the country where public transportation is less frequent and/or unavailable. This bill would also assist veterans who cannot utilize public transportation as a result of their existing medical condition and/or disability.

The American Legion believes that no veteran should be penalized based on where they chose to live and that the VA has an obligation to provide veterans across the country access to the medical center and/or community based outpatient clinic closest to them in order to receive care.

The American Legion supports this bill.

S. 522, WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

To direct the Secretary of Veterans Affairs (VA) to award grants to eligible institutions to: (1) establish a master's or doctoral degree program in orthotics and prosthetics, or (2) expand upon an existing master's degree program in such area; to re-

quire a grant priority for institutions in partnership with a medical center administered by the VA or a facility administered by the Department of Defense (DOD); to provide grant amounts of at least $1 million and up to $1.5 million. Defines as eligible institutions those either accredited by the National Commission on Orthotic and Prosthetic Education or demonstrating an ability to meet such accreditation requirements if receiving a grant; and to require the Secretary to award a grant to an institution with orthotic and prosthetic research and education experience to: (1) establish the Center of Excellence in Orthotic and Prosthetic Education; and (2) improve orthotic and prosthetic outcomes for veterans, members of the Armed Forces, and civilians by conducting orthotic- and prosthetic-based research.

Due to an aging population, increased rates of diabetes and cardiovascular disease, and advances in military medicine, more Americans will continue to need the skills of prosthetists and orthotists in the coming years. Newer models of orthotics and prosthetics improve the lives of many Americans but are hard to fit and require highly skilled professionals at the same time that many orthotists and prosthetists are retiring.

Currently, only five universities offer O&P master's programs accredited by the Commission on Accreditation of Allied Health Education Programs; the University of Hartford is among those five programs.[1] Only ten educational institutions offer any kind of currently accredited O&P program, but five will have to adapt their programs in order to meet the new master's degree requirement.

The proposed bill would devote $5 million per year for three years to award competitive grants to institutions that prove their ability to create or expand an accredited master's or doctoral program in O&P. The grants would be between $1 million and $1.5 million and could be used to build new programs, expand existing programs, further faculty development, supplement salaries, fund faculty research projects, or construct O&P facilities.

The second part of this bill appropriates $5 million for the VA to establish a second Center of Excellence in Prosthetic and Orthotic Education to provide evidence-based research in the knowledge, skills and training most needed by clinical professionals in the field. The first Center of Excellence is in Long Beach, CA. The legislation directs the VA Secretary to consider joint applications from a VA medical center and an academic institution with an established orthotics and prosthetics program.

The bill also establishes DOD grants to research best practices for the use of O&P, including for wounded warriors. The legislation calls on the Defense Department to work in coordination with the VA, use data from peer-reviewed sources, and draw on the expertise of individuals and institutions outside of the Federal Government. $30 million is appropriated for the grants.

Resolution No. 108: *Request Congress Provide the Department of Veterans Affairs Adequate Funding for Medical and Prosthetic Research*, passed at the 2012 National Convention states that The American Legion "supports adequate funding for VA biomedical research activities," and requests that "Congress and the Administration encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), rehabilitation, and others—jointly with the Department of Defense, the National Institutes of Health, other Federal agencies, academic institutions and the Department of Veterans Affairs."

The American Legion supports the bill.

S. 529, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO MODIFY THE COMMENCEMENT DATE OF THE PERIOD OF SERVICE AT CAMP LEJEUNE, NORTH CAROLINA, FOR ELIGIBILITY FOR HOSPITAL CARE AND MEDICAL SERVICES IN CONNECTION WITH EXPOSURE TO CONTAMINATED WATER, AND FOR OTHER PURPOSES

To amend title 38, United States Code, to modify the commencement date of the period of service at Camp Lejeune, North Carolina, for eligibility for hospital care and services in connection with exposure to contaminated water, and for other purposes.

For a period of over thirty years, servicemembers in the Marine Corps and other branches of service, as well as their families, were exposed to contaminated ground water at the Marine Corps Base at Camp Lejeune, North Carolina. In response to this, the government has acted to provide medical care to those affected by this terrible contamination.

This bill, S. 529, would extend the affected period under the law, expanding the period from its current onset of January 1, 1957 back to an onset date of August 1,

[1] http://www.caahep.org/Find-An-Accredited-Program/

1953. Should the Secretary of Veterans Affairs, in consultation with the Agency for Toxic Substances and Disease Registry determine the need for an earlier effective onset date, the earlier date should be set after a proper publication of such a date in the *Federal Register*.

Since at least the early 1980s, The American Legion has been at the forefront of advocacy for veterans exposed to toxic, environmental hazards such as Agent Orange, Gulf War related hazards, ionizing radiation, and others, by pushing for epidemiological studies based on DOD records, in order to address environmental exposure issues. The American Legion's Resolution 95[2] thoroughly supports vigorous research into the effects of environmental exposures on servicemembers, and the expansion of benefits and treatment to ameliorate such exposures when research determines those benefits are merited. The American Legion supports this expansion of effective dates, to reflect the most accurate knowledge of the periods of exposure at Camp Lejeune. Furthermore, continued monitoring of the period to determine the full extent of damage done to those who served and their families is essential to ensure this country fulfills its obligations to those who have served.

The American Legion supports this bill.

S. 543, VISN REORGANIZATION ACT OF 2013

To direct the Secretary of Veterans Affairs to organize the Veterans Health Administration (VHA) into 12 geographically defined Veterans Integrated Service Networks (VISNs), and for other purposes.

According to The American Legion's Resolution No. 162, *Department of Veterans Affairs Veterans Integrated Service Networks (VISN's)*, passed at the 2012 National Convention, "The American Legion urges Congress to direct the Government Accountability Office (GAO) and Department of Veterans Affairs (VA) Office of the Inspector General conduct a comprehensive study to include purpose, goals, objectives and budget and evaluation of the effectiveness of the 21 Veteran Integrated Service Networks (VISNs)," and "urges the Veterans Health Administration (VHA) leadership conduct an internal review and develop an action plan to address VISN management, staffing and its current geographic boundaries/catchment areas concerns, in order to better provide timely access and quality health care for veterans."

Department of Veterans Affairs (VA) Veterans Health Administration is organized into a national central office and 21 VISN's (or regions) which oversee several VA medical facilities and Community Based Outpatient Clinics (CBOC's). The concept of VISN's was established by Dr. Kenneth Kizer, former Undersecretary for Health for VHA, in order to decentralize the medical centers and associated CBOC's from the central office. VISN's were established to promote best practices, innovation, and be responsible for all financial and operational activities for the medical facilities within their jurisdiction.

Since the model was developed, however, there has been no official documentation from VHA leadership on the overall effectiveness of the current structure. Therefore, before any comprehensive restructuring of the VISNs, of the type required by this legislation, is implemented, The American Legion believes that Congress should direct the GAO and VA Office of Inspector General conduct a comprehensive study to include purpose, goals, objectives and budget evaluation of the effectiveness of having 21 VISNs, and that the VHA leadership conduct an internal review and develop an action plan to address VISN management, staffing and its current geographic boundaries/catchment areas concerns, in order to better provide timely access and quality healthcare for veterans.

The American Legion does not support this bill.

S. 633, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROVIDE FOR COVERAGE UNDER THE BENEFICIARY TRAVEL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS OF CERTAIN DISABLED VETERANS FOR TRAVEL IN CONNECTION WITH CERTAIN SPECIAL DISABILITIES REHABILITATION, AND FOR OTHER PURPOSES

To authorize payment under the Department of Veterans Affairs (VA) beneficiary travel program of travel expenses in connection with medical examination, treatment, or care of a veteran with vision impairment, a spinal cord injury or disorder, or double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program, if such care is provided: (1) on an inpatient basis, or (2) while a veteran is provided temporary lodging at a VA facility in order to make such care more accessible and to require a report from the Secretary to the congressional veterans committees on the travel program.

[2] Resolution 95: Environmental Exposure, Indianapolis, IN August 2012.

The American Legion has no position on this bill

S. 800, TRETO GARZA FAR SOUTH TEXAS VETERANS INPATIENT CARE ACT OF 2013

To require the Secretary of Veterans Affairs to ensure that the South Texas Department of Veterans Affairs Health Care Center at Harlingen, located in Harlingen, Texas, includes a full-service inpatient health care facility of the Department of Veterans Affairs, to redesignate such center, and for other purposes.

The American Legion has no position on this bill.

S. 825, HOMELESS VETERANS PREVENTION ACT OF 2013

To amend title 38, United States Code, to improve the provision of services for homeless veterans, and for other purposes.

In order to fully implement VA's pledge to end homelessness among veterans by 2015, Congress must continue making responsible investments in affordable housing and supportive services programs that move veterans and their families off the streets and into stable housing. These homeless assistance programs should be intended to serve all groups of low-income veterans—veterans at risk of becoming homeless, veterans who are homeless for a short time, and veterans and their families who have spent years without a place to call home. To make this seamless system of care work, funding must be provided for a broad range of appropriate and effective interventions. Funding that prevents veterans from becoming homeless or quickly re-house veterans who need nothing more than short-term rental assistance and limited case management in order to get back on their feet could be used effectively by community organizations and other stakeholders. These funds could also be used to pay for employment services, utility assistance, child care costs, legal services, and other housing-related expenses. Additionally, there is still a need for funding that can provide short-term housing to help homeless veterans get stabilized, along with allowing them to get connecting with jobs, supportive services, more permanent housing, and ultimately to become self-sufficient.

With the affects of the wars in Iraq and Afghanistan, it is widely known that psychological stress, such as PTSD, TBI and other mental illnesses play a significant role in pushing a certain population of veterans into homelessness. Funding, along with grants that go to homeless veterans programs and organizations that assist this vulnerable demographic, are needed more than ever. Due to our work with homeless veterans and their families, The American Legion understands that homeless veterans need a sustained coordinated effort that provides secure housing and nutritious meals; essential physical healthcare, substance abuse aftercare and mental health counseling; as well as personal development and empowerment. Veterans also need job assessment, training and placement assistance. The American Legion believes all programs to assist homeless veterans must focus on helping veterans reach their highest level of self-management.

Furthermore, The American Legion has provided housing for homeless veterans and their families as well (i.e., Departments of Pennsylvania, North Carolina and Connecticut). One of the goals of The American Legion is to help bring Federal agencies, non-profit organizations, faith-based communities and other stakeholders to the table to discuss best practices, along with funding opportunities, so homeless veterans and their families can obtain the necessary care and help in order for them to properly transition from the streets/shelters into gainful employment and/or independent living.

Last, The American Legion strongly believes that with more collaboration and civic engagement, access to stable and affordable housing, and economic security to prevent and end homelessness, the goal of eliminating veteran homelessness is well within reach.

According to Resolution No. 306, *Funding for Homeless Veterans*, passed at the 2012 National Convention, The American Legion is committed to assisting homeless veterans and their families, continue to support the efforts of public and private sector agencies and organizations with the resources necessary to aid homeless veterans and their families, and, support any legislative or administrative proposal that will provide medical, rehabilitative, and employment assistance to homeless veterans and their families.

The American Legion supports this bill.

S. 832, IMPROVING THE LIVES OF CHILDREN WITH SPINA BIFIDA ACT OF 2013

To require the Secretary of Veterans Affairs to carry out pilot programs on furnishing case management services and assisted living to children of Vietnam vet-

erans and certain Korea service veterans born with spina bifida and children of women Vietnam veterans born with certain birth defects, and for other purposes.

The effects of Agent Orange and other herbicides on veterans of the Vietnam conflict appear to be ongoing. Recent changes regarding the expansion of presumptive conditions reveal that the medical community has yet to realize the full effects of herbicide exposure. Considering the manifestation of some conditions by children of Vietnam veterans, it would stand to reason that the medical community has yet to determine the long term effects of Agent Orange upon the children of Vietnam veterans.

Through the awarding of benefits associated with herbicide exposure to children of Vietnam veterans, VA has conceded a chronic condition was caused by herbicide exposure and passed from parent to child. We encourage VA to provide the necessary resources to ensure the highest quality of life possible for these children of Vietnam veterans. Additionally, we "seek legislation to amend title 38, United States Code, Chapter 18, to provide entitlement to spina bifida benefits for the child or children of any veteran who was exposed to Agent Orange as the result of service in the Republic of Vietnam or in other locations where Agent Orange was tested, sprayed, or stored."[3] The American Legion, as one of the longest standing advocates for veterans exposed to environmental hazards, will continue the push to ensure that all those who have been affected and continue to suffer as a result of this exposure are cared for.

The American Legion supports this bill.

S. 845, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE DEPARTMENT OF VETERANS AFFAIRS HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES.

To extend Department of Veterans Affairs Health Professional Scholarship Program until December 31, 2019; To repeal the cap on the amount of Education Debt Reduction Payments Under Department of Veterans Affairs Education Debt Reduction Program, and to stipulate that the maximum amount—the total amount payable to a participant in the Education Debt Reduction Program for any year may not exceed the amount of the principal and interest on certain loans paid by the individual during such year.

The nation is facing an unprecedented health care shortage that could potentially have a profound impact on the care given to this Nation's veterans. Shortages in health care staff threaten the Veterans Health Administration's (VHA's) ability to provide quality care and treatment to veterans. These shortages also influence VHA's ability to provide timely access to quality care and, in some instances, its ability to provide certain types of care.

The American Legion supports comprehensive efforts to establish VA as a competitive force in attracting and retaining health care personnel, especially nurses, essential to the mission of VA health care. The Federal Government estimates that, by 2020, nurse and physician retirements will create a shortage of about 24,000 physicians and almost 1 million nurses nationwide. The American Legion strongly believes that what happens at the Department of Veterans Affairs Medical Centers (VAMCs) often reflects the general state of affairs within the health care community as a whole.

The Health Professionals Educational Assistance Program (HPEAP) and the VA Learning Opportunities Residency are the major education related programs currently in use to promote nurse recruitment and retention. HPEAP is comprised of the Employee Incentive Scholarship Program (EISP) and the Education Debt Reduction Program (EDRP). The EISP authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this initiative include education and training programs in fields leading to appointments or retention in Title 38 or Hybrid Title 38 positions. The specific health care professions include: physician, dentist, podiatrist, pharmacist, licensed practical/vocational nurse, expanded-function dental auxiliary, registered nurse, certified registered nurse anesthetist, physician assistant, optometrist, physical therapist, occupational therapist, certified respiratory therapy technician, and registered respiratory therapist.

The Education Debt Reduction Program (EDRP) authorizes VA to provide education debt reduction payments to employees with qualifying loans who are recently appointed to positions providing direct-patient care services or services incident to

[3] Resolution No. 199: Agent Orange

direct-patient care services for which recruitment and retention of qualified personnel is difficult. The EDRP has been a powerful recruitment incentive for registered nurses.

The American Legion is appreciative of the many contributions of VHA nursing personnel and recognizes their dedication to veterans who rely on VHA health care. Every effort must be made to recognize, reward and maximize their contributions to the VHA health care system because veterans deserve nothing less.

The American Legion supports this bill.

S. 851, CAREGIVERS EXPANSION AND IMPROVEMENT ACT OF 2013

To amend title 38, United States Code, to extend to all veterans with a serious service-connected injury eligibility to participate in the family caregiver services program

Currently under title 38, only veterans who receive 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 September 11, 2001 are eligible for the family caregiver benefits. This bill would amend the law and afford all veterans with a serious injury, as defined, to be eligible to participate in the family caregivers service program.

According to The American Legion's Resolution No. 126, *Veterans Receive Same Level of Benefits*, passed at National Convention 2012, "The American Legion urge[s] Congress to direct the Department of Veterans Affairs to provide the same level of benefits for any veteran, regardless of the dates or theater of operations during their military service." This legislation would ensure that veterans of every era receive the benefits they earned through their service. This would recognize that, for the purpose of receiving care for serious injuries incurred or aggravated in the line of duty, all service is equal. The American Legion, as the voice of America's wartime veterans, believes this is the right thing to do.

The American Legion supports this bill.

S. 852, VETERANS' HEALTH PROMOTION ACT OF 2013

To improve health care furnished by the Department of Veterans Affairs by increasing access to complementary and alternative medicine and other approaches to wellness and preventive care, and for other purposes.

While modern medicine has proven immensely powerful in finding treatments and cures for a host of health issues, there remain some areas in which so-called "alternative" medicine has proven just as, and at times perhaps more, effective. The Department of Veterans Affairs has been exploring Complementary and Alternative Medicine (CAM) since 2002. While a number of VA medical centers offer some sort of CAM, it is not currently offered in any uniform manner.

The American Legion developed a Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) Ad Hoc Committee in 2010 to look to "investigate the existing science and procedures, as well as alternative methods for treating TBI and PTSD currently being employed by the DOD and VA." The primary treatment of both agencies for TBI and PTSD were treatment of the symptoms, and in many cases, overuse or misuse of medications such as Risperidone, an anti-psychotic medication that had no therapeutic benefit to veterans. The evidence based treatments defined by DOD/VA's joint clinical practice guidelines are cognitive processing therapy, prolonged exposure therapy and antidepressants.

The American Legion's TBI and PTSD Ad Hoc Committee's was concerned with the lack of research studies on new and innovative treatments such as Virtual Reality Therapy, Hyperbaric Oxygen Therapy and other complementary and alternative therapies. To this end, the Committee worked with the Veterans Affairs and Rehabilitation Commission to adopt American Legion Resolution No. 108, passed at the 2012 National Convention that stated that The American Legion recommends "Congress and the Administration encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, PTSD, TBI, rehabilitation, and others—jointly with the Department of Defense, the National Institutes of Health, other Federal agencies, academic institutions and the Department of Veterans Affairs."

Unfortunately, most of the existing research for the last several years has validated the current evidence-based treatments being used. In addition, there seems to be no fast-track mechanism to employing innovative or novel therapies in a standardized way. This legislation would make important strides toward the implementation of alternative medicine by requiring VA to establish a minimum of one center of innovation for complementary and alternative medicine in health research,

education, and clinical activities in each Veterans Integrated Service Networks (VISN). This legislation would also require the initiation of a pilot program to assess the feasibility and advisability of establishing complementary and alternative medicine centers within VA medical centers in order to promote the use and integration of complementary and alternative medicine services for mental health diagnoses and pain management. Finally, this legislation would require the VA to conduct a comprehensive study of the barriers encountered by veterans in receiving complementary and alternative medicine from the Department of Veterans Affairs.

The American Legion believes that all possibilities should be considered in the attempt to find treatments and cures for these conditions which affect significant numbers of veterans, including alternative medicine, if it be shown to be effective, and that these treatments and cures should be available to all veterans, once they are verified.

The American Legion supports this bill.

S. XXX, THE VETERANS AFFAIRS RESEARCH TRANSPARENCY ACT

To require the Secretary of Veterans Affairs to allow public access to research of the Department, and for other purposes.

The mental health issues facing veterans, particularly with regard to Traumatic Brain Injury and Post Traumatic Stress Disorder, require collaboration between the Department of Veterans Affairs (VA), the Department of Defense (DOD), medical health professionals, The American Legion and Veteran Service Organizations (VSOs) in order to find cures and best-practice solutions. Therefore, it makes sense that the research efforts of VA and DOD should be available to VSOs and others in order to facilitate the necessary collaboration.

The American Legion believes that the provisions in this bill would be beneficial by allowing for communication of what the VA and DOD have accomplished in their research efforts. This would allow The American Legion, along with other VSOs, and any other interested parties, to track and analyze the activities associated with the research in order to understand how the VA and DOD are working to solve issues related to veterans and servicemembers.

The American Legion's Resolution No. 285 Traumatic Brain Injury and Post Traumatic Stress Disorder Programs, passed at National Convention 2012, calls for direct collaboration between VA& DOD and the compilation of research of the two agencies in one location (including an office). Resolution No. 44 Decentralization of Department of Veterans Affairs Programs, passed in the Fall of 2012 by the National Executive Committee of The American Legion, calls for the decentralization of programs, especially IT, which will allow the VA Office of Research & Development to improve their IT technology in order to create the warehouse of research studies. The American Legion believes that this bill makes strides toward these ends.

The American Legion supports this bill.

PREPARED STATEMENT OF DIANE M. ZUMATTO,
NATIONAL LEGISLATIVE DIRECTOR, AMVETS

INTRODUCTION

Chairman Sanders, Ranking Member Burr and distinguished members of the Senate Veterans' Affairs Committee, it is my pleasure, on behalf of AMVETS, to offer this testimony on pending health care legislation.

I would like to begin today by commending the Committee for all of its work on behalf of American veterans everywhere, especially its dedication to improving efficiencies by eliminating redundant and/or counterproductive programs and its unwavering commitment to all of the men and women whose job it is to protect and defend this country.

As the United States absorbs the aftereffects of more than a decade of continuous war and in the face of the planned draw-down of military personnel, the VA health care system will be severely stressed to adequately meet the physical and mental health care needs of this Nation's veterans. Thanks to improvements in battlefield medicine, swift triage, aeromedical evacuations and trauma surgery, more combat-wounded than ever before are surviving horrific wounds and will be needing long-term rehabilitation, life-long specialized medical care, sophisticated prosthetics, etc. Your committee has a responsibility to ensure that the VA and our Nation live up to the health care obligations imposed by the sacrifices of our veterans.

It is encouraging to acknowledge at this time that, despite the extraordinary sacrifices being asked of our men and women in uniform, the best and the brightest

continue to step forward to answer the call of our Nation in its time of need. I know that each of you is aware of and appreciates the numerous issues of importance facing our military members, veterans, retirees, families, and survivors, therefore this testimony will be, following these introductory remarks limited to specific health care legislation.

I would also like to delineate several general issues that AMVETS would like the Committee to monitor and enforce as it goes about its work:

- ensure that the VA provides a continuity of health care across all the service branches and for all individuals who were wounded or injured in the line of duty including those who are ill due to their service;
- ensure that member of our Reserve Components not only have adequate access, but timely and appropriate treatment, for all of their physical and mental healthcare needs;
- continue to press the VA to work collaboratively with the DOD in creating and implementing a completely operational and fully integrated electronic medical records system;
- continue the strictest oversight to ensure the safety, physical and mental health and confidentiality of victims of military sexual trauma;
- ensure that the VA continues to provide competent, compassionate, high quality health care to all eligible veterans; and
- ensure that the VA continues to receive sufficient, timely and predictable funding for VA health care.

SPECIFIC HEALTH CARE LEGISLATION

S. 131: AMVETS fully supports this legislation which seeks to improve VA health care options for women veterans to include fertility counseling and treatment. Thanks to the proliferation of improvised explosive devices (IEDs) in Iraq and Afghanistan, the issues of urotrauma and infertility have become a growing concern among active military personnel and veterans.

IEDs, which are generally detonated on the ground, can cause severe trauma to the sexual organs and genitourinary system. These debilitating injuries can have devastating impacts—not only to urinary and sexual function, but also on fertility. If the issue of infertility is not adequately addressed for the young men and women, it will be adding insult to injury. Thanks to the horrific wounds received in battle on behalf of our country, many servicemembers have entirely lost or had their reproductive capabilities severely compromised.

This legislation also requires the VA to provide reproductive counseling and treatment, including the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded, Ill, or injured veteran who has an infertility condition incurred or aggravated in the line of duty. AMVETS believes that this aspect is of critical importance to the intent of this legislation.

Another important aspect of this bill the requirement to facilitate research conducted by DOD and HHS with the intent of improving VA's ability to meet the long-term reproductive health care needs of veterans who have incurred service-connected uro-trauma or other line of duty injuries that affect a veterans' ability to reproduce.

AMVETS fully supports all of the provisions of this legislation and feels strongly that these disabilities are not merely health issues; they are quality of life issue as well.

S. 325: AMVETS supports this legislation which seeks to amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the CHAMPVA program. AMVETS sees this as an equity issue since the expansion of eligibility for CHAMPVA for eligible children up to age 26 is in line with provisions in both the Patient Protection and Affordable Care Act (ACA) and the TRICARE Young Adult benefit.

According to a new GAO Report on the relationship of TRICARE and VA care to the ACA, "[the] ACA requires that if a health insurance plan provides for dependent coverage of children, the plan must continue to make such coverage available for an adult child until age 26. This requirement relating to coverage of adult children took effect for the plan years beginning on or after September 23, 2010. Under ACA, both married and unmarried children qualify for this coverage. The authorizing statute for CHAMPVA currently does not conform to this requirement."

AMVETS appreciates the concern expressed in this legislation for the sacrifices of children who have had their lives negatively impacted by:

- the loss of a veteran-parent's mobility;
- the battlefield death of a veteran-parent; and/or
- the loss of a veteran-parent due to a chronic, service-connected condition.

S. 852: AMVETS supports this legislation which seeks to improve health care provided by the VA by increasing access to complementary/alternative medicine and innovative approaches to wellness/preventative care. This is a multi-part piece of legislation with several important and specific requirements including:

- the designation and operation of centers of innovation for complementary/alternative medicine;
- a pilot program on the establishment of complementary/alternative medicine centers within VA medical centers;
- a pilot program on the use of wellness programs;
- a pilot program on health promotion for overweight/obese veterans;
- a pilot program on health promotion for veterans through the establishment of VA fitness facilities; and
- a study on the barriers veterans face in receiving complementary/alternative medicine

Considering the stress being put on the VA's traditional clinical services, AMVETS believes that this legislation, by promoting wellness and preventative medicine, will both improve timely access to services and provide cost-effective treatment options for all participants of the VA's health care system.

AMVETS believes that veterans should be afforded the opportunity to utilize alternative medical therapies to help ameliorate the effects of any chronic or residual mental and/or physical distress they may be experiencing. The term "alternative therapy" covers a wide variety of treatments, which would vastly expand the health care options available to veterans including:

- exercise therapy;
- acupuncture;
- group experiential activities;
- chiropractic therapy; and
- other forms of unorthodox medical treatment.

These alternative health care options might provide stand alone or coordinated treatment options which could not only provide better results but would be more cost effective too.

PREPARED STATEMENT OF ANTHONY A. WALLIS, LEGISLATIVE DIRECTOR/DIRECTOR OF GOVERNMENT AFFAIRS, THE ASSOCIATION OF THE UNITED STATES NAVY

Regarding Consideration of S. 629, The Honor America's Guard and Reserve Retirees Act

INTRODUCTION

Chairmen, Ranking Member and Members of the Senate Veterans' Affairs Committee, the Association of the United States Navy (AUSN) would like to thank you and the Committee for the work that you do in support of our Navy, retirees and Veterans, as well as their families. Your hard work has allowed significant progress in creating legislation that has left a positive impact on our military community. AUSN supports legislation seeking the classification of certain affected groups of our Navy Reservists as Veterans of the Armed Forces.

THE PROBLEM

Currently, a problem exists whereby a Reserve Component member can successfully complete a military career, 20 plus years, but not earn the title of "Veteran of the Armed Forces of the United States," unless he or she served on Title 10, U.S. Code, Active Duty for other than training purposes for a period consisting of over 180 consecutive days of Active Duty service. Drill training, annual training, Active Duty for training and Title 32 duty are not deemed qualifying service to qualify for "Veteran" status under the current definition. For instance, the service of our Guard and Reserve members in Operation Noble Eagle (ONE) would not qualify to earn the status of "Veterans of the Armed Forces," because it is technically a "training" status. The same goes for those Guard and Reserve members who served in Southern Border Security missions, as well as those who served in Hurricane Sandy, Hurricane Katrina and other disaster relief missions. Reserve Component members in the aforementioned operations have performed countless tasks that contribute to the overall well-being of the populace. In addition, the U.S. Navy has orders often written for "training" due to funding reasons. However, the fact may be that the mission could be considered Active Duty, further excluding Navy Reservists from qualifying under the current definition of "Veteran."

Section 101(2) of Title 38, U.S. Code provides the basic definition of the term "Veteran" for purposes of benefits under laws administered by the Department of Veterans Affairs (VA). The term "Veteran" is used repeatedly in Title 38, U.S. Code, to identify an individual, "who is eligible for benefits by virtue of his or her service." The Section 101(2) definition establishes a standard regarding the quality of active service which dictates eligibility for Veterans' benefits. (www.va.gov/ogc/docs/1991/PREC_61–91.doc)

Many of these affected Reserve Component members, despite never being called to Title 10, U.S. Code, Active Duty, already receive many of the same benefits as their full-time counterparts, placing them within the thinking behind the current definition of "Veteran." However, these affected Reserve Component members, classified as retirees but not Veterans due to the consecutive service day parameters, are already eligible for benefits such as TRICARE, GI Bill benefits and Reserve Retirement Pay. Current Veterans that fulfill the 180 consecutive days are eligible for these same benefits, leaving these Retirees in 'limbo', not knowing if they are classified to be a Veteran.

According to the Defense Manpower Data Center (DMDC), currently over 280,000 Reservist Component members and, in particular, nearly 46,000 Navy Reservists across the country could be affected by this problem.

SOLUTION

AUSN applauds the Senate for the introduction of S. 629, the Honor America's Guard and Reserve Retirees Act, which would rightfully grant full Veteran status to members of the Reserve Component who have served at least 20 years but have not been called for the Active Duty parameters required under the current definition. AUSN was pleased to see that the bill was introduced earlier this year by Senator Mark Pryor (D-AR) and is continuing to garner support from a bipartisan list of cosponsors including Senators John Boozman (R-AR), Mark Begich (D-AK), Al Franken (D-MN), Chuck Grassley (R-IA), Tom Harkin (D-IA) Tim Johnson (D-SD), Patrick Leahy (D-VT), Jon Tester (D-MT), and Ron Wyden (D-OR), Kirsten Gillibrand (D-NY), Jeff Sessions (R-AL), Amy Klobuchar (D-MN), Mazie Hirono (D-HI) and Mike Crapo (R-ID). S. 629 would authorize Veteran status under Title 38 for Guard and Reserve members of the Armed Forces who are entitled to a non-regular retirement under Chapter 1223 of 10 U.S.C. but were never called to active Federal service during their careers through no fault of their own. In the 112th Congress, the bill passed through the House in the form of H.R. 1025 by Unanimous Consent. Now, having passed through the House Veterans' Affairs Committee (HVAC), Subcommittee on Disability Assistance and Memorial Affairs (DAMA) last month and on its way to Full Committee consideration, currently in the form of H.R. 679, AUSN hopes the Senate will approve S. 629 as well.

UNWARRANTED CONCERNS

Critics have suggested that this bill is not needed since these Reserve Component members already receive many of the same benefits. Reserve military service opens eligibility to certain benefits provided the member meets the specific criteria established in law. As previously noted, Reservists already can qualify for certain Veterans' benefits, such as educational benefits under Chapter 1606, 10 U.S.C. for an initial enlistment of 6 years in the Selected Reserve; VA-backed home mortgage loans upon completion of 6 years' Reserve service; Servicemembers Group Life Insurance (SGLI) managed by the VA while serving in the National Guard or Reserve Burial in a national cemetery if qualified for a Reserve retirement at age 60. Ironically, however, 20+ year career Reservists who have earned specified Veterans' benefits but never served on Active Duty orders are not "Veterans of the Armed Forces."

Critics have also suggested that expanding the definition of "Veteran" to include these Reserve Component members could lead to bestowing additional benefits they currently do not receive. This argument is not sound, as Section 2(b) of the bill states stronger language than similar legislation in previous years with a provision of "Clarification Regarding Benefits," which states "No person may receive any benefit under the laws administered by the Secretary of Veterans Affairs solely by reason [of passage of this act]." As a result, the Congressional Budget Office (CBO) has scored this bill at zero cost. Concerns about Congress passing legislation to bestow additional benefits as a result of this change in the future would be even more difficult if S. 629, and H.R. 679, passes as the anti-benefits language would be codified. Thus, it is in the best interest of critics to have this bill passed so as to not confer additional benefits in the future.

All said, there are three main reasons for this legislation. First, honor. Honor is important to those who have volunteered to serve the Nation in uniform. Second, for decades Guard and Reserve Component men and women have performed military missions at home and overseas but because of accounting technicalities, including funding sources and duty codes, their military missions were not considered valid active duty work; i.e., they performed the mission, but the orders did not credit the work as Active Duty. Thus, their very real contributions to the national security appear underappreciated, leaving them in a no-man's land of "non-Veteran" status. Third, the bill simply provides statutory and public recognition that a full career of service in uniform qualifies a person with recognition as a Veteran. Career reservists have earned specific military retirement and Veterans' benefits but technically are excluded from being recognized as Veterans under the law.

However, if the arguments stated above are not evidence enough, there is another positive impact that passage would have.

POTENTIAL ECONOMIC IMPACT

This zero-cost bill has the potential to help combat high levels of unemployment among the Reserve Component community, including the approximately 101,000 Gulf War era Reservist and National Guard personnel who are currently unemployed in this country. The Reserve Component currently suffers from rather high unemployment, as stated in data from a recent House Veterans' Affairs, Subcommittee on Economic Opportunity hearing on 14 March 2013.

During the hearing, according to Ronald D. Young, Director of Family and Employer Program and Policy for the Department of Defense, overall Guard and Reserve unemployment stood at 13.1% for February 2013. For E–1s and E–4s, according to Young, the unemployment rate soared to 23%. However, the overall Guard and Reserve figures following the latest status of force survey, now stand at 11%, with junior enlisted at 18% compared to the original 23%. Also testifying was Major General Terry M. Haston, Adjutant General for the Tennessee National Guard and Major Ty Shepard, Director of the California National Guard Employment Initiative, who provided state-level perspectives on Guard and Reserve unemployment. Major General Haston described returning deployed units as suffering from a 25–30% unemployment rate, while, Major Shepard noted that units returning from deployment had even suffered in the past from "unemployment rates well over 50%."

With such high unemployment rates among the Reserve Component one may conclude that by providing "Veteran" status to affected Reservists, employment opportunities may be available for them to be hired by employers that actively seek Veterans in the workplace.

SUMMARY

In conclusion, S. 629 would not bestow any benefits other than the honor of claiming Veteran status for those who honorably served and sacrificed as career Reserve Component members. AUSN believes that our Reserve Component deserve nothing less. We look forward to hearing of the progress of this legislation and welcome any questions or concerns you or your staff may have.

AUSN continues to stand ready to be the Voice for America's Sailors, abroad and upon their return home, and looks forward to working with Congress and the VA on serving our Veterans. Thank you.

PREPARED STATEMENT OF THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION

INTRODUCTION

The Blinded Veterans Association (BVA) is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. The organization has served blinded veterans for 68 years. On behalf of BVA, thank you for this opportunity to submit for the record on the current legislation before the Committee on VA Health Care Programs. Chairman Sanders, Ranking Member Burr, and members of the Senate VA Committee, thank you for the changes you already have made to Beneficiary Travel in recent years, and today we appreciate the introduction of S. 633 and S 455 both to improve the access for disabled blind and spinal cord injured veterans who require services at the VA specialized Blind Rehabilitation Centers (BRCs) and Spinal Cord Injury Centers (SCIs) and authorize local VA personnel to transport veterans who are unable to use volunteer vans for transportation.

Beneficiary Travel for Blinded Veterans: S. 633

BVA thanks Senator Tester for introducing S. 633 and S. 455. We also express appreciation to Congresswoman Brownley for H.R. 1284 the companion House legislation for disabled SCI and blinded veterans who are currently ineligible for travel benefits. This bill would assist mostly low-income and catastrophically disabled veterans by removing the travel financial burdens to access vital care that improve independence and quality of life. Veterans who must currently shoulder this hardship, which often involves airfare, can be discouraged by these costs to travel to a BRC or SCI site. The average age of veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation programs with 13 Blind Centers and with high quality inpatient specialized services, only to tell low income, non-service-connected disabled blinded veterans that they must pay their own travel expenses to access the training they need. To put this dilemma in perspective, a large number of our constituents are living at or below the poverty line while the VA Means threshold for travel assistance sets $14,340 as the income mark for eligibility to receive the benefit. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as either a rural resident or a highly rural resident. The data also indicate that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without this financial assistance analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group.[1] In FY 2007, rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400)[2]. The median income of highly rural veterans showed a larger gap at $18,528, adding significant barriers to paying for air travel or other public transportation to enter a BRC or SCI rehabilitation program. More than 70 percent of highly rural veterans must drive more than four hours to receive tertiary care from VA. Additionally, states and private agencies do not operate blind services in very rural regions. In fact, almost all private blind outpatient agency services such as Lighthouse for Blind are all located in large urban cities and majority are established as all outpatient visits again barrier for rural veterans traveling long distances every day to get training verses VA rehabilitation centers. With the current economic problems with state budgets clearly in view, we expect further cuts to these types of state social services that will bring even more challenges to the disabled in rural regions.

Consider the following facts:

- In a study of new applications for recent vision loss rehabilitation services, 7 percent had current major depression and 26.9 percent met the criteria for subthreshold depression.[3]
- Vision loss is a leading cause of falls in the elderly. One study found that visual field loss was associated with a six-fold risk of falls.[4]
- While only 4.3 percent of the 65 and older population lives in nursing homes, that number rises to 6 percent of those who are visually impaired, and 40 percent of those who are blind and Medicaid direct costs of $11 Billion per year.[5]
- Individuals who are visually impaired are less likely to be employed–44 percent are employed compared to 85 percent of adults with normal vision in working population age 19–64.[6]

If blinded veterans are not able to obtain the blind center training to learn to function at home independently because of travel cost barriers, the alternative—institutional care in nursing homes—may be far more expensive. The average private room charge for nursing home care was $212 daily ($77,380 annually), and for a

[1] Department of Veterans Affairs, Office of Rural Health, Demographic Characteristics of Rural Veterans Issue Brief (Summer 2009).

[2] VSO *IB* 2013 Beneficiary Travel pg 119–120, 124–125.

[3] Horowitz et al. 2005, Major and Subthreshold Depression Among Older Adults Seeking Vision Rehabilitation Services The Silver Book 2012, Volume II pg 9 www.silverbook@agingresearch.org.

[4] Ramratten, et al. 2001 Arch Ophthalmology 119(12) 1788–94. Prevalence and Causes of Visual Field Loss in the Elderly, www.Silverbook.org/visionloss Silver Book, Volume II 2012 pg 9.

[5] Rein, David B., et al. 2006 The Economic Burden of Major Adult Visual Disorders in the U.S. www.Silverbook.org/visionloss Silver Book, Volume II 2012 pg 9.

[6] Rein, et al. The Economic Burden of Major Adult Vision Disorders in the U.S. 2006 www.Silverbook.org/visionloss Volume II pg 10.

semi-private room it was $191 ($69,715 annually), according to a MetLife 2008 Survey. Even assisted living center charges of $3,031 per month ($36,372) rose another 2 percent in 2008. BVA would point to these more costly alternatives in describing the advantages of VA Beneficiary Care so that veterans can remain in their homes, functioning safely and independently, and with the rehabilitation training needed to re-enter the workforce.

We caution that private agencies for the blind are almost always outpatient centers and located in large urban cities. Many rural states have no vision rehabilitation centers and they do not have the full specialized nursing, physical therapy, audiology, pharmacy, radiology or laboratory support services that are necessary for the clinical care that VA BRCs and SCIs provide. BVA requests that private agencies demonstrate peer reviewed quality outcome measurements that are a standard part of VHA Blind Rehabilitative Service and they must be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

S. 455, Proposed Program Change in Law:

Current Law or Practice: Under 38 U.S.C. 111A, the Secretary has the authority to transport any Veteran to or from a VA facility or other place in connection with vocational rehabilitation, counseling, or for the purpose of examination, treatment, or medical care. Last session 112th Congress this Committee passed Public Law 112–260, section 202 that revised VA's transportation authority's providing VA the authority to supplement volunteer drivers with VA staff to drive VTS vehicles which BVA supports. The clarifying authority established under Public Law 112–260 expires on January 10, 2014 unless Congress acts though and must be changed.

BVA supports proposed legislation to extend this recently enacted provision, change Title 38 U.S.C. § 111A that authorized VA to transport any person to or from a VA facility or other place in connection with vocational rehabilitation or counseling required by the Secretary pursuant to chapter 34 or 35 of Title 38, or for the purpose of examination, treatment, or care. This authority was enacted in January 2013 under Public Law 112–260, Section 202, of the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012 and expires one year after the data of enactment. This proposal would extend the authority for an additional five years.

VA launched a Veterans Transportation Service (VTS) initiative in 2010 to enhance, support, and organize transportation efforts for Veterans by VA health care facilities to improve access. Through the VTS program, VA provided funding to local VA facilities for mobility managers, transportation coordinators and vehicles to complement the existing access to care that volunteers already provide. The service provides Veterans with the ability to be transported to and from their VA health care appointments. Between October 2011 and May 2012, VTS transported more than 43,000 Veterans door to door, making more than 50,000 trips that totaled more than 2.1 million miles.

The average length of a trip is almost 60 miles—a considerable distance in some rural communities, and a prohibitive distance for those with poor health if transportation was not available. However, with increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers in all regions of the country to sustain the current level of service. Furthermore, volunteer drivers generally do not transport Veterans who are not ambulatory, require portable oxygen, have undergone a procedure involving sedation, or have other clinical issues.

Additionally, some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. We have had reports of volunteer drivers not assisting blinded veterans in walking out to find the vans when parked in various locations, whereas VA employees will assist the veteran. Section 111A allows VA to supplement volunteer drivers with VA staff to drive the VTS vehicles for one year and VHA has stated its full support for this law. Without the proposed extension, it is possible that VTS will need to be significantly reduced or curtailed in January 2014, particularly in rural areas of the country.

S. 325: BVA supports this bill to amend title 38 U.S.C., to increase the maximum age for children eligible for medical care under the CHAMPVA program that would allow same coverage mandated in other current Federal programs. Dependent children who currently turn age 21 have loss of coverage under CHAMPVA and have difficulty finding and being able to afford health insurance.

S. 522: BVA supports Senator Durbin's bill to require the Secretary of Veterans Affairs to award grants to establish, or expand upon, master's degree or doctoral degree programs in orthotics and prosthetics, and for other purposes. The VA population of disabled veterans requires more advanced degree specialists in the area of

prosthetics as technological advances are made in these devices. VA must have the ability to provide support for these orthotics and prosthetic specialists.

S. 845: BVA supports extension of the Department Veterans Affairs Health Professional Educational Assistance Program. This program is valuable as recruiting and retention tool for allied health care professionals and allows VA to be competitive in assisting employees in advancing in their college degrees.

S. 851: Chairman of the Senate Veterans' Affairs Committee Bernie Sanders introduced S. 851, the Caregivers Expansion and Improvement Act of 2013.

BVA strongly supports this bill as it would expand eligibility for comprehensive benefits and services to family caregivers of all veterans who were severely injured in the line of duty while serving in the Armed Forces. Currently, only family caregivers of veterans severely injured on or after September 11, 2001, are eligible for these benefits and services such as: caregiver training; support groups, counseling and other support services; a monthly stipend; health coverage through CHAMPVA; respite care; mental health services and counseling related to the caregiver role and burden. Our catastrophically disabled service-connected veterans from previous wars caregivers have sacrificed for decades trying to keep their family member at home. They should have the same Caregiver support as in the current law for Post-9/11 veterans.

CONCLUSION

Chairman Sanders and Ranking member Burr, BVA again expresses its support for these proposed changes to VHA programs listed above and will limit our submission to those because we have no resolutions on some of the other bills being considered here today. BVA requests support for these bills which will ensure that VHA can improve care and access for disabled veterans. BVA appreciates the opportunity to provide this statement for the record today.

PREPARED STATEMENT OF CONSORTIUM OF ACADEMIC HEALTH CENTERS FOR INTEGRATIVE MEDICINE

CONSORTIUM *of* ACADEMIC HEALTH CENTERS *for* INTEGRATIVE MEDICINE
612-624-9166 | www.imconsortium.org

Statement of the Consortium of Academic Health Centers for Integrative Medicine
in support of S.852
Hearing on Pending Health Care Legislation
Senate Committee on Veterans' Affairs
May 9, 2013

The Consortium of Academic Health Centers for Integrative Medicine (the Consortium) supports the creation of Senate Bill 852 to address veterans' needs for complementary and alternative medicine (CAM) in congruence with conventional care, or as the Consortium refers to it – integrative medicine. We appreciate the opportunity to provide written comment for the record.

The Consortium is a 501(c)3 nonprofit organization comprised of 55 highly esteemed academic medical centers (see attached) and 3 affiliate institutions; the Mayo Clinic, Cleveland Clinic and Allina Health. The mission of the Consortium is to advance the principles and practices of integrative healthcare within academic institutions through: 1) supporting and mentoring academic leaders, faculty, and students 2) disseminating information on rigorous scientific research, educational curricula in integrative health, and sustainable models of clinical care and 3) informing health care policy.

The Consortium defines integrative medicine as "the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing." We feel that the passage of S. 852 will support the important pilot programs that may demonstrate improved health outcomes of veterans and may help to reduce health care costs as the result of an integrative approach to health.

Millions of American veterans and civilians suffer from chronic pain, and the prevalence of the top 7 modifiable chronic diseases (cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders) is staggering. As you well know, the U.S. spends on health care per capita roughly twice that spent by our peer developed nations, yet we are shamefully behind other industrialized nations regarding our population's health quality, including the health and quality of life of our veterans.

While conventional medicine excels at emergency care, technology, pharmaceuticals and surgical interventions, it stumbles at motivating health promoting lifestyle choices that could change this picture, and improve quality of life for those chronically ill or disabled. Integrative medicine looks at both prevention and treatment of chronic pain, mental health and other conditions as a team effort, with the patient at the center of the team.

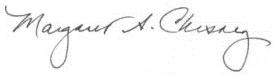
To further support S. 852, we briefly summarize the rapidly growing evidence base indicating the role that complementary and integrative medicine and wellness centers may play in supporting the complex health challenges faced by veterans in a patient-centered yet cost-effective manner:

- Substantial high quality research evidence supports non-pharmacological approaches to pain management as part of an interdisciplinary strategy. For example, acupuncture has been shown to improve chronic pain conditions (head, neck, knee and back) at almost twice the rate of guideline-based conventional treatment[i].
- A Medicaid demonstration project providing integrative health care found an 86% reduction in pain levels, 25% reduction in health care utilization and 20% reduction in prescription drug use in an underserved community[ii].
- Research is demonstrating the benefit of integrative approaches to health for mental health conditions including depression, addictions, and post-traumatic stress disorder[iii].
- Behavioral and mind-body practices have been repeatedly demonstrated to enhance quality of life, improve self-care and reduce costs[iv].

As you seek to pass and operationalize the programs set forth in this bill, we urge you to support participating Veteran Affairs' health centers to employ licensed CAM providers and providers who are dually trained in conventional and CAM therapies. Historically there have been several barriers to integrative health care, including lack of reimbursement mechanisms for CAM providers and prevention/wellness services. We believe that S. 852 and Section 2706 (non-discrimination in health care) of the Affordable Care Act both present opportunities to overcome these obstacles.

We commend S.852's focus on chronic pain, mental health conditions and prevention and wellness in the context of care provided by interdisciplinary teams of licensed conventional and CAM providers. Utilizing the collective expertise represented in our academic health centers and health systems, the Consortium would be happy to provide assistance as you work to pass and implement this important legislation.

Sincerely,



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[i] Haake M, Muller HH, Schade-Brittinger C, et al. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. Sep 24 2007;167(17):1892-1898. Diener HC, Kronfeld K, Boewing G, et al. Efficacy of acupuncture for the prophylaxis of migraine: a multicentre randomised controlled clinical trial. Lancet Neurol. Apr 2006;5(4):310-316.

[ii] Sarnat RL, Winterstein J, Cambron JA. Clinical utilization and cost outcomes from an integrative medicine independent physician association: an additional 3-year update. J Manipulative Physiol Ther. May 2007;30(4):263-269.

[iii] Sargent, P, Campbell, J, Richter, K, McLay, R, Kofman, R. Integrative Medical Practices for Combat-Related Posttraumatic Stress Disorder. Psychiatric Annals. April 2013;43(4):181-187.

[iv] Sobel DS. MSJAMA: mind matters, money matters: the cost-effectiveness of mind/body medicine. JAMA. Oct 4 2000;284(13):1705.

PREPARED STATEMENT OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Sanders, Ranking Member Burr and Members of the Committee: On behalf of the DAV (Disabled American Veterans) and our 1.2 million members, all of whom are wounded and injured veterans, I am pleased to present our views on several of the legislative measures that are of particular interest to the Committee or to DAV and our members.

S. 49, VETERANS HEALTH EQUITY ACT OF 2011

This measure would require availability of at least one full-service Department of Veterans Affairs (VA) hospital or comparable services be provided through contract, in each of the 48 contiguous states.

Arguments have been made that New Hampshire is the only lower 48 state without a VA full-service medical center and that most ill veterans in that state routinely must drive or be transported to Boston for more comprehensive health care services. Members of Congress have stated they are particularly concerned that the sickest and generally very elderly veterans with complex and chronic health problems were subjected to having to first report to the VA's Manchester facility—which could be up to a three-hour drive—and then continue on for another hour to the Boston VA Medical Center (VAMC) or other VA provider sites, in order to receive their care. It was also noted (during her first term) by Representative Shea-Porter of New Hampshire, that it may not be fiscally responsible, given the veteran population of New Hampshire, to force VA to directly provide a full continuum of hospital services, and that contracting for such services may be a better option.

Convenient access to comprehensive VA health care services remains a problem for many of our Nation's sick and disabled veterans. While VA must contract or use fee-basis arrangements to provide care to some veterans, it maintains high quality care and cost effectiveness by providing health services directly within the system. According to VA, the Manchester VAMC in New Hampshire provides urgent care,

mental health and primary care services, ambulatory surgery, a variety of specialized clinical services, hospital based home care and inpatient long-term care. In addition, community-based outpatient clinics (CBOCs) are located in Somersworth, Tilton, Portsmouth, Littleton and Conway.

In light of the escalating costs of health care in the private sector, and to its credit, VA has done a remarkable job of providing high quality care and holding down costs by effectively managing in-house health programs and services for veterans. However, outside care coordination is poorly managed by VA. When it must send veterans outside the system for care, those veterans lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health records, and bar code medication administration program (BCMA). The proposal in S. 49 to use broad-based contracting for necessary hospital services in the New Hampshire area concerns us because these unique internal VA features noted above culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector health systems, equate to diminished oversight and coordination of care, and, ultimately, may result in lower quality of care for those who deserve it most. However, we agree that VA must ensure that the distance veterans travel, as well as other hardships they face in gaining access, be considered in VA's policies in determining the appropriate locations and settings for providing VA health care services.

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

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

Nevertheless, after considerable deliberation, and in good faith to be responsive to those who have come forward with legislative proposals such as S. 49, to offer alternatives to VA health care and VA's flawed fee-basis program, VA has developed and is implementing a new, nationwide program entitled "Patient Centered Community Care (PCCC)." As we understand the concept, VA will be awarding contracts to intermediary managed-care firms that will, in turn, establish networks of providers and facilities for referred veterans when VA's internal resources are not available or are insufficient to meet known needs, when academic affiliates cannot meet them, and when no preexisting VA-contracted provider can provide for that need. We are optimistic that the principles of our recommendations from the "Contract Care Coordination" section of the FY 2014 Independent Budget will be used to guide VA's approaches in this new effort. We support the requirement that firms that are awarded these PCCC contracts must agree to meet a number of VA's standards for quality, safety, data security, records management, etc.

VA must work to improve access for veterans that are challenged by long commutes and other obstacles in getting reasonable access to a full continuum of health care services at VA facilities and explore practical solutions when developing policies in determining the appropriate location and setting for providing VA health care services. We believe that the PCCC initiative may offer a practical resolution to this longstanding dilemma.

S. 62, CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013

S. 62 would amend the Internal Revenue Code of 1986 to allow taxpayers at the time of filing the tax return to designate any overpayment of taxes not less than $1.00, as well as make additional contributions to the Homeless Veterans Assistance Fund. It also notes that the Secretary could designate another time other than at the filing of a tax return to make a contribution to the fund. This addition to the

Internal Revenue Code would also be coupled with the creation of a trust fund to become known as the Homeless Veterans Assistance fund which would use contributions to develop and implement new and innovative strategies to prevent and end veteran homelessness as well as toward implementation of current homeless programs in the Department of Veterans Affairs, the Department of Labor Veterans' Employment and Training Service, and the Department of Housing and Urban Development. These Departments will also include a description of the use of the funds from the previous fiscal year, beginning with FY 2014, in the President's annual budget submission.

DAV Resolution 234 urges Congress to sustain sufficient funding to support VA's initiative to eliminate homelessness among veterans and strengthen the capacity of the VA Homeless Veterans Program, to include: increasing its mental health and substance-use disorder programs capacity, provide vision and dental care services to homeless veterans as required by law, and improve its outreach efforts to help ensure homeless veterans gain access to VA's specialized health and benefits programs. Additionally, we urge Congress to continue to authorize and appropriate funds for competitive grants to community-based and public organizations including the Department of Housing and Urban Development to provide health and supportive services to homeless veterans placed in permanent housing.

Although this bill would provide additional funding to support VA's Homeless Program and initiatives to prevent and end veterans' homelessness DAV has no specific resolution from our membership related to this funding being provided on a voluntary basis from the American public. Therefore, we take no position on this bill.

S. 131, WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013

Sections 2 through 8 of the bill would require VA to provide fertility counseling and treatment for spouses or surrogates of severely wounded, ill, or injured veterans (enrolled in the VA health care system) who have infertility conditions incurred or intensified in the line of duty. In addition to fertility counseling and treatment, adoption assistance may be provided for covered veterans. The Secretary of Veterans Affairs would be required to prescribe regulations on the furnishing of fertility treatment to veterans and annually report to the Committee on Veterans' Affairs of the Senate and House of Representatives on such treatment provided to veterans.

The bill instructs the Secretary of Veterans Affairs to facilitate reproductive and infertility research conducted collaboratively by the Secretary of Defense and the Director of the National Institutes of Health to find ways to meet the long-term reproductive health care needs of veterans who have a service-connected genitourinary disability or a condition that was incurred or aggravated while serving on active duty, such as spinal cord injury, that affects their ability to conceive. The Secretary would ensure that any information produced by the research deemed useful for other activities of the VHA be disseminated throughout the VHA and report to Congress on the research activities conducted within three years after the date of enactment.

While DAV has no specific resolution from our membership related to reproductive and infertility research and fertility counseling and treatment, this section of the bill is focused on improving the Departments' ability to meet the long-term reproductive health care needs of veterans who have a service-connected injury or condition that affects the veteran's ability to conceive. For these reasons, DAV has no objection to the passage of these sections of the bill.

Section 9 of this bill requires that the Secretary of Veterans Affairs enhance the capabilities of the VA Women Veterans Call Center by responding to requests by women veterans for assistance with accessing health care and benefits and by referring such veterans to community resources to obtain assistance with services not furnished by VA. Since introduction of this measure, VA has launched a new hotline, 1–855-VA-WOMEN, to receive and respond to questions from veterans, their families and caregivers about VA resources available to women veterans. We are pleased that VA has added this service, similar to the provisions proposed in this section of the bill, and is making progress to better communicate and inform women veterans of their benefits, specialized services and health care options. We recommend VA provide periodic updates to the Committee and veterans service organizations related to the number of women veterans calling the hotline and the types of requests for information received to assess its effectiveness.

Sections 10 and 11 of the bill seek to modify the pilot program of counseling women veterans newly separated from active duty in retreat settings by increasing the number of locations from three to fourteen and by extending the time of the pilot program from two years to four years. The bill also directs the Secretary to carry out a pilot program of providing child care assistance to veterans receiving or

in need of VA readjustment counseling and related mental health services or other intensive health care services in at least three Veterans Integrated Service Networks and in no fewer than three Readjustment Counseling Service Regions.

Child care assistance under this subsection may include: stipends for the payment of child care offered by licensed child care centers either directly or through a voucher program; payments to private child care agencies; collaboration with facilities or programs of other Federal departments or agencies; or other forms of assistance as the Secretary considers appropriate. When the child care assistance under this subsection is provided as a stipend, it must cover the full cost of such child care.

Section 12 of the bill directs the Secretary to impose a contractor user fee for each contract entered into by the VA for goods or services as a term of the contract. The fee amount is to equal 7 percent of the total value of the contract and authorizes the Secretary to waive the fee if the contractor is an individual or a small business. This bill would also establish a VA Fertility Counseling and Treatment Fund in the Department of the Treasury and all funds received as a result of the contractor user fee imposed by this section would be deposited into the Fund.

We support the Committee's continued efforts on improving VA's women veterans health programs and services and are pleased to support this bill in keeping with DAV Resolution 213. DAV has heard positive feedback related to the pilot program of counseling women veterans newly separated from active duty in retreat settings and the child care pilots established by Public Law 111–163 and look forward to a full and comprehensive report from VA on these initiatives. We supported the original provisions for these pilot programs and are pleased to support the proposal to expand them.

S. 229, CORPORAL MICHAEL J. CRESCENZ ACT OF 2013

S. 229 would designate the Department of Veterans Affairs medical center located at 3900 Woodland Avenue in Philadelphia, Pennsylvania, as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center." DAV has no national resolution on this issue and has no national position on this bill; however, we leave the decision up to the local DAV leadership in Pennsylvania.

S. 287, TO AMEND TITLE 38, UNITED STATES CODE, TO EXPAND THE DEFINITION OF HOMELESS VETERAN FOR PURPOSES OF BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS

This bill seeks to amend Section 2002(1) of title 38, United States Code, by striking 'in section 103(a) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302(a))' and inserting 'in subsection (a) or (b) of section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302)'. This change would expand the definition of a homeless veteran by including veterans who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

Currently, in order to qualify for assistance under the homeless veteran programs governed by title 38 of the U.S. Code, veterans must meet the definition of "homeless veteran." This term may appear straightforward but it has two layers, the first of which is the definition of "veteran" which for purposes of title 38 benefits is a person who "served in the active military, naval or air service who was not dishonorably discharged." The second layer is that veterans are considered homeless if they meet the definition of a "homeless individual" codified as part of the McKinney-Vento Homeless Act (P.L. 100–77) which was signed into law in 1987. Until recently a "homeless individual" was: 1) a person who lacks a fixed, regular and adequate nighttime residence; 2) who has a nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary housing; an institution that provides a temporary residents for individuals intended to be institutionalized; and 3) who utilizes a public or private place not designed for regular sleeping accommodation for human beings.

In December 2011, as a result of the HEARTH Act passed in the 111th Congress that expanded the definition of "homeless individual," HUD issued regulations regarding the new definition that took effect on January 4, 2012. This definition moves away from the requirement for literal homelessness and added three new categories: 1) imminent loss of housing; 2) the addition of unaccompanied youth and homeless families with children who have experienced a long-term period without living independently in permanent housing, and 3) a person who has had frequent moves and can be expected to continue in unstable housing due to a number of

chronic health factors. Another Federal change to the definition of a homeless individual is, "a person fleeing a situation of domestic violence or other life-threatening condition," but until title 38 is changed to include the subsection of the McKinney-Vento Act, this definition is not part of the definition of a homeless veteran, and while DAV does not have a national resolution specific to defining a homeless veteran, defining a homeless veteran to match the national standard is fair and we do not oppose passage of this bill.

S. 325, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO INCREASE THE MAXIMUM AGE FOR CHILDREN ELIGIBLE FOR MEDICAL CARE UNDER THE CHAMPVA PROGRAM

This measure would address a needed adjustment to current eligibility requirements for adult children who receive health care through age 18 (or age 23 if in school) under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Established in 1973, CHAMPVA provides cost reimbursement for private health care services provided to dependents, survivors, and some primary caregivers, of certain disabled veterans. CHAMPVA enrollment has grown steadily over the years and, and as of fiscal year 2011, CHAMPVA covers approximately 355,000 beneficiaries.

Under current law, a dependent child loses eligibility for CHAMPVA upon turning 18 years of age, unless the person is enrolled in school on a continuing and full time basis. Under current law, a dependent child loses eligibility for CHAMPVA upon turning 18 years of age, unless that individual is enrolled in school on a continuing and full time basis, up to age 23. If full-time school attendance is discontinued, or upon attaining the age of 23 years, the individual loses eligibility.

With the passage of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152), DAV on behalf of numerous service-connected veterans and their families has expressed concern regarding these individuals' health care coverage. We rest our position on the precedent that PPACA extends health insurance coverage to dependent children until age 26, except for those in the CHAMPVA program, and we believe the omission of these CHAMPVA beneficiaries was inadvertent but inequitable.

In accordance with DAV Resolution No. 222, we fully support enactment of this bill that would ensure CHAMPVA recipients, without regard to their student status, remain eligible for health care coverage under their parents' plans in the same manner as for adult children of the vast majority covered under PPACA.

S. 412, A BILL TO AUTHORIZE MAJOR MEDICAL FACILITY LEASES FOR THE DEPARTMENT OF VETERANS AFFAIRS

If enacted, this bill would authorize (and in three cases, reauthorize) VA to carry out leases for community-based outpatient clinics in 15 locations in 12 states, and one in Puerto Rico.

DAV has not received a national resolution from our membership on the specific topic of VA facility leases, but we would not object to passage of this bill.

It is important to note for the record that the authorizing statute requires VA to obtain Congressional approval for a commercial lease of a future VA medical facility if the estimated first-year lease cost exceeds $1 million. This policy has been in place for decades. Hundreds of leases for VA-operated community-based outpatient clinics have been approved by Congress and executed by VA under this procedure. Using a leasing authority rather than constructing VA-owned facilities allows VA to quickly establish convenient primary care facilities for veterans in communities where they live. Veterans who use these community clinics report high satisfaction with their care and the convenience they offer. Employing leased facilities is a cost-effective method of providing high quality VA primary care.

In 2012, in evaluating a similar bill for these 15 proposed VA leases that each exceed the $1 million threshold, the Congressional Budget Office (CBO) concluded that Congressional rules require that funds to offset the entire 20-year prospective lease cost would need to be included either in the VA budget, or would be taken from funding of ongoing veterans programs—all in the first year of each lease. CBO indicated this policy also would apply in the future to renewals of existing VA leases that exceed the threshold cost. This CBO decision multiplied VA's costs for these proposed 15 leases 20-fold, for a total need of $1.2–$1.5 billion in fiscal year (FY) 2013 funds. Since funds of this magnitude could not be diverted from other VA accounts for this surprising new requirement and were not covered in the budget request that had been submitted to Congress, these 15 leases were dropped from further Congressional consideration last year only to return once again.

In VA's current planning, including these 15 clinics for California, Connecticut, Florida, Georgia, Hawaii, Kansas, Louisiana (2 sites), Massachusetts, New Jersey, New Mexico, Puerto Rico, Texas (2 sites), and South Carolina, VA projects a need to lease or renew existing leases for 38 community-based health care facilities through FY 2017 to provide care for more than 340,000 veterans across 22 states and US territories.

Unless CBO changes its policy or Congress acts to overturn this CBO decision with legislation or makes a change in House Rules in current funding policy, most if not all these leases remain in jeopardy. Veterans consequently will be denied convenient VA health care.

Absent a change VA may be forced to buy land and construct government-owned clinics, or more likely will require veterans who need VA care to travel longer distances to receive it. VA-built clinics would be more expensive, would take much longer to activate, and would reduce VA's flexibility to place and move facilities based on the changing needs of the veteran population. Forcing veterans to travel for care would increase inconvenience and add additional costs.

We ask the Committee to take action in consideration of this dilemma to ensure the leases that would be authorized in this bill, and future leases, can be accommodated in the budget process without VA's having to reserve or offset billions of dollars from other VA programs in order for them to be authorized.

S. 422, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

S. 422 would accelerate the expansion of chiropractic care by requiring VA to provide chiropractic care and services at no fewer than 75 medical centers by December 31, 2014, and at all VA medical centers by December 31, 2016.

The National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM) cites spinal manipulation as one of several options—including exercise, massage, and physical therapy—that can provide mild-to-moderate relief from low-back pain.

VA was authorized to offer chiropractic care and services under the provisions of section 204 of Public Law 107–135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001. By January 2011, 43 VA facilities directly provided chiropractic care and by January 2012, 45 VA facilities were providing on-site chiropractic care. The Department of Defense also offers chiropractic care at 60 military treatment facilities including the Walter Reed National Military Medical Center.

Progress toward providing chiropractic care at each VA medical center is contingent on discretionary decisions made locally. Many facilities have decided that eligible veterans can receive chiropractic care through VA's outpatient fee-basis program (based only on referrals by primary care providers, with advance authorization). Directly providing chiropractic care would provide more practical access compared to the eligibility criteria for fee-basis care, which generally restricts access to a limited number of veterans. Our interpretation of the law is that chiropractic care through fee-basis may only be provided to a smaller subset of enrolled veterans,[1] and this result conflicts with Section 204(b) of Public Law 107–135, which states, "veterans eligible to receive chiropractic care and services under the program are veterans who are enrolled in the system of patient enrollment under Section 1705 of title 38, United States Code."

Therefore, in conjunction with DAV Resolution No. 217, adopted by the delegates to DAV's most recent national convention, calling for more complementary and alternative medicine (CAM) programs in VA facilities for the care of veterans, DAV supports enactment of this bill that will bring additional and non-traditional care options to veterans enrolled in VA health care.

S. 455, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO AUTHORIZE THE SECRETARY OF VETERANS AFFAIRS TO TRANSPORT INDIVIDUALS TO AND FROM FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS IN CONNECTION WITH REHABILITATION, COUNSELING, EXAMINATION, TREATMENT, AND CARE

This bill would provide VA a renewed authority to transport individuals in connection with their vocational rehabilitation, counseling, examination, treatment, or care, and would specifically vitiate a prior act of Congress that eliminated an important transportation program after only one year of life.

Notably, VA has implemented the provisions of Section 202 of Public Law 112–260, the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012, except for eliminating the authority granted under Section 111A of title 38, United

[1] 38 U.S.C. 1703, and 38 C.F.R. §§17.52–17.56.

States Code, to create a VA-operated transportation program one year after enactment. That act had prompted VA to initiate the Veterans Transportation Service (VTS), supported by the Veterans Health Administration (VHA) Chief Business Office (CBO). The VTS was established to provide veterans with convenient and timely access to transportation services and to overcome access barriers certain veterans may have experienced, and in particular to increase transportation options for veterans who need specialized forms of transportation to VA facilities. The VTS transportation services to VA medical centers include the use of technology and mobility management training for medical center staff that in turn enable VTS services to better interface with other community transportation resources.

VA medical centers and sites where VTS is operating can be ideal partners with the DAV National Transportation Network and for the Veterans Transportation and Community Living Initiative grant projects establishing One-Call/One-Click Transportation Resource Centers. Based on our review of this situation, were it not for the expiration of statutory authority from Public Law 112–260, VTS would have grown from its current 45 sites to all remaining VA locations by 2015.

The DAV National Transportation Network continues to show tremendous growth as an indispensable resource for veterans. Across the Nation, DAV Hospital Service Coordinators operate 200 active programs. They have recruited 9,249 volunteer drivers who logged over 27 million miles last year, providing almost 721,000 rides for veterans to and from VA health care facilities. These veterans rode in vans DAV purchased and donated to VA health care facilities for use in the DAV National Transportation Network. DAV Departments and Chapters, together with our national organization, have now donated 2,586 vans to VA health care centers nationwide at a cost to DAV of $56.7 million.

DAV believes VTS serves the transportation needs of a special subset of the veteran patient population that the DAV National Transportation Network is unable to serve—veterans in need of special modes of transportation due to certain severe disabilities. We believe that with a truly collaborative relationship, the DAV National Transportation Network and VTS will meet the growing transportation needs of ill and injured veterans in a cost-effective manner.

Currently, DAV supports enactment of this bill; however, our support is based on the progress gained through our collaborative working relationship with VHA and CBO to resolve weaknesses we have observed in the VTS program. As you may be aware, VTS operates with resources that would otherwise go to direct medical care and services for veterans. These resources should be used carefully for all extraneous programs to ensure veterans are not denied care when they most need it.

We thank VHA and CBO for their commitment and efforts in working with DAV to ensure VTS will indeed work in concert with all existing and emerging transportation resources for veterans who need VA care, and to guard against fraud, waste and abuse of these limited resources.

We look forward to continuing our work with the Committee on this measure, and to work for its passage.

S. 522, THE WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

This bill would establish two VA grant programs, one to be made to educational institutions to establish or enhance orthotic and prosthetic masters and doctoral education programs, with an appropriations limitation of $15 million; and the other to establish a private "center of excellence in orthotic and prosthetic education," with an appropriations limitation of $5 million.

DAV has no resolution from our membership that would support the establishment of these specific activities. Nevertheless, prosthetic and orthotic aids and services are important to injured and wounded veterans, and constitute a specialized medical program within the VA. Nevertheless, absent a defined shortage of individuals who possess related skills and knowledge in these fields, justification for enactment of this bill seems questionable. Also, assuming the grant programs take form, graduating students who benefited from them would not be required to provide obligated employment within VA to repay the government's investment in their education such as is required in VA's existing health professional scholarship programs under Chapters 75 and 76 of title 38, United States Code. We believe consideration of that existing and highly successful mandate be considered in adopting the concept embedded in this bill, to ensure that VA regains at least some of the value of the work of these students following their VA-subsidized education and training. Finally, assuming the establishment of a center of excellence in this particular field is warranted, DAV questions whether the center should be outside VA, rather than become a new VA in-house center of excellence along the lines of those centers al-

ready established in law in Chapter 73 of title 38. We ask that the sponsor of this bill reconsider the proposal in light of our testimony.

S. 529, TO AMEND TITLE 38, UNITED STATES CODE, TO MODIFY THE COMMENCEMENT DATE OF THE PERIOD OF SERVICE AT CAMP LEJEUNE, NORTH CAROLINA, FOR ELIGIBILITY FOR HOSPITAL CARE AND MEDICAL SERVICES IN CONNECTION WITH EXPOSURE TO CONTAMINATED WATER.

This bill would expand the number of eligible persons to the benefits extended to certain persons by Public Law 112–154, the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. This proposed expansion will add tens of thousands of new individuals to the estimated 750,000 currently eligible.

DAV has no resolution specific to this issue, but we remain concerned that the burden of care for this population rests with VA through its CHAMPVA program rather than with the military TRICARE program. Adding more eligible persons as proposed will only make VA's burden of care more challenging.

S. 543, THE VISN REORGANIZATION ACT OF 2013

This bill would consolidate VA's current 21 Veterans Integrated Service Networks (VISNs) into 12 prescribed new units with similar responsibilities but significantly smaller staffs than at present. Excess staffs would be integrated into subordinate VA medical facilities or be provided other reemployment assistance. Also, in making this consolidated restructuring, the bill would require VA to collaborate with other Federal offices, state and local offices, with VA affiliates and certain private and voluntary organizations within each of the 12 new geographical areas. The bill would establish no more than four regional support centers that would provide certain administrative and analytic functions dealing with effectiveness and efficiency of the VISNs. Finally, the bill would require several reports associated with the proposed consolidations.

DAV has not received a national resolution from our membership on this specific issue, but we wish to bring a number of concerns to the attention of the sponsor, and of the Committee as it considers this bill.

VA's adoption of VISNs as a regional health care organization was derived from the geographic service area concept of the 1991 VA Commission on the Future Structure of Veterans Health Care, a Federal advisory commission chartered by then-VA Secretary Edward J. Derwinski to make recommendations for organizational, structural, quality, safety and cultural improvement in VA health care, among other aims. VA considered the Commission's recommendations for three years before implementing this one as a part of VHA's 1995 administrative reorganization. Initially, 22 VISNs were established but two of them—the smallest in terms of patient workload, staff and funding—were not independently viable and were soon consolidated, so that today 21 networks remain, covering the continental US, Hawaii, Puerto Rico and US possessions.

DAV supported the VA's decision to restructure the VA health care system, the principle benefit of it being a regionalization of health care delivery, coordination of leadership and decentralization of decisionmaking with a corresponding reduction of VA Central Office's involvement in local health care management matters. Like Congress at the time, we believed that health care decisions were best left to local VA facility managers and clinicians, while VA Central Office should focus on national strategy and policies, program development, practices and standards-setting. The idea was simple: policy is set at the top; implementation occurs at the local level.

Testimony before this Committee in the last year suggested VA facility managers are "gaming the system" to meet goal numbers established by the VISNs, rather than providing needed care to veterans as provided for by law. Potential gaming is also one of our concerns. We receive much anecdotal information from our members and VA employees that is consistent with such allegations—although these troubling reports are difficult to prove in any systematic way. The House Veterans' Affairs Committee's 2012 oversight hearing on chronic problems at the Miami VA Medical Center was illustrative of how such challenges can fester undetected because of lack of adequate public reporting and the general unavailability of documentary data.

A second concern is the number of staff assigned to the VISNs. When the networks were formed, VA asserted that they would be staffed by network directors with small cadres of staff. Management functions that exceeded this staff's ability to perform them were to be accomplished by working groups composed of VAMC staffs on temporary assignments. Over the past 15 years, however, the network offices grew dramatically, and morphed into 21 permanent mini-central offices, staffed

with full-time professional staffs focused on operations, clinical care, human resources, quality, safety, internal and external review, media, press, public affairs, budget, academic affairs, and numerous other functions.

Perhaps the most worrisome concern with the VISN organization has been the enormous administrative overhead that is being incurred by these seemingly bloated numbers of staff. We believe thousands of VA permanent, full-time staff may now be assigned to VISN offices (but until recently exact numbers were elusive due to lack of publicly available information). Within VA these network positions are popular because they represent opportunity for career mobility, professional advancement, and promotion of local VA employees. We believe a large number are clinicians who in their network assignments no longer provide clinical care to veterans. While we believe that clinical leadership is a strength of VA health care, we believe that the size and complexity of the current VISNs depart from the recommendations of the Commission's report, and from the original vision of those who implemented the geographic service area recommendation. Not only are clinical staff members being taken away from frontline positions but also valuable technical and administrative staff have been drained from medical centers to VISN offices.

Many of the additional positions were VACO-mandated to respond to the "crisis of the day" phenomena. Instead of developing thoughtful solutions for recognized problems, previous Administrations simply added new mandatory positions, functions or new offices.

Our third concern with the networks deals with the geographical boundaries of VISNs. With the exception of the one major consolidation change mentioned above, no adjustment of VISN boundaries has occurred in the 15-plus years of the life of this organizational model. The original VISN geographic boundaries were drawn based on VA patient-referral patterns and delivery systems from well over twenty years ago; these may well have changed. Also, some historical anomalies of the VISN map seem to cry out for review, for example, the small state of West Virginia remains subdivided into parts of four VISNs; the western Panhandle of Florida is part of the eight-state VISN 16, while the remainder of the large state of Florida is in VISN 8. We see other examples in the current VISN map that raise questions as well.

Another concern is the allocation of appropriated medical care funds below the level of the network offices. VA's Veterans Equitable Resource Allocation system is a risk-adjusted capitation model that allocates Congressional appropriations to the networks rather than the facilities. Theoretically, this model enables regional coordination and funding of highly specialized, scarce medical resources, while the facilities remain the major delivery systems and serve as VHA's basic building blocks to formulate VHA's annual budget request. VHA's appropriations have grown dramatically over the past several years—yet VA facilities often indicate to us that they are significantly underfunded and must ration spending for numerous categorical needs across the operating year. We believe the resource allocation model or the systems being employed by the VISN offices to allocate resources to the VAMCs might need scrutiny and possibly re-balancing for their effects on local operations.

Less than one month ago, the VA announced its intention to dramatically reduce VISN offices' core staffing, limiting it to between 55–65 persons on average for each of the 21 offices, depending on size and complexity. VA has not provided DAV information about disposition of the staff affected by the new organizational model. We reserve judgment on whether the new staffing pattern changes any of our expressed concerns.

With these thoughts in mind, rather than advancing this bill now, we would recommend the Committee commission an independent, outside review of the VA network concept, subsequent implementation and current status of VA's new plan, with recommended changes that may be warranted by review findings. We believe the time has come for a critical review of the organization, functions, operations, and budgeting process at the VISN and VAMC levels. We recommend the review be conducted by the Institute of Medicine (IOM) rather than by VA or a private contractor. Involving the IOM would ensure a thoroughgoing, apolitical and unbiased review. In addition to examining the current referral patterns, the analysis should account for future demand, changes in veteran and family expectations, and the changing trends in health care delivery.

Also, we would recommend that the IOM's review and analysis be comprehensive to include a review of the VHA Central Office organization. This evaluation should address a value-based analysis of those programs that are optimally managed and funded at a national, VISN or VAMC service level.

While the IOM's report should be made to the Committee, VA should be permitted to comment on the report. We would also recommend the Committee hold hearings on the results of this review to include testimony from IOM, VA, this community

and other interested parties. The IOM reviewers should be carefully instructed as to the goals of the study, which we believe should focus on ways to improve health care quality, safety, satisfaction, consistency and access. The study should focus on delivery of comprehensive, patient-centered care to today's veterans that builds on the obvious progress VA has made over the past 17 years. The IOM's work on this project should be closely monitored by the Committee as the process occurs to ensure your goals, and those of this bill's sponsor, are met.

S. 633, TO AMEND TITLE 38, UNITED STATES CODE, TO PROVIDE FOR COVERAGE UNDER THE BENEFICIARY TRAVEL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS OF CERTAIN DISABLED VETERANS FOR TRAVEL IN CONNECTION WITH CERTAIN SPECIAL DISABILITIES REHABILITATION

This bill would amend the VA beneficiary travel statute to ensure beneficiary travel eligibility for travel expenses in connection with medical examination, treatment, or care on an inpatient basis, and while a veteran is being provided temporary lodging at VA medical centers. Veterans eligible for this benefit would be restricted to those with vision impairments, spinal cord injury or disorder, and those with double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program.

Currently, VA is authorized to pay the actual necessary expenses of travel (including lodging and subsistence), or in lieu thereof to pay an allowance based upon mileage, to eligible veterans traveling to and from a VA medical facility for examination, treatment, or care. According to title 38, United States Code, Section 111(b)(1), eligible veterans include those with service-connected ratings of 30 percent or more; those receiving treatment for service-connected conditions; veterans in receipt of VA pensions; those whose incomes do not exceed the maximum annual VA pension rate, or; veterans traveling for scheduled compensation or pension examinations.

DAV has no resolution on this specific issue and thus takes no position on this bill. However, we would note that while the intended recipients of this expanded eligibility criteria would certainly benefit from it, we would urge the Committee to consider a more equitable approach rather than one based on the specific impairments of disabled veterans. Further, we ask that if the Committee does favorably consider this measure, it also take appropriate action to ensure that sufficient additional funding be provided to VA to cover the cost of the expanded program.

S. 800, THE TRETO GARZA FAR SOUTH TEXAS VETERANS INPATIENT CARE ACT OF 2013

This bill would require VA to establish an inpatient bed service for veterans at its Harlingen, Texas facility. DAV has no national resolution on this issue and has no national position on this bill; however, we leave the decision up to the local DAV leadership in Texas.

S. 825, THE HOMELESS VETERANS PREVENTION ACT OF 2013

S. 825, the Homeless Veterans Prevention Act of 2013, is a comprehensive bill that focuses on improving services for homeless veterans.

Section 2 of the bill requires that recipients of VA grants for comprehensive service programs for homeless veterans meet physical privacy, safety, and security needs of such veterans.

Sections 3 and 4 authorize increased per diem payments for transitional housing assistance that becomes permanent housing for homeless veterans. Also, the section would authorize per diem payments for furnishing care for a dependent of a homeless veteran while the veteran receives services from a grant recipient.

Section 5 requires the VA to assess and measure the capacity of service programs for homeless veterans for which entities receive grants under section 2011 of title 38, United States Code, or per diem payments under sections 2012 or 2061 of the same title. The Secretary would be required to develop and use tools to examine whether sufficient capacity exists to meet the needs of the population of homeless veterans in each geographic area, and to determine the capacity of services that grant and per diem recipients provide. The information that the Secretary collects would be used to set goals to ensure that the grant and per diem homeless programs are effectively serving the needs of homeless veterans, to improve the homeless veteran referral process, to assess if the programs are meeting goals, and to inform future funding allocations. The Secretary would be required to submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives no later than 180 days after the completion of the assessment.

Section 6 would repeal the requirement for annual reports on assistance to homeless veterans. Section 7 would make permanent the authority in section 2033, title 38, United States Code, for VA to carry out a program of referral and counseling

services for veterans at risk for homelessness who are tramsuitionMing from certain institutions.

Section 8 authorizes the Secretary to partner with public and private entities to provide legal services in an equitably distributed geographic area to include rural areas and tribal lands, to homeless veterans and veterans at risk of homelessness subject to availability of funding. The legal services provided would be related to housing, including eviction defense and landlord-tenant cases; family law, including assistance with court proceedings for child support, divorce and estate planning; income support, including assistance in obtaining public benefits; criminal defense, including outstanding warrants, fines and driver's license revocation, and to reduce the recidivism rate while overcoming reentry obstacles in employment or housing. The Secretary may require entities that have partnered with VA and provided legal services to homeless veterans to submit periodic reports.

Section 9 expands the authority of VA to provide dental care to eligible homeless veterans who are enrolled for care, and who are receiving assistance under section 8(o) of the United States Housing Act of 1937 (42 U.S.C. 17 1437f(o)) for a period of 60 consecutive days; or receiving care (directly or by contract) in a domiciliary; therapeutic residence; community residential care coordinated by the Secretary; or a setting for which the Secretary provides funds for a grant and per diem provider.

Section 10 of this measure extends the sunset dates affecting homeless veterans for the following programs in title 38, United States Code:

- Comprehensive Service programs
- Homeless veterans reintegration programs
- Treatment and rehabilitation for seriously mentally ill and homeless veterans
- Centers for the provision of comprehensive services to homeless veterans
- Housing assistance for homeless veterans
- Financial assistance for supportive services for very low-income veteran families in permanent housing
- Grant program for homeless veterans with special needs
- Technical assistance grants for non-profit community-based groups; and
- The Advisory Committee on Homeless Veterans

DAV is pleased to support S. 825, the Homeless Veterans Prevention Act of 2013, in conjunction with DAV Resolution No. 234, which calls for us to support sustained and sufficient funding for the VA's initiative to eliminate homelessness among veterans and improve its existing supportive programs. This resolution also urges Congress to strengthen the capacity of VA's programs to end homelessness among veterans by increasing capacity for health care, specialized services for mental health, substance-use disorders as well as vision and dental care.

S. 832, IMPROVING THE LIVES OF CHILDREN WITH SPINA BIFIDA ACT OF 2013

This bill would require VA to carry out pilot programs to furnish case management and assisted living services to children of Vietnam veterans and certain Korea service veterans who were born with spina bifida, and children of women Vietnam veterans who have certain birth defects, and for other purposes.

There are approximately 1,200 enrollees in VA's Spina Bifida Health Care Program (SBHCP). The SBHCP is administered for those biological children diagnosed with spina bifida of veterans who served in Vietnam, and of veterans who served in Korea during the period September 1, 1967, through August 31, 1971.[2] The program provides reimbursement for comprehensive medical care for those beneficiaries diagnosed with spina bifida, except for conditions associated with spina bifida occulta.

Approximately 15 individuals are enrolled in the Children of Women Vietnam Veterans Health Care Program (CWVV). Under this program, VA reimburses for care related to conditions associated with certain birth defects except spina bifida, which is covered under the VA's Spina Bifida Program identified by the VA as resulting in permanent physical or mental disability of the biological child of a woman veteran who served in Vietnam between February 28, 1961, and May 7, 1975.[3]

We note that children suffering from associated with certain birth defects are now dependent adults. Furthermore, Vietnam veterans who care for dependent adult children are also aging and in all likelihood are contending with their own health care needs.

Although DAV has no specific resolution regarding this proposal, DAV would not oppose passage of this legislation since SBHCP and CWVV are currently provided

[2] 38 U.S.C. §§1803; 1821.
[3] 38 U.S.C. §§1811; 1812; 1813.

to children of veterans exposed to Agent Orange during service in the Republic of Vietnam and would greatly assist Vietnam veterans.

S. 845, TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE DEPARTMENT OF VETERANS AFFAIRS HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES.

This bill would extend for five years VA's existing health professionals scholarship program, and would place a limitation on the annual amount of VA-paid educational debt reduction not to exceed actual amounts paid by eligible employees.

DAV has no resolution from our membership on these specific issues, but we would not object to enactment of this bill.

S. 851, CAREGIVERS EXPANSION AND IMPROVEMENT ACT OF 2013

S. 851 would to extend eligibility to all veterans with a serious service-connected injury for the comprehensive caregiver support and services program under Section 1720G of title 38, United States Code.

For generations, wives, husbands, parents and other family members have taken the role of caregivers of veterans who were seriously ill or injured while serving. Family caregiving is a complex role that bridges both quality of care and quality of life of disabled veterans. Caregivers play a critical role in facilitating recovery and maintaining veterans' independence and quality of life while residing in the community, and are an important component in the delivery of health care by the VA. The critical care they provide amounts to significant personal sacrifice resulting in lost professional opportunities and reduction in income. Caregiving exacts a tremendous toll on that caregiver's health and well-being.

Implementation of caregiver benefits and services authorized by the Caregivers and Veterans Omnibus Health Services Act of 2010, has improved the lives of caregivers by giving them the support they need. These services and benefits include a tax-free monthly stipend, travel expenses, health coverage through CHAMPVA, mental health services and counseling, caregiver training and respite care for caregivers of veterans seriously injured on or after September 11, 2001. However, these services were not made available to caregivers in need of support caring for veterans with equally serious injuries incurred in military service before September 11, 2001.

Many caregivers of veterans have been caring for injured veterans for years with little or no support and DAV believes it is appropriate to provide equal benefits to veterans and their family caregivers from all eras.

DAV believes caregivers of severely disabled veterans should be seen as a resource and supported in their role. Accordingly, the delegates to our most recent National Convention, held in Las Vegas, Nevada, August 4–7, 2012, approved resolution number 221 calling for legislation that would expand eligibility for comprehensive caregiver support services, including but not limited to financial support, health and homemaker services, respite, education and training and other necessary relief, to caregivers of veterans from all eras of military service. Accordingly, DAV supports this legislation and urges its enactment.

DAV urges Congress to provide sufficient program funding to expand and sustain this program's success. We also urge the Committee to consider other needed changes to Section 1720G of title 38, United States Code.

These changes include adding the term "seriously ill" as we believe was intended by Congress under title 38 United States Code, section 1720G(a)(2)(B). Clarification is also needed of the term "independent activity of daily living" contained in 1720G(d)(4)(A) to define "personal care services." VA indicated the statutory term "independent activity of daily living," [d]oes not have a commonly understood usage or meaning," and interprets the phrase to mean, "[p]ersonal functions required in everyday living to sustain health and well-being and keep oneself safe from hazards or dangers incident to one's daily environment.[4] DAV agrees that "independent activity of daily living" is not a commonly used phrase; however, based on the context of the statute, the goal of this program, and VA health care programs and services that allow disabled veterans to remain in the community, we believe it is reasonable for VA to include in its proposed definition, services that provide the veteran assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

The Committee's strong oversight is critical to ensure the effectiveness and viability of this key program. Notably, the two reports on caregiving required by law have yet to be submitted to the House and Senate Veterans' Affairs Committees not later than two years after the effective date (January 30, 2013) on a comprehensive annual evaluation on implementation and on the feasibility and advisability of expand-

[4] 76 Fed. Reg. at 26149.

ing caregiver assistance under Section 1720G of title 38, United States Code, to caregivers of veterans seriously injured in the line of duty prior to September 11, 2001.

DAV and others have submitted comments on VA's Interim Final Rule (IFR) to implement title I of the Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111–163. The natural tendency for Federal agencies in rulemaking is to be intolerant and at times defensive once it makes a formal rule determination. However, VA has testified before this Committee that it considers the IFR to be a good start and that VA is open to suggestions. We urge this Committee to ensure that VA carries out the required good faith and serious consideration of post-promulgation comments from the public on the proposed IFR. Congressional oversight is critical in this instance to ensure the IFR is not perceived as, and is not allowed to become, a monocratic decision.

S. 852, VETERANS HEALTH PROMOTION ACT OF 2013

This bill would establish a new complementary and alternative medicine (CAM) program in the Department of Veterans Affairs, including basic legislative authority; 21 new centers of innovation for CAM in research, education and clinical activities, to include conducting research, education and outreach on CAM. The bill would authorize a series of pilot programs in CAM and wellness, including the award of grants to non-profit entities focused on CAM for veterans with mental health conditions, and for their families who are eligible for counseling from VA's Vet Centers; in health promotion for overweight and obese veterans through direct support of fitness center memberships, and through establishment of fitness facilities within VA medical centers and community-based outpatient clinics. The bill would also authorize a study by an outside entity of barriers to veterans' receiving CAM within VA facilities. The bill would require a series of reports to Congress specific to these authorities, if enacted.

In accordance with DAV Resolution No. 217, adopted by our membership, DAV supports the purposes of the bill to advance CAM initiatives within the VA health care system, in addition to those already in place. Whether the various pilot programs the bill would authorize help cement CAM within VA is difficult to assess, but if VHA establishes the innovation centers as envisioned in the bill, they could serve to spark VHA's existing CAM programs into new areas that could be very helpful to veterans seeking alternatives to traditional health care.

DAV is concerned with one aspect of the bill. It would not only enable CAM practitioners to compete for VA's Medical and Prosthetic Research funding, but in cases of rural CAM practitioners it would promote a "priority" for funding of their research proposals. DAV strongly supports the scientific merit review practices endemic to VA research management of awards; DAV does not recommend specific research be funded by VA; and, we see no justification for granting one type of research proposal a special priority in law, especially if it had the potential to introduce bias in the research award process. Therefore, we ask that this provision be dropped from the bill.

DRAFT BILL, THE VETERANS AFFAIRS RESEARCH TRANSPARENCY ACT OF 2013

This bill would require VA to make available in a publicly accessible form research data from VA-funded projects, and post-publication manuscripts of research funded by VA. The bill would require VA to observe copyright law and to provide reports of activities occurring under this authority subsequent to enactment.

DAV has no resolution from our membership on these specific issues, but we would not object to enactment of this bill.

DAV would again like to thank the Committee for the opportunity to submit our views on the numerous legislative measures under consideration at this hearing. Much of the proposed legislation would significantly improve VA benefits and services for our Nation's servicemembers, veterans and their families.

This concludes my testimony. I am happy to answer any questions Committee Members may have related to my statement.

PREPARED STATEMENT OF IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Bill #	Bill Name	Sponsor	Position
S. 49	Veterans Health Equity Act of 2013	Shaheen	Support
S. 62	Check the Box for Homeless Veterans Act of 2013	Boxer	Support
S. 131	Women Veterans & Other Health Care Improvements Act of 2013	Murray	Support
S. 229	Corporal Michael J. Crescenz Act of 2013	Toomey	Support
S. 287	Bill to amend title 38 to expand the definition of homeless veteran for purposes of benefits under the law.	Begich	Support
S. 325	Bill to amend title 38 to increase the maximum age for children eligible for medical care under CHAMPVA.	Tester	Support
S. 412	Keep Our Commitment to Veterans Act	Landrieu	Support
S. 422	Chiropractic Care Available to All Veterans Act of 2013	Blumenthal	Support
S. 455	Bill to amend title 38 to authorize the Secretary of Veterans Affairs to transport individuals to and from VA facilities.	Tester	Support
S. 522	Wounded Warrior Workforce Enhancement Act	Durbin	Support
S. 529	Bill to amend title 38 to modify the commencement date of the period of service at Camp Lejeune.	Burr	Support
S. 543	VISN Reorganization Act of 2013	Burr	Support
S. 633	Bill to amend title 38 to provide for coverage under the beneficiary travel program	Tester	Support
S. 800	Tetro Garza Far South Texas Veterans Inpatient Act of 2013	Cornyn	Support
S. 825	Homeless Veteran Prevention Act of 2013	Sanders	Support
S. 832	Bill to require the Secretary of Veterans Affairs to carry out certain pilot programs	Donelly	Support
S. 845	Bill to amend title 38 to improve the Department of Veterans Affairs Health Professionals Educational Assistance Program.	Tester	Support
S. 851	Caregiver Expansion and Improvement Act of 2013	Sanders	Support
S. 852	Veterans Health Promotion Act of 2013	Sanders	Support
S. 877	The Veterans Affairs Research Transparency Act of 2013	Begich	Support

Chairman Sanders, Ranking Member Burr, and Distinguished Members of the Committee: On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for this opportunity to share with you our views and recommendations regarding these important pieces of legislation.

IAVA is the Nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is important but simple—to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of over 200,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

IAVA believes that all veterans must have access to quality health care and related services. The men and women who volunteer to serve in our Nation's military do so with the understanding that they and their families will be cared for during their period of service, and also after their period of service should they sustain injuries or disabilities while serving.

S. 49

IAVA supports S. 49, the Veterans Health Equity Act of 2013. Ensuring equal access to quality care and services is critical to helping veterans maintain their qual-

ity of life. This bill ensures that eligible veterans in the 48 contiguous states can receive services in at least one in-state, full-service Department of Veterans Affairs medical center, or receive comparable services provided by contract care.

S. 62

IAVA supports S. 62, the Check the Box for Homeless Veterans Act of 2013, which will allow taxpayers to check a box on their tax forms to indicate that a portion of their tax refund can be donated to the Homeless Veterans Assistance Fund. Homelessness within the veteran community is an alarming trend that deserves national attention and resources, and IAVA stands behind any effort to support ending veterans homelessness and to engage the public in this effort.

S. 131

IAVA supports S. 131, the Woman Veterans and Other Health Care Improvements Act of 2013. IAVA believes that all servicemembers and veterans should be able to pursue one of the most fundamental of American dreams—starting a family. Unfortunately, many of our Nation's severely wounded veterans are not able to pursue this goal as a direct result of their service-connected injuries. This bill will help give these injured veterans an alternative pathway to starting a family if they so choose.

IAVA also believes this bill is a step in the right direction toward eliminating yet another hurdle to mental health care that many veterans with children may experience. By establishing a pilot program to provide child care assistance to veterans receiving or in need of VA readjustment counseling or other mental health services, this legislation helps veterans who need counseling and treatment to also be able to pursue that care.

S. 229

IAVA supports S. 229, the Corporal Michael J. Crescenz Act of 2013. This bill will designate the Department of Veterans Affairs medical center at 3900 Woodland Avenue in Philadelphia, Pennsylvania, as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center."

S. 287

IAVA supports S. 287. This bill would expand the definition of "homeless veteran" to include veterans fleeing domestic violence, sexual assault, or stalking so that they are able to qualify for assistance from the VA under the McKinney-Vento Homeless Assistance Act. The definition of homelessness was updated in the 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act to cover individuals escaping domestic violence. We strongly believe that title 38 must be updated as well to reflect this definition of homelessness and to provide services to those veterans who are fleeing domestic violence.

S. 325

IAVA supports S. 325. With the enactment of the Affordable Care Act, children up to age 26 can now be covered by their parents' health insurance plans. However, these provisions did not extend to recipients of TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). While legislation was subsequently enacted to extend this coverage option to eligible children of TRICARE recipients, no action has been taken on behalf of the same population under CHAMPVA. IAVA believes that we must enact this bill so that CHAMPVA benefits continue to be provided to the children of our Nation's wounded warriors and those who paid the ultimate price in service to our country.

S. 412

IAVA supports S. 412, the Keep Our Commitment to Veterans Act. This bill will authorize the VA to carry out specified major medical facility leases in FY 2013-FY 2014 in New Mexico, New Jersey, South Carolina, Georgia, Hawaii, Louisiana, Florida, Puerto Rico, Texas, Connecticut, and Massachusetts. This bill also reduces lease amounts authorized in previous fiscal years for VA outpatient clinics in Johnson County, Kansas, San Diego, California, and Tyler, Texas.

S. 422

IAVA supports S. 422, the Chiropractic Care Available to All Veterans Act of 2013. This bill will require VA to provide chiropractic care and services to veterans

at all Department of Veterans Affairs medical centers. It will also expand access to chiropractic care to veterans as an option for physical rehabilitation and preventative wellness care. IAVA believes this bill will benefit all veterans who are seeking new options as a part of their overall health care plan. Furthermore, IAVA has always advocated that all veterans should have equal access to VA care and services regardless of where they reside in the Nation. This bill is a step in the right direction toward achieving that goal.

S. 455

IAVA supports S. 455. This bill offers a long-term solution to the VA's Veterans Transportation Service (VTS) program. In 2010 the VA launched its VTS initiative to enhance transportation services for disabled veterans accessing VA health care and resources. However, in the summer of 2012 the VA Office of the Inspector General decided that the VA never had the authority to run such an initiative and thus halted the program. This quickly became a problem in communities throughout the Nation because VTS, which had been in operation for approximately seven months, had been tremendously successful in connecting tens of thousands of veterans to the care they needed. It became clear that while volunteers were providing an amazing service, they, in many instances, were unable to transport veterans who were not ambulatory, required portable oxygen, or had other medical needs associated with their disability. While Congress did answer this need with a one-year extension of the VTS program, IAVA believes that it is time to address the transportation needs of disabled veterans with a more long-term approach. IAVA believes S. 455 will start this process.

S. 522

IAVA is pleased to offer our support for S. 522, the Wounded Warrior Workforce Enhancement Act of 2013. This bill will authorize funding to help schools train more professionals in the fields of orthotics and prosthetics (O&P), and it establishes a second VA Training Center of Excellence for O&P. Today's wounded warriors are returning from combat with injuries that are more complex than those we have seen during past conflicts. These complex wounds require highly trained professionals in specialized fields like O&P. However, while the need for these highly trained professionals is at an all time high, the number of schools designed to train individuals in this complicated field remains incredibly low. The Wounded Warrior Workforce Enhancement Act of 2013 addresses this critical shortage of providers and helps further advancements in the field of O&P so that our wounded warriors can receive the highest quality of care and services available.

S. 529

IAVA supports S. 529, which would modify the date set out in Section 1710(e)(1)(F) of title 38 from January 1, 1957 to August 1, 1953. Public Law 112–84, or the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, provides hospital and related medical services to veterans and their families who were exposed to a contaminated water supply while they were stationed at Camp Lejeune, North Carolina. Since the enactment of this law, further research has shown that the water contamination at Camp Lejeune started in 1953, as opposed to the originally designated year of 1957. IAVA believes it is necessary to care for any servicemember, veteran, or military family member who has suffered an illness or disability as a result of exposure to toxins while serving this Nation.

S. 543

IAVA supports S. 543, the VISN Reorganization Act of 2013. According to numerous reports released by the VA Office of the Inspector General in 2011 and 2012, the Veterans Health Administration has failed to manage and monitor the growth of Veterans Integrated Service Network (VISN) offices. These reports also noted that the VA lacked adequate management controls and needed to improve the quality of VISN office data to oversee and evaluate the effectiveness of VISN staff and organizational structures. IAVA believes that given our Nation's current economic situation and the projected increase of veterans seeking VA care over the next few years, the VA must demonstrate more fiscal responsibility and purpose driven resource allocation. IAVA believes that the VISN structure has grown far beyond its original intent and no longer necessarily functions in the best interest of the veteran or the VA's overall budget. IAVA believes S. 543 will help eliminate duplication of efforts, bring VISN staffing levels back to where they should be, and ultimately offer veterans more options in health care.

S. 633

IAVA supports S. 633, which will authorize the VA to reimburse the travel costs associated with seeking approved in-patient care at a VA Special Disabilities Rehabilitation Program for additional categories of catastrophically disabled veterans. Under current law, the VA reimburses certain veterans for costs associated with travel to and from approved VA medical facilities. However, there are certain categories of catastrophically disabled veterans who are not entitled to this reimbursement. We believe this legislation would provide critical assistance for more disabled veterans to allow them to receive the specialized in-patient treatment they need.

S. 800

IAVA supports S. 800, the Tetro Garza Far South Texas Veterans Inpatient Act of 2013. This bill will require the South Texas VA Health Care Center at Harlingen, Texas to include a full-service inpatient health care facility, an urgent care center, and to provide gender-specific care to women veterans. IAVA supports these requirements given the large veterans population currently residing in this area.

S. 825

IAVA strongly supports S. 825, the Homeless Veterans Prevention Act of 2013. This comprehensive piece of legislation provides a multifaceted approach to assisting the VA in its goal of eradicating veteran homelessness by 2015 and ensuring the safety of veterans while working toward that goal. This piece of legislation also addresses other often-overlooked needs that homeless veterans may have, including free legal services and dental care.

S. 832

IAVA supports S. 832, the Improving the Lives of Children with Spina Bifida Act of 2013. This bill requires the VA to conduct pilot programs for certain services for the children of Vietnam and Korea-era veterans with Spina Bifida and other birth defects. IAVA believes these pilot programs will be helpful in measuring the potential impact of such services on the children of these veterans. They can also provide useful data and metrics for the VA to use should future presumptive conditions arise from the wars in Iraq and Afghanistan. We must ensure that our newest generation of veterans and their families do not have to endure the unnecessary hardships that many Vietnam and Korean War veterans had to endure.

S. 845

IAVA supports S. 845. This bill improves the VA's Health Professional Education Assistance Program by extending the Health Professional Scholarship Program through 2019 and increasing the maximum amount of funding that program participants can receive. These adjustments will be critical in recruiting and retaining high quality health professionals within the VA's health care system. IAVA, also believes this bill will assist the VA in filling certain health care provider vacancies that it has struggled to fill.

S. 851

IAVA supports S. 851, the Caregiver Expansion and Improvement Act of 2013. IAVA believes that every veteran who has sustained severe injuries and illnesses as a result of their service must be cared for, regardless of which war or conflict they served in and when those injuries or illnesses present. Part of caring for our wounded warriors entails caring for the family members who devote their time and their lives to rendering necessary care for those veterans. All of our Nation's veteran caregivers deserve support, and this bill would help provide that support to more veteran caregivers.

S. 852

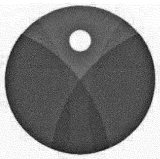
IAVA supports the understood intent of S. 852, the Veterans Health Promotion Act of 2013. IAVA has been a proponent of various types of alternative medicine programs and practices, which many veterans of all generations have found to be very helpful and therapeutic. However, we are still unclear as to the specific complementary and alternative medicine programs referred to in this bill and look forward to finding out more about what these specific programs referred to here would entail.

S. 877

IAVA supports S. 877, the Veterans Affairs Research Transparency Act of 2013. This bill requires the VA to allow public access to research executed by its Department of Research and Development. IAVA believes that transparency as well as the sharing of important findings with the public is an important goal and practice, and this bill will allow and encourage those types of practices with respect to VA research.

We again appreciate the opportunity to offer our views on these important pieces of legislation, and we look forward to continuing to work with each of you, your staff, and the Committee to improve the lives of veterans and their families. Thank you for your time and attention.

PREPARED STATEMENT OF INTEGRATIVE HEALTHCARE POLICY CONSORTIUM



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May 8, 2013

Committee on Veterans' Affairs
United States Senate
Senator Bernie Sanders, Chair
Washington, DC

RE: S 852

Dear Senator Sanders and Members of the Senate Committee on Veterans' Affairs:

The Integrative Healthcare Policy Consortium (IHPC) is pleased to provide this letter in support of S. 852, the Veterans' Health Promotion Act of 2013. IHPC is the consensus voice of 14 healthcare organizations including the American Medical Student Association (AMSA) and the MD-led integrative pain organization, the American Academy of Pain Management (AAPM). IHPC 's base of organizations and educational institutions represent the 375,000 licensed, whole person-oriented integrative healthcare disciplines including chiropractic, acupuncture, naturopathy, certified professional midwifery, massage therapy and homeopathy. IHPC is delighted to see the language in this bill supporting the provision of complementary and alternative medicine (CAM) as part of an integrative approach to healthcare for our veterans and we fully support efforts to make it readily available to Americans, including both veterans and non-veterans.

We would like to call your attention to page 7 of the bill, in section (2)(A), where the bill states, "Covered services shall be administered by clinicians who exclusively provide services consisting of complementary or alternative medicine" [emphasis added]. We believe the current wording could unintentionally and unnecessarily restrict some integrative healthcare providers from providing the full array of services within their scope of practice. We assume the intent of the word "exclusively" is to provide for the *inclusion* of providers who exclusively practice CAM, which we support; however, use of this word also would serve to *exclude* many providers who combine conventional medical approaches with CAM approaches. IHPC takes the position that neither conventional medicine nor CAM is optimal as a stand-alone approach; rather, it is the *integration* of these approaches that provides optimal care, and excluding providers who do that within their own practices may limit proper healthcare to our veterans.

We will be following the progress of S. 852 with great interest, and stand ready to assist the committee and others in Congress in understanding the great importance of this bill, as well as to helping in any way with the implementation of the Centers of Innovation when S. 852 becomes law, including the challenges of credentialing. Thank you for your interest in this issue, and for considering our position.

Sincerely,

Leonard Wisneski, MD, FACP
IHPC Board of Directors, Chair

PREPARED STATEMENT SUBMITTED BY JANET R. KAHN, PH.D., LMT, PRESIDENT AND CEO, PEACE VILLAGE PROJECTS, INC.

I thank Senator Sanders and Members of the Committee for the opportunity to offer a statement for the record regarding pending legislation to increase access to complementary and alternative medicine and other preventive and wellness oriented care, for those receiving health care through the Department of Veterans' Affairs. This is important legislation with real promise to address the physical, mental and spiritual injuries incurred in war, and I am honored to address to it.

My name is Janet Kahn. I am a medical sociologist, a massage therapist, and a social scientist actively engaged in research with veterans of Iraq and Afghanistan. I am Research Assistant Professor in the Department of Psychiatry at the University of Vermont, where we have a MindBody Medicine Clinic. I currently serve the Federal Government as a member of the Advisory Group on Prevention, Health Promotion and Integrative and Public Health, for which I chair the Working Group on Integrative Healthcare. Previous service includes terms as a member the National Advisory Council for NIH's National Center for Complementary and Alternative Medicine, and reviewer for the Institute of Medicine on their Report of the Committee on the Use of Complementary and Alternative Medicine by the American.

I am also President of Peace Village Projects (PVP), a 501(c)(3) non-profit organization of Burlington, Vermont and Acton. PVP engages in both educational and research efforts, and is currently involved in a Phase II SBIR grant from NIMH entitled "Mission Reconnect: Promoting Resilience and Reintegration of Post-Deployment Veterans and their Families," for which I am I am Co-Principal Investigator with William Collinge, Ph.D. As a Vermonter I am particularly interested in provision of care to veterans in rural areas and those too far from care to access it easily. I am also aware that many veterans perceive, somewhat accurately, that there may be a career price paid for accessing mental health services. For that reason, Mission Reconnect is designed as a self-education program in which veterans and their partners are provided with media materials through which they teach themselves mind-body techniques known to beneficially alter neurochemistry (e.g. increase of serotonin production, decrease of cortisol), which in turn may render a veteran more able to benefit from contemplative techniques to quiet the mind, control anger, etc.

While Phase I data (see below) indicate positive results from Mission Reconnect, and demonstrate veterans' openness to these therapies, I have no doubt that the best care for the mental health spectrum we address—which is worried well through high PTSD—would be a combination of in-person treatment by professionals supplemented by a Mission Reconnect-like program that the veteran can use at home, on their own schedule, as often as they like. The pending "Veterans Health Promotion Act of 2013" will make this possible, at the same time that it makes possible complementary and alternative medicine care for veterans with acute and chronic pain conditions.

In addition to mind-body and contemplative techniques, Mission Reconnect provides veterans and their partners instruction in relaxation massage techniques which Phase I participants found very helpful in reducing pain and anxiety and in promoting better sleep. Sleeplessness is a serious issue for veterans and exacerbates other problems including irritability, pain levels and more. A growing body of literature indicates that therapeutic massage enhances sleep and we were delighted to find that this was true even of non-professional partner-provided massage. Given the findings of Mission Reconnect, I encourage you to be sure that the legislation is written such that educational programs may be included along with complementary and alternative health care clinical treatments.

While I am aware that the VA generally treats only the veteran, not family members, I have become acutely aware of the extent of secondary trauma suffered by spouses of veterans with PTSD. In addition, the design of Mission Reconnect draws on lessons learned in 1995 when PVP was unexpectedly drawn into teaching Israeli and Palestinian parents touch-based and mind-body techniques to ease children who were suffering from war trauma. In fact, we were asked to treat children who had gone mute from war trauma. Despite having been a massage therapist since 1969, I was stunned to see the power of touch with these children, a number of whom cried and then spoke for the first time in a few years.

While the children of U.S. veterans have not experienced the immediate danger and trauma faced by Palestinian and Israeli children in the 1990's, our children are suffering and it is possible that complementary and alternative medicine care and education would be helpful to the entire family. Perhaps there can be at least one Center of Innovation allowed to conduct research on this.

The VA and the Department of Defense have each served at times as leaders for this country in advancing health care, as well as other areas of science and technology. A solid body of literature indicates the potential of individual complementary and alternative medicine therapies and of integrated healthcare for servicemembers and civilians alike. The potential of integrated care can only be explored when lack of reimbursement and other obstacles to complementary and alternative care are removed. I believe that S. 852 will give us the opportunity to pilot these methods responsibly within the VA in ways that target the mental health and pain issues with which so many of our soldiers are returning home. I expect this will be another instance in which the country learns from the VA.

The attention given in the bill to staff training, and the decision to coordinate this through Dr. Gaudet's Office of Patient Centered Care and Cultural Transformation are important. My experience at the Community Health Center of Burlington included critical lessons about the challenges of integration in a clinic whose staff had not chosen specifically to work in an integrated environment. Many integrated clinics in the US are private clinics attracting a workforce seeking an integrated care environment. That will not be true of the whole VA. The training, beginning with listening to the staff of the VA Centers for Innovation, will be a critical element in the success of this program.

I applaud the intention and design of this bill and commend you for taking the initiative in this vital area.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Sanders, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. These important bills will help ensure that veterans receive the best health care services available to them.

S. 49, THE "VETERANS HEALTH EQUITY ACT OF 2013"

PVA does not support S. 49, the "Veterans Health Equity Act of 2011," which proposes to amend title 38, U.S.C. to require veterans to have access to at least one full-service Department of Veterans Affairs (VA) medical center in each of the 48 contiguous states, or have access to hospital care and medical services comparable to the services typically provided by full-service VA medical centers through contract with health care providers in the state. Under this legislation, if a VA medical center is not a full-service facility, "does not provide hospital care, emergency medical services, and surgical care that is rated by the Secretary as having a surgical complexity level of 'standard,'" veterans may utilize contracted services from private health care providers in their state. While this legislation is an attempt to address issues involving access to health care, PVA believes that if enacted, S. 49 will lead to diminution of VA health care services, and increased health care costs in the Federal budget. This legislation would turn VA's current fee-basis policy, which allows VA to purchase care from a private provider when VA medical care is not "feasibly available to veterans," into a permanent treatment plan.

While access is indeed a critical concern for PVA, we believe VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Unfortunately, funding for VA health care in the past has had difficulty keeping pace with the growing demand. Even with the passage of Advance Appropriations and record budgets in recent years, funding is not guaranteed to be sustained at those levels and PVA is concerned that contracting health care services to private facilities is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care.

PVA is also concerned about the continuity of care. The VA's unique system of care is one of the Nation's only health care systems that provides developed expertise in a broad continuum of care. The VA provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, Traumatic Brain Injury, prosthetic services, mental health, and war-related polytraumatic injuries. Coordination of such care is critical to providing veterans quality care, and contracting out to private providers will leave the VA with the difficult task of not only ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care, but also coordinating the various types of care that may be provided by a contractor. The quality of VA's health care and "veteran-specific" expertise cannot be adequately duplicated in the private sector.

For these reasons, PVA does not support S. 49, and strongly believes that VA remains the best option available for veterans seeking health care services.

S. 62, THE "CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013"

PVA does not have a position on the, "Check the Box for Homeless Veterans Act of 2013," a bill to amend the Internal Revenue Code of 1986 to allow tax payers to designate overpayments of tax as contributions and to make additional contribu-

tions to the Homeless Veterans Assistance Fund. PVA, however, fully supports the VA and the Secretary's goal to eradicate homelessness among veterans.

S. 131, THE "WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013"

PVA strongly supports S. 131, the "Women Veterans and Other Health Care Improvements Act of 2013." If enacted, this bill would improve health care services for women veterans within the VA.

PVA is particularly pleased to see the provisions related to reproductive services for catastrophically disabled service-connected veterans. One of the most devastating results of spinal cord injury or dysfunction for many individuals is the loss of the ability to have children and raise a family. PVA has long sought inclusion of reproductive services in the spectrum of health care benefits provided by the VA. Sections 2, 3 and 4, of the proposed legislation are significant steps in securing these much needed and long overdue treatment modalities that are critical components of catastrophically disabled veterans' maximization of independence and quality of life.

Advancements in medical treatments have for some time made it possible to overcome infertility and reproductive disabilities. For some paralyzed veterans procreative services have been secured in the private sector at great cost to the veteran and family. In April 2010, a Memorandum promulgated by the Office of the Assistant Secretary of Defense (Health Affairs) extended reproductive services, including in-vitro fertilization, to servicemembers and retired servicemembers who had a loss of reproductive ability due to serious injury while on Active Duty. The Memorandum notes "Although many medical and other benefits are available to these members and their families, members with spinal and other injuries that make it impossible to conceive a child naturally are not provided TRICARE coverage, which can assist them in becoming a parent."

An implementing guidance memorandum described available reproductive services as sperm retrieval, oocyte retrieval, in-vitro fertilization, artificial insemination, and blastocyst implantation. Similar to the Department of Defense's recognition that reproductive services are crucial elements in affording catastrophically disabled individuals and their spouses with life-affirming ability to have children and raise a family, so too will passage of the provisions of this bill that authorize the VA to offer similar services to veterans disabled in service to the Nation.

This bill also proposes to improve the VA's Women Veterans Contact Center by making information involving health care services and benefits, provided in the community or by the VA, readily available to women veterans when it is requested. PVA believes that the VA must continue working toward developing a comprehensive model of care that provides woman veterans with a variety of quality services. As the number of woman veterans seeking health care services and benefits through the VA continues to increase, we must not only work to improve the variety of services available to meet women's health care needs, but also work to ensure that there is adequate care coordination and referral services with the non-VA providers as well. Care coordination is the only way to monitor the quality of care provided to women veterans outside the VA health care system. Women veterans are one of the fastest growing populations within the VA health care system and we must make certain that they have access to, and receive, quality health care services.

PVA also supports the proposed modifications of the pilot program for counseling in retreat settings for women veterans newly separated from service, and the assistance programs for child care for certain veterans. Providing veterans with child care assistance eliminates a barrier to care that prevents many veterans from receiving appropriate health services.

S. 229

PVA's National office has no position on naming the VA medical center in Philadelphia, Pennsylvania as the "Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. With that in mind, we would defer to the views of PVA's Keystone Chapter or to our Colonial Chapter.

S. 287

PVA supports S. 287, a bill that expands the legal definition of "homeless veterans" to align with the commonly accepted legal standard for homelessness that exists in this country. Due to an oversight in the law, the legal definition of "homeless veterans" differs significantly from the existing definition of homelessness. Specifically title 38 U.S.C. does not recognize as being homeless an "individual or family

who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation" (42 U.S.C. § 11302b). The wording change proposed by S. 287 would allow veterans who experience a domestic violence situation, and choose to leave that situation, to access the same benefits available to all other homeless veterans. Currently, in order to qualify for benefits offered to homeless veterans through the VA, an individual must only meet the definition of homeless in outlined by 42 U.S.C. § 11302a. It only makes sense that the VA's definition for homelessness align with the larger Federal standard.

S. 325

PVA supports S. 325, legislation to amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) program. CHAMPVA is a comprehensive health care program in which the VA shares the cost of covered health care services for eligible beneficiaries, including children up to age 21. As a part of health reform, all commercial health insurance coverage, as well as health care coverage provided to servicemembers and their families through TRICARE, the age for covered dependents to receive health insurance on their parents plan was increased from 21 years of age to 26 years, in accordance with the provisions of Public Law 111–148, the "Patient Protection and Affordable Care Act."

At this time the only qualified dependents that are not covered under a parent's health insurance policy up to age 26 are those of 100 percent service-connected disabled veterans covered under CHAMPVA. This unfortunate oversight has placed a financial burden on these disabled veterans whose children are still dependent upon the parents for medical coverage, particularly if the child has a preexisting medical condition. This legislation makes the necessary adjustment in this VA benefit.

S. 412, THE "KEEP OUR COMMITMENT TO VETERANS ACT"

PVA supports S. 412, a bill which would authorize major medical leases by the Veterans Health Administration (VHA). However, we remain concerned with the ongoing problem VHA has to complete a number of capital leases as a result of new rules that the Congressional Budget Office (CBO) is now using to score the costs of those leases. Last year, CBO changed its methodology for estimating costs of capital leases. While previously, CBO recognized that capital lease costs were spread out over a 15 or 20-year period, now the CBO scores all of the cost of a major capital lease up front. This leads to lease authorization legislation having very large cost estimates. As a result, without having a method to pay this high cost, legislation is essentially blocked from consideration. This has left a number of major medical facility leases in limbo with many more still pending. We encourage the Committee and Congress to take whatever action is necessary to correct this action by CBO. Otherwise, veterans face the real possibility of not receiving critical care as a result of political nonsense.

S. 422

PVA supports the provisions of S. 422, the "Chiropractic Care Available to All Veterans Act." Chiropractic care has become a widely accepted and used medical treatment. It is a treatment covered by TRICARE and it is only appropriate that it should be provided at VA facilities. But it is also important for the Subcommittee to recognize that by providing this treatment benefit to veterans, it will entail a new type of care which is currently not considered in funding. When new treatments are authorized at VA facilities, they must be considered when determining VA appropriations to prevent those becoming unfunded mandates.

S. 455

PVA supports S. 455, a bill to amend title 38 U.S.C. to authorize the Secretary of Veterans Affairs to transport individuals to and from facilities of the VA in connection with rehabilitation, and counseling required by the Secretary; or for the purpose of examination, treatment, or care. Often disabled veterans do not have adequate access to health care services because they do not have transportation that is cost efficient or accessible. While PVA believes that S. 455 is a step toward the elimination of transportation as a barrier to health care access, we strongly suggest that language be included in the bill that requires the VA to provide accessible transportation for disabled veterans, specifically veterans who have incurred a spinal cord injury or disorder, or veterans who use a wheelchair. For disabled veterans

who do not have personal means of transportation, arranging for accessible transportation can be very arduous and time consuming. Unfortunately, it is not uncommon for disabled veterans who are not able to drive themselves to delay medical visits until transportation can be arranged or forgo medical attention completely. PVA believes that authorizing the VA to provide veterans with accessible transportation to and from VA facilities will increase veterans' access to care.

S. 522

PVA does not have a position on S. 522, the "Wounded Warrior Workforce Enhancement Act," legislation that would provide funds for the VA to award grants to eligible institutions to assist in establishing post- graduate degree programs in orthotics and prosthetics, or to expand on existing masters or doctoral programs. PVA members utilize VA prosthetic services on a regular basis and rely on prosthetics devices daily, and therefore, we fully support and understand the importance of enhancing the quality of VA prosthetic services, and developing a professional staff that is able to meet the complex prosthetic needs of veterans. While PVA supports increased promotion and development of professionals in the field of prosthetics, we believe that any partnership that VA enters into with an educational institution must include specific agreements that help VA recruit and retain quality professionals in the field of prosthetics.

S. 522 would also provide funds to an institution with experience in these areas to establish a Center of Excellence in orthotic and prosthetic education. While PVA agrees that such a center is much needed to conduct research, and coordinate and disseminate information involving veterans and prosthetics, it must first be determined if it is best for both veterans and the VA to have such a center established within the VA or with an outside entity. PVA believes that the primary focus of a Center of Excellence in Orthotic and Prosthetic Education should be the prosthetic needs of veterans.

S. 529

PVA has no objection to the provisions of S. 529. However, we believe that the emphasis should be placed on providing the VA Secretary all the discretion necessary to make a determination as to the commencement date for the period of military service to establish the eligibility for hospital care and medical services provided to servicemembers and their families who experienced toxic exposure at Camp Lejeune, North Carolina. In fact, we believe that a specific delimiting date should be removed all together.

S. 543, THE "VISN REORGANIZATION ACT OF 2013"

PVA opposes S. 543, a bill that would establish a new organizational structure for the alignment of the Veterans Integrated Service Networks (VISN) around the country. PVA has serious concerns about the precedent that this legislation would set. The VA currently uses the VISN structure as a management tool for the entire VA health care system. It makes no sense for Congress to legislate how the VA should manage its system. Furthermore, this sets a dangerous precedent whereby any member could decide that the VA's VISN alignment is not satisfactory (in their opinion), and that it should be redrawn in such a way to support his or her own state or district.

However, we believe that the current network alignment could be reassessed and possibly realigned. There is certainly nothing that suggests that 21 service networks is the optimal structure. But where does the VA draw the line when establishing its health care system structure? With the current 21 VISN's, the VA seems to do a good job of managing a massive health care system. This is not to suggest that the administration of these networks is not bloated, but the alignment itself seems satisfactory.

Meanwhile, it is our understanding that the Veterans Health Administration is already considering a realignment of its VISN structure. With this thought in mind, we believe it would be prudent to withhold this proposed legislation until all of the details of the VA's plan can be assessed.

S. 633

PVA strongly supports S. 633, a bill to amend title 38, United States Code, to provide for coverage under the beneficiary travel program of the VA of certain disabled veterans for travel in connection with certain special disabilities rehabilitation. If enacted, this legislation would provide reimbursement for travel that is in connection with care provided through a VA special disabilities rehabilitation program to

veterans with a spinal cord injury or disorder, double or multiple amputations, or vision impairment. Such care must also be provided on an inpatient basis or during temporary lodging at a VA facility. For this particular population of veterans, their routine annual examinations often require inpatient stays, and as a result, significant travel costs are incurred by these veterans. Too often, catastrophically disabled veterans choose not to travel to VA medical centers for care due to significant costs associated with their travel. When these veterans do not receive the necessary care, the result is often the development of far worse health conditions and higher medical costs for the VA. For veterans who have sustained a catastrophic injury like a spinal cord injury or disorder, timely and appropriate medical care is vital to their overall health and well-being.

PVA believes that expanding VA's beneficiary travel benefit to this population of severely disabled veterans will lead to an increasing number of catastrophically disabled veterans receiving quality comprehensive care, and result in long-term cost savings for the VA. Eliminating the burden of transportation costs as a barrier to receiving health care, will improve veterans' overall health and well being, as well as decrease, if not prevent, future costs associated with both primary and long-term chronic, acute care.

S. 800, THE "TRETO GARZA FAR SOUTH TEXAS VETERANS INPATIENT CARE ACT OF 2013"

PVA generally supports the provisions of S. 800, the "Treto Garza Far South Texas Veterans Inpatient Care Act." This bill would ensure that the Department of Veterans Affairs (VA) has the resources and capacity to meet the health care needs of veterans living in the Far South Texas area. Specifically, this bill will require the VA medical center in Harlingen, Texas, to provide "full-service" inpatient health care for veterans in Far South Texas. This legislation improves access to VA health care for approximately 108,000 veterans.

We do have questions about the provisions of the legislation that specifically require adding inpatient beds, an urgent care center, and women veterans' services. It is our understanding that this facility and its network have established a women veterans' health care program. Additionally, we are uncertain as to what analysis has been done to justify the increased number of inpatient beds. We certainly see no problem with providing urgent care services, if those services do not already exist at this facility.

However, PVA's National office has no position on naming the VA medical center in Harlingen, Texas as the "Treto Garza South Texas Department of Veterans Affairs Health Care Center. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. With that in mind, we would defer to the views of PVA's Lonestar Chapter or Texas Chapter.

S. 825, THE "HOMELESS VETERANS PREVENTION ACT OF 2013"

PVA supports S. 825, the "Homeless Veterans Prevention Act of 2013," a bill that will help insure the safety of facilities that offer services to homeless veterans and extend VA's authority to provide and fund support programs and services for veterans. Many of the grant programs outlined in the legislation will help veterans who are homeless, or facing the prospect of homelessness, overcome the hurdles that prevent them from becoming socially and financially established. PVA believes that S. 825 is in direct alignment with Secretary Shinseki's goal of eradicating homelessness among America's veterans. Ultimately, in order to ensure that the myriad of homeless programs are successful, fully sufficient resources must be provided to these programs. Otherwise, overcoming homelessness becomes a policy without the possibility of true success.

S. 832

PVA supports, S. 832, the "Improving the Lives of Children with Spinal Bifida Act of 2013." This legislation would require the VA to carry out two pilot programs that furnish case management services and assisted living to children of Vietnam veterans, and certain Korea service veterans born with Spina Bifida and children of women Vietnam veterans born with certain birth defects. When living with physical disabilities and disorders such as Spina Bifida, the impact of associated illnesses and complications requires frequent medical visits and various types of routine medical treatments and therapies. Managing such care can be extremely difficult and overwhelming. Providing case management services will help ensure that proper care is received by the children of veterans who are living with Spina Bifida. PVA believes that both pilot programs promote independence and allow people with dis-

abilities a degree of personal freedom, and give them the opportunity to become a part of and engaged in their local communities.

S. 845

PVA strongly supports, S. 845, a bill to amend title 38 U.S.C., to improve the VA Health Professionals Educational Assistance Program. Maintaining a skilled and competent professional staff is critical to the successful delivery of high-quality VA medical services. Extending the Health Professionals Educational Assistance Program will not only serve as a recruitment incentive for potential VA employees, but also prove to be an effective retention tool within VHA. This legislation also proposes to repeal the cap on the amount of the Education Debt Reduction Program (EDRP). PVA supports this change and believes that as educational costs continue to rise and new professional graduates enter the workforce with educational debt, this is a benefit that the VA must improve in order to attract the highest caliber of new graduates and students from degree programs to provide quality care to veterans, and remain competitive with private sector employers in the health care industry.

S. 851, THE "CAREGIVER EXPANSION AND IMPROVEMENT ACT OF 2013"

PVA fully supports S. 851, the "Caregiver Expansion and Improvement Act of 2013." This legislation addresses the greatest concern that we had with the original legislation when this program was established. PVA was extremely disappointed that veterans who became injured or ill prior to September 11, 2001, were excluded from the comprehensive caregiver support programs. The fact is, PVA's members—veterans with spinal cord injury or disorder—would benefit from this program more than any other population of veterans. And yet, the majority of those veterans were excluded by the arbitrary date of September 11, 2001, from the comprehensive caregiver program. No reasonable justification (other than cost considerations) can be provided for why pre-9/11 veterans with a service-connected injury or illness should be excluded from the comprehensive caregiver program. Catastrophically disabled veterans needs are not different simply because they may have been injured prior to the selected date.

PVA also encourages the Committee to consider amending the legislation to ensure that veterans who have incurred a catastrophic illness or disease will benefit from the caregiver program. Currently, veterans who have incurred a severe illness or disease as a result of their service are excluded from consideration as eligible for this program. This proposed legislation excludes these veterans as well. Aside from the fact that nearly all PVA members are unfairly excluded from this program, the second biggest complaint that we have received from our members who are eligible under the Post-9/11 criteria for this program is the exclusion for serious illnesses or diseases. A spinal cord disease is no less catastrophic than a spinal cord injury. It is a fact that veterans who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and Multiple Sclerosis (MS) will eventually experience a catastrophic impact on their activities of daily living. And yet, these individuals who may be in greater need of caregiver services than any other population of injured veterans have no avenue for support through the new caregiver program. We strongly urge the Committee to consider these issues when marking up this legislation.

Additionally, we urge the Committee to follow through on oversight regarding the reporting requirements that the VA has as a result of Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act." In accordance with the provisions of the law, the VA is required to report on the feasibility of expanding the caregiver program. Specifically, the law states:

> "Not later than 2 years after the date described in subsection (a)(3)(A), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of expanding the provision of assistance under section 1720G(a) of title 38, United States Code, as added by subsection (a)(1), to family caregivers of veterans who have a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service before September 11, 2001."

As of this time, the VA has already missed its deadline for submitting this important report. We understand that VA is currently in the process of developing this report. However, the Committee must not allow the VA to simply choose to ignore this requirement so as not to draw attention to an obvious deficiency in the caregiver program that it cannot or will not be able to implement. The VA must ensure that it fulfills this reporting requirement as it is an integral part of the implementa-

tion of the caregiver program. This critical report will pave the way to access to much-needed caregiver assistance for many more catastrophically disabled veterans who are currently being denied eligibility simply because of the arbitrary date assigned to this benefit by Congress.

S. 852, THE "VETERANS HEALTH PROMOTION ACT OF 2013

PVA does not have a position on S. 852, the "Veterans' Health Promotion Act of 2013," a bill to improve health care furnished by the VA by increasing access to complementary and alternative medicine and other approaches to wellness and preventive care. Nonetheless, PVA fully supports the use of complementary and alternative medicine and believes such care options will give veterans with catastrophic injuries and disabilities additional options for pain management and rehabilitative therapies. However, PVA cautions VA to make certain that clinicians utilize evidence-based therapies when selecting complementary and alternative forms of medicine. Veterans' safety and overall health and well-being must not be compromised. PVA also believes that the implementation of preventive health programs within VA will potentially lead to positive health outcomes for veterans, as well as create long-term cost savings for the VA if veterans are informed of the prevention health services and incentivized to use them.

THE "VETERANS AFFAIRS RESEARCH TRANSPARENCY ACT OF 2013"

PVA supports the "Veterans Affairs Research Transparency Act." PVA is intimately involved in research activities, funding a great deal of research in the areas of spinal cord injury and disorder with the long-term goal of finding a cure for spinal cord injury. We certainly recognize the benefits of having information about research activities being conducted through VA available to the larger public. Much of the American public is not even aware of the great advancements and discoveries that have been made through the efforts of VA research. This legislation should help disseminate that work.

However, we would offer a couple of cautions as this legislation is considered. First, we must emphasize the importance of confidentiality of any human subjects involved in the research that is made available. Additionally, we believe some clarification is necessary to address copyright and intellectual property issues that may arise from outside entities accessing research that VA essentially owns.

PVA would once again like to thank the Committee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care services available to veterans, servicemembers, and their families. We would be happy to answer any questions that you may have for the record.

PREPARED STATEMENT OF SERVICE WOMEN'S ACTION NETWORK

Chairman Sanders, Ranking Member Burr and distinguished Members of the Committee: Thank you for the opportunity to submit written testimony for the record and thank you for your continued leadership on veteran's issues and for convening this hearing today.

The Service Women's Action Network (SWAN) is a non-profit, non-partisan veterans led civil rights organization. SWAN's mission is to transform military culture by securing equal opportunity and freedom to serve without discrimination, harassment or assault; and to reform veterans' services to ensure high quality health care and benefits for women veterans and their families.

We challenge institutions and cultural norms that deny equal opportunities, equal protections, and equal benefits to servicemembers and veterans. SWAN is not a membership organization, instead we utilize direct services to provide outreach and assistance to servicemembers and veterans and our policy agenda is directly informed by those relationships and that interaction.

SWAN extends opportunities to and promotes the voices and agency of service women and women veterans without regard to sex, gender, sexual orientation or gender identity or the context, era, or type of their service.

SWAN welcomes the opportunity to share our views on three of the bills before the Committee today, S. 131, the Woman Veterans and Other Healthcare Improvement Act of 2013, S. 287, a bill to amend title 38, United States Code, to expand the definition of homeless veteran for purposes under the laws administered by the Secretary of Veterans Affairs and S. 325, the proposed bill to amend title 38, United States Code and increase the maximum age for children eligible for medical care under CHAMPVA.

S. 131

SWAN supports S. 131. This bill will provide access to much needed fertility treatments for seriously injured veterans and their spouses, research into infertility treatments adoption assistance, permanent authority for VA to provide child care, and in addition improve the responsiveness of the VA to women's health issues and significantly expand a critical pilot program for women's VA heath retreat centers.

After a decade at war, many women servicemembers are still at risk for reproductive and urinary tract issues due to deployment conditions and a lack of predeployment women's health information, compounded by privacy and safety concerns. Moreover, the nature of the current conflict and increasing use of improvised explosive devices leaves both men and women servicemembers far more susceptible to blast injuries including spinal cord injury and trauma to the reproductive and urinary tracts. Pentagon data shows that between 2003 and 2008 nearly 2,000 women and men suffered these life-altering battle injuries while serving in Iraq or Afghanistan.[1]

Infertility is a devastating diagnosis to receive and it is further complicated by a lack of access to readily available infertility treatments. S. 131 would provide research, treatment and adoption assistance to veterans grievously wounded in the line of duty and allow them to have the family that many of them right now can only dream of having.

Additionally, S. 131 would assist VA in making greater strides in improving the area of women's health services. The bill would enhance the Department of Veterans Affairs women veterans contact center to respond to requests for assistance with accessing health care and providing referrals. It would also improve the VA's women's health retreat pilot program by more than quadrupling the number of facilities (from 3 to 14) and doubling the length of the program.

It is important for the Committee to note that more than 250,000 women have served in Iraq and Afghanistan, and as the population of women veterans continues to grow, VA must continue to adapt to meet the unique health care needs of women veterans and their families. VA has taken steps in this direction, yet studies have indicated that women veterans who use VA services reported a lower quality of care and higher dissatisfaction compared to women using outside care.[2] Clearly more work remains to make VA a friendly environment for women veterans.

S. 287

SWAN supports S. 287. This is an extremely important bill that ensures veterans fleeing domestic violence or another life threatening condition are eligible for VA homeless assistance. The 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act updated the definition of homelessness to cover individuals fleeing domestic violence. However, the definition of "homeless veteran" was not updated to reflect this change. The Department of Veterans Affairs has developed a number of programs to assist homeless veterans, however the outdated definition of "homelessness" could cause problems for victims of domestic violence. S. 287 addresses this issue by updating the legal definition of "homeless veteran" to bring it to the same standard as the rest of the law, and it will allow veterans who are in a domestic violence situation to access the same benefits available to other homeless veterans. It corrects a grievous oversight and will allow those who have served our country and find themselves in difficult and dangerous domestic violence situations to receive the support and benefits they have earned.

S. 325

SWAN supports S. 325. This common-sense bill would allow CHAMPVA beneficiaries to keep coverage until age 26. Currently, beneficiaries lose coverage at age 18 unless they are enrolled as full-time students. Then, they become ineligible at age 23. The bill would create program parity with age requirements of the Affordable Care Act, which now allows adult children to remain on their parents' health insurance until age 26. This bill is similar to a law passed in January 2011 that increased coverage for adult children of TRICARE beneficiaries, bringing it on par with the Affordable Care Act.

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[1] http://blogs.seattletimes.com/today/2012/12/senate-lifts-ban-on-va-funding-for-in-vitro-fertilization/

[2] Kelly et al. 2008. "Effects of Military Trauma Exposure on Women Veterans' Use and Perceptions of Veterans Health Administration Care." Journal of General Internal Medicine 23 (6):741–747.

Again, we appreciate the opportunity to offer our views on these key bills and we look forward to continuing our work together to improve the lives of veterans and their families. Any questions can be directed to Greg Jacob, Policy Director at 646–569–5216 or greg@servicewomen.org.

PREPARED STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

WITH RESPECT TO S. 49, S. 62, S. 131, S. 229, S. 287, S. 325, S. 412, S. 422, S. 455, S, 522, S. 529, S. 543, S. 633, S. 800, S. 825, S. 832, S. 845, S. 851, S. 852, AND DRAFT LEGISLATION

S. 49, VETERANS HEALTH EQUITY ACT OF 2013

VA routinely assesses veterans' health care access needs through its Strategic Capital Investment Plan (SCIP). SCIP prioritizes all levels of construction projects based on a scoring system, placing those with the highest score at the top of the list. This model of evaluation and resource allocation allows for equitable and consistent distribution of capital funding. However, for SCIP to fully be realized, sufficient funding must accompany the plan.

The requirement in S. 49 mandating VA to maintain a full-service medical center in each of the 48 contiguous states could cause funding for a higher priority construction project to be redirected. The VFW does encourage VA to reevaluate New Hampshire, to ensure at any gaps in service are identified and prioritized by SCIP.

S. 62, CHECK THE BOX FOR HOMELESS VETERANS ACT OF 2013

The VFW appreciates the spirit of this legislation, but has some reservations about the possible negative unintended consequences of creating non-traditional funding sources for important VA programs. This bill would give taxpayers the option of donating to a new Homeless Veterans Assistance Fund, which would be established through the U.S. Treasury, by checking a box on their annual tax returns. That money would then be made available to VA, the Department of Labor, and the Department of Housing and Urban Development, for the purposes of supporting programs that serve homeless veterans. It also provides for oversight of the Homeless Veterans Assistance Fund by requiring that the secretaries of the aforementioned departments submit detailed expenditure plans prior to using the funds, and that the use of the funds for the prior and upcoming years must be described in the President's annual budget submission.

Although the VFW commends the intent of this legislation which is designed to support the administration's goal of ending homelessness by 2015, we are concerned that the establishment of the Homeless Veterans Assistance Fund may create the rationale for future reductions in traditional funding for homeless veterans' programs. VA has made marked and consistent progress toward that goal over the past several years through adequate funding for effective initiatives such as Supportive Services for Veterans Families, the Grant Per Diem Program, the Homeless Veterans Reintegration Program, and HUD-VASH vouchers. The VFW feels that now is not the time to experiment with alternative funding sources for these critical services. We must continue to pay for these programs with congressionally appropriated dollars in order to ensure that they receive consistent and reliable funding levels.

S. 131, WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2013

A decade of war has put servicemembers at risk for experiencing reproductive and urinary tract issues due to the lack of pre-deployment health information, and the use of improvised explosive devices (IED) leaving many more susceptible to blast injuries including trauma to the reproductive areas. DOD has reported that from 2003 to 2011at least 2,000 servicemembers have suffered from reproductive and/or urinary tract trauma.

Providing reproductive services that meet the complex needs of our severely wounded veterans is critical in helping many move forward with their lives and aspirations. Dreams of having a family often are at the top of the list. Currently, VA offers some fertility services, but they often do not meet the needs of those severely injured with more complex reproductive needs (In-vitro fertilization or IVF is excluded from VA medical benefits package under 38CFR 17.38 (c) (2)).

The VFW thanks Senator Murray for taking the lead on this issue and supports Sections 2 and 3 which will provide fertility counseling and treatment to include assisted reproductive technology, like IVF, to a spouse or surrogate of a severely

wounded, ill or injured veteran who has an infertility condition which was incurred in the line of duty or while on active duty. The patient must be enrolled in VHA and, in the case of a spouse or surrogate of a veteran not enrolled, VA would coordinate fertility and counseling for them. VA is not required to find or certify a surrogate, or connect the veteran with a surrogate, or provide maternity care for the spouse or surrogate, which will negate any legal issue that may arise during the process.

The legislation also calls on VA to conduct collaborative research with DOD and Health and Human Services (National Institutes of Health) to address the long-term reproductive health care needs of veterans with service-connected reproductive injuries. We believe that this research is critical in addressing and treating the unique infertility issues of veterans with combat injuries now and in to the future.

The VFW also supports section 9 which improves access to services for women veterans through VA's Women Veterans Call Center. With an increasing number of female veterans entering the health care arena, VA must take every opportunity to reach out and provide assistance and guidance, as well as referrals to community resources for services not offered within VA.

We are also pleased to see provisions in sections 10 and 11 of the bill that would expand the child care pilot program for veterans seeking readjustment counseling at Vet Centers, and also increase the number of counseling retreat locations which help to ease newly separated female veterans back into civilian life. The VFW supported the original language established in Public Law 111–163, and is happy to see these programs continue.

S. 229, CORPORAL MICHAEL J. CRESCENZ ACT OF 2013

The National VFW does not take positions on the designation of Federal property. We do encourage our state and local VFW members to be involved in these designations to ensure community buy-in.

S. 287, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO EXPAND THE DEFINITION OF HOMELESS VETERAN FOR PURPOSES OF BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES.

The VFW is pleased to support S. 287, legislation that would clarify the definition of "homeless," thereby aligning it with the McKinney-Vento Act to include those displaced by domestic violence.

No veteran should ever be homeless, and expanding the definition to include those veterans who are fleeing situations of domestic abuse is the right thing to do. By making this change, we support this population of veterans and help them to have the courage and means to leave their abusive and sometimes life-threatening situation. This bill will also ensure they receive access to the benefits VA already provides thousands of homeless veterans.

We believe this legislation will significantly improve the lives of those who become homeless as a result of difficult circumstances outside of their control, and help them on their way to beginning a new chapter in their lives. We urge the Committee to pass this bill quickly.

S. 325, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO INCREASE THE MAXIMUM AGE FOR CHILDREN ELIGIBLE FOR MEDICAL CARE UNDER THE CHAMPVA PROGRAM, AND FOR OTHER PURPOSES.

The VFW strongly supports this legislation to extend the age limit for coverage of veterans' dependents through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to the level set by the Patient Protection and Affordable Care Act.

The health care reform legislation, passed in early 2010, allowed families with private health insurance coverage to keep their children on their plans until age 26. Left out of that change was TRICARE and CHAMPVA recipients. Thanks to responsible leaders in Congress, TRICARE coverage has been guaranteed to this age group. Unfortunately, CHAMPVA beneficiaries have not been afforded the same privileges. This program, which was established in 1973 and has more than 330,000 unique beneficiaries comprised of dependents and survivors of certain veterans, should in no instance ever receive less than the national standard. This legislation would provide equity to CHAMPVA beneficiaries and rectify this outstanding issue.

S. 412, KEEP OUR COMMITMENT TO VETERANS ACT

The VFW supports S. 412. Congress must authorize the funding of the FY 2013-FY 2014 major medical leases. Without this funding, twelve VA facilities across the

United States may not be able to properly serve their communities. For example, the Errera Community Care Center (ECCC), a leading center of innovation providing psychological rehabilitation, homeless reintegration, substance abuse counseling, and employment services to over 4,700 veterans in the greater West Haven, Connecticut area must relocate to a larger facility in order to remain effective. The facility that currently houses the ECCC is so insufficient to meet the demand for services that veterans' group therapy sessions are conducted in hallways, and two to three staff members share a single desk. In order to ensure that the momentum that has recently been achieved in solving the complex problems many veterans face is maintained, community centers like the ECCC must be provided with adequate facilities.

However, the passage of this Act does not solve the long-term problem of funding VA major medical leases under the Congressional Budget Office's new lease evaluation. While S. 412 is a good first step, Congress must take action to ensure that these annually appropriated leases are not continually delayed.

S. 422, CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT OF 2013

The VFW supports this legislation which would establish chiropractic care services at all VA medical centers by the end of 2016. In accordance with Public Law 107–35, chiropractic care is currently offered at 47 of the 152 VA medical centers nationwide, with at least one facility being in each VISN. This bill would initiate a gradual expansion of chiropractic care services, requiring that they be made available at no fewer than 75 medical centers by December 31, 2014, and all medical centers by December 31, 2016.

It is well known that servicemembers who deploy to combat and participate in military training are subject to extraordinary physical demands, often resulting in the premature onset of painful spine and joint conditions. The 2010 VA analysis of health care utilization among OIF and OEF veterans listed "diseases of musculoskeletal system/connective system" as the number one condition for which Iraq and Afghanistan veterans sought VA care. Chiropractic care can often be a successful alternative to drugs or invasive procedures for treating musculoskeletal disorders, while also offering suggestions for lifestyle modifications which promote overall wellness. The VFW believes that chiropractic care is a valuable option and should be made available to veterans at all VA medical centers.

S. 455, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO AUTHORIZE THE SECRETARY OF VETERANS AFFAIRS TO TRANSPORT INDIVIDUALS TO AND FROM FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS IN CONNECTION WITH REHABILITATION, COUNSELING, EXAMINATION, TREATMENT, AND CARE, AND FOR OTHER PURPOSES.

The VFW supports this legislation to permanently authorize the Veterans Transportation Service (VTS). This program, commissioned by the VHA Office of Rural Health in 2010, has greatly improved access to care for rural and seriously disabled veterans by allowing VA facilities to establish and coordinate networks of local transportation providers including VSOs, community and commercial transportation providers, and government transportation services. The VTS serves an innovative supplement to the existing beneficiary travel programs of mileage reimbursement, which does nothing to assist in the coordination of transportation for those who need it, and special mode travel, for which few veterans medically qualify.

The VTS program suffered a major setback in 2012 when it was temporarily suspended following a determination by the VA Office of General counsel that VA lacked the statutory authority to provide the new benefits. Congress wisely passed a one-year authorization of the program in January 2013, but a long-term fix is still needed.

The VFW believes that unnecessary hardships associated with accessing VA health care should be eliminated at every opportunity. This legislation would guarantee the continuation and future expansion of VTS, which plays a critical role in minimizing the challenges many veterans face in traveling to their appointments due to physical disabilities or great distances.

S. 522, WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

The VFW does not support this legislation which would require the VA to award grants to eligible educational institutions that establish or expand existing master's degree programs in orthotics and prosthetics. The bill would also create a grant to be awarded to an institution that establishes a private Center of Excellence in Orthotic and Prosthetic Education. Although the VFW recognizes the importance of promoting the development of high quality prosthetic staff and services, we feel that this bill takes the wrong approach. Since it mandates no service requirement for the

students who would benefit from the funding provided by the grants, VA does not stand to reap any direct benefit from their enhanced training. Additionally, the VFW questions whether veterans would be better served by a Center of Excellence in this field within the VA, as opposed to one that is privately operated.

S. 529, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO MODIFY THE COMMENCEMENT DATE OF THE PERIOD OF SERVICE AT CAMP LEJEUNE, NORTH CAROLINA, FOR ELIGIBILITY FOR HOSPITAL CARE AND MEDICAL SERVICES WITH EXPOSURE TO CONTAMINATED WATER, AND FOR OTHER PURPOSES.

The VFW supports this legislation which would adjust the date for VA health care eligibility associated with exposure to contaminated water at Camp Lejeune, North Carolina from January 1, 1957 to August 1, 1953 or an earlier date specified by the Secretary in consultation with the Agency for Toxic Substances and Disease Registry, due to recent findings by the ATSDR that the drinking water at that installation was contaminated as early as 1953.

S. 543, VISN REORGANIZATION ACT OF 2013

The VFW does not support the enactment of S. 543. The intent of this bill has merit. VA should assess the VISN structure for improved efficiency and possible VISN realignment. VA has taken steps to improve efficiency and is studying the impacts of VISN realignment. Congress should continue oversight of this process to ensure veterans are receiving the highest level of care in the most effective and efficient manner.

S. 633, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO PROVIDE FOR COVERAGE UNDER THE BENEFICIARY TRAVEL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS OF CERTAIN DISABLED VETERANS FOR TRAVEL IN CONNECTION WITH CERTAIN SPECIAL DISABILITIES REHABILITATION, AND FOR OTHER PURPOSES.

The VFW supports this legislation which would extend beneficiary travel benefits to veterans with certain severe non-service-connected disabilities who travel to receive care provided through a VA special disabilities rehabilitation program. Veterans who are catastrophically disabled due to spinal cord injuries, visual impairments, and multiple amputations often require in-patient care in order to achieve full rehabilitation. Not all VA facilities, however, offer the specialized programs of care needed to properly treat these severe disabilities, and many veterans are forced to travel great distances to receive the care they need. Those not eligible for travel reimbursement must do so at great personal cost and, as a result, may be forced to forego essential primary or preventative care for financial reasons. This legislation would alleviate that hardship for this small but vulnerable population of veterans.

S. 800, TRETO GARZA FAR SOUTH TEXAS VETERANS INPATIENT CARE ACT OF 2013

The VFW does not hold an opinion regarding this legislation. The bill calls for the expansion of the Harlingen VA Outpatient Clinic to a full-service, inpatient care facility. The VFW would suggest that VA assess South Texas' access and utilization gaps to ensure that veterans in that region are receiving a full continuum of care without the burden of excessive travel, and if there are gaps, prioritize the need and have it added to Strategic Capital Investment Plan.

S. 825, HOMELESS VETERANS PREVENTION ACT OF 2013

The VFW supports most provisions of this legislation which expands and reauthorizes a number of programs aimed at addressing the unacceptable problem of homelessness among veterans. It also keeps families together by allowing VA to house the children of veterans in transitional housing, while also improving the security of those facilities. The VFW firmly believes that no veteran who has honorably served this Nation should have to suffer the indignity of living on the streets. We praise the great progress that has been made in reducing veterans' homelessness in recent years as a direct result of coordinated efforts across multiple government agencies to provide transitional housing, rapid re-housing, and employment programs for veterans in need. The extension and adequate funding provided by this bill for these and other programs are vital to achieving the Secretary's goal of eradicating homelessness among veterans by 2015.

The VFW generally supports Section 8 of the bill which would allow the Secretary to "enter into partnerships with public or private entities" to fund a portion of certain legal services for homeless veterans. While we recognize that legal problems are often a significant barrier to homeless reintegration and must be addressed, we are

concerned that there may be some for-profit legal entities that would view this program as an opportunity to exploit the availability of government resources in exchange for poor or inadequate services. For this reason, we suggest that the language in this section be changed to allow VA to only enter into partnerships with public or non-profit private legal entities that provide services to homeless veterans.

S. 832, IMPROVING THE LIVES OF CHILDREN WITH SPINA BIFIDA ACT OF 2013

Current law (Chapter 18, title 38, United States Code) defines the services provided to children of Vietnam veterans and certain Korea service veterans born with spina bifida to include comprehensive health care, but some veterans have reported that they have had difficulty accessing these benefits for their severely handicapped children.

This bill will help remedy some of these issues by requiring VA to carry out a pilot program in rural areas, and report to Congress on services they are providing to children under the law. The legislation is of little or no cost to VA and will allow Congress an inside view of specifics within the program to include statistics on what types of services and how many are being provided.

The VFW believes that this is an appropriate use of Congressional oversight and the findings will provide insights into the program, specifically answering questions as to whether VA is doing everything within the law to provide care and services to this most vulnerable population. The VFW encourages Congress to enact this legislation so those in need of care and services can access what is rightfully and legally theirs—we owe them nothing less.

S. 845, A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE DEPARTMENT OF VETERANS AFFAIRS HEALTH PROFESSIONALS ASSISTANCE PROGRAM, AND FOR OTHER PURPOSES.

The VFW supports this legislation which removes the $60,000 cap on the total amount payable under the Education Debt Reduction Program (EDRP) and extends the expiration date of the Health Professionals Education Assistance Program from December 31, 2014 to December 31, 2019. VA must be given the tools to recruit and retain high quality medical professionals in order to guarantee the continued delivery of the highest level of care. By providing targeted education debt repayment incentives to physicians in specific fields based on VA need in exchange for service obligations, these programs play a vital role in properly meeting VA staffing needs.

S. 851, CAREGIVERS EXPANSION AND IMPROVEMENT ACT OF 2013

The VFW strongly supports this legislation which would extend current caregiver benefits to those who care for veterans who were severely injured prior to September 11, 2001. We believe that severely wounded veterans of all conflicts have made incredible sacrifices, and that all family members who care for them are equally deserving of recognition and support.

The VFW applauded the passage of the Caregivers and Veterans Omnibus Health Services Act of 2010 which provided a monthly stipend, respite care, mental and medical health care, and the necessary training and certifications required for caregivers of severely disabled Post-9/11 veterans, but have consistently maintained that eligibility should be expanded to include veterans of all eras. By striking "on or after September 11, 2001" from 38 U.S.C. Section 1720G(a)(2)(B), this bill would accomplish that objective.

S. 852, VETERANS' HEALTH PROMOTION ACT OF 2013

This legislation would create a new complementary and alternative medicine (CAM) program within VA in order to promote the overall health and well-being of veterans. Although the VFW feels that CAM and wellness programs have the potential to play a significant role in VA health care, we would like to offer several suggestions which we feel would strengthen this bill.

S. 852 would establish at least one Center of Innovation for CAM in each of the 21 VISNs for health research, education, and clinical activities in each VISN, while simultaneously establishing a three year pilot program to assess the feasibility of CAM centers in VA medical facilities. The VFW feels that it would be more appropriate to conduct the pilot program and analyze its results before mandating the establishment of CAM Centers of Innovation across VA. Additionally, we are concerned that some VISNs may not currently have a medical center suitable to be designated a center of excellence.

The bill also establishes two pilot programs intended to address the issue of obesity. The first would subsidize fitness center memberships for veterans who are de-

termined to be overweight or obese by VA physicians. The VFW suggests that veterans who participate in such programs should be required to report for regular examinations to ensure that fitness programs are being executed effectively and benefits are being achieved. The second pilot program would establish fitness centers at VA facilities which would be made available to any veteran enrolled in the VA health care system. Recognizing that space and resources are scarce, the VFW recommends that the use of such fitness centers be reserved for those veterans deemed overweight or obese by a VA physician. With these changes, we believe that these programs would enhance the overall wellness of the veterans' community, while allowing VA to most effectively experience the associated long-term cost savings.

DRAFT BILL, VETERANS AFFAIRS RESEARCH TRANSPARENCY ACT OF 2013

The VFW has no position on this legislation which would establish a new Web site to make VA research data available to the public, and require the Veterans Affairs-Department of Defense Joint Executive Committee to submit recommendations on the establishment of a data—sharing program between VA and DOD in order to better facilitate research. Although we see the value of the public dissemination of information and greater cooperation between VA and DOD with regards to data-sharing, we are unable to comment on whether the mandates of this bill would achieve those objectives most effectively.

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

Chairman Sanders, Ranking Member Burr, and Members of the Committee: Thank you for inviting Wounded Warrior Project (WWP) to provide views on pending health-related legislation. Several of the measures under consideration address issues of keen importance to wounded warriors and their family members.

HEALTH PROMOTION

Among these bills, Mr. Chairman, we welcome the focus on health-promotion in S. 852, and believe VA health care facilities can be important settings to advance the goal of wellness. As an organization deeply engaged in developing and operating programs to empower wounded warriors, we work very actively to promote health and wellness. Complementing WWP's programmatic work, we see merit in advancing health-promotion and wellness in the VA, and in expanding through rigorous scientific study our understanding of the potential benefits of complementary and alternative medicine (CAM) for certain chronic health conditions. Given its size and reach, the VA health care system could certainly serve as a national laboratory to participate in studying the potential of certain avenues of complementary and alternative medicine to treat, or complement the conventional treatment of, particular conditions. Working in concert with NIH's National Center for Complementary and Alternative Medicine, VA could, for example, help mount large-scale, rigorous studies to assess the effectiveness and safety of particular practices in the treatment of certain chronic conditions.

S. 852 would direct VA to operate in each network at least one center to conduct CAM research, education and training, and clinical care. The bill would also direct VA to establish several pilot programs, including establishing an additional 15 centers to provide services involving CAM for veterans who have mental health conditions and suffer with pain; a grant program to assess the use of wellness programs for combat veterans and their family members; and pilot programs involving fitness activities. While we are supportive of an increased emphasis in VA on health promotion and wellness for wounded warriors, we would encourage further refinement of S. 852.

We see particular value in fostering the study and evaluation of promising therapies to complement the treatment of certain behavioral health conditions and the management of chronic pain and to help improve overall wellness of wounded warriors and their family members. These are areas where we—and many warriors—see a need for more therapeutic options than conventional health care offers. But there exist a wide range of therapies, products and practices under the umbrella of "complementary and alternative medicine." These include alternative health care systems (such as homeopathic medicine, naturopathic medicine, ayurvedic medicine, traditional Chinese medicine, and Native American medicine); mind-body interventions (including hypnosis, meditation, and guided imagery); biological-based therapies (including herbal therapies, special diets, and megavitamin therapy); therapeutic massage and somatic movement therapies; energy therapies (quigong, reiki,

and therapeutic touch); and bioelectromagnetics.[1] Some of these systems of care have evolved over generations (such as in traditional Chinese medicine), and others from the clinical experiences of a single practitioner or small groups of practitioners who have developed a particular intervention.[2] Some seem much more promising than others. To illustrate, the National Center for PTSD recently reported on the current state of research for complementary and alternative treatments for PTSD. They concluded that while CAM treatments like acupuncture, relaxation, and meditation hold some promise as an adjunct to traditional therapies, there is limited evidence of their effectiveness as alternative or stand-alone approaches. They report there is better support for using complementary methods in addition to other treatments or as a gateway to evidence-based services to engage those veterans who might otherwise not take part in other approaches.[3] Not only should distinctions be drawn among interventions in terms of their likely efficacy, but establishing the safety of interventions can be no less important with respect to complementary and alternative medicine than to conventional medicine.[4]

We recommend that S. 852 provide for a specific framework to assure that any CAM programs carried out under VA's auspices adhere rigorously to such fundamental imperatives as safety and effectiveness. Equally important, we urge that any legislation involving CAM be built on the bedrock of the scientific method, to assure that any VA provision of CAM interventions, through pilot programs or otherwise, contributes to scientific and medical understanding, and better care in the future. Finally, we would suggest consideration of further revisions to the bill to take account of the following:

- that priority for research funding for CAM or any other health-related research should be determined through a merit-based peer-review process;
- that the designation of any specific number of new centers or programs involving the study or evaluation of CAM should be based on a methodology that includes such elements as (1) an independent assessment of what are the most promising CAM interventions that have particular relevance to health care issues prevalent among veterans, and (2) rigorous evaluation of the capabilities (including the potential size of a study cohort) of one or more VA medical centers to study each such issue (independently, collaboratively with other VA medical centers, or in partnership with an affiliated academic center(s); and
- whether a particular proposed pilot program can produce statistically significant results or is susceptible of meaningful evaluation.

CAREGIVER-ASSISTANCE

S. 851 would expand VA's comprehensive caregiver-assistance program to cover caregivers of veterans who were injured prior to 9/11. The Caregivers Act of 2010 was historic legislation that directed VA to provide important services and supports. However VA has yet to meet in full its obligations under that law. More than two years after initial implementation, VA still has not answered—let alone remedied—the problems and concerns that WWP and other advocates raised regarding the Department's implementing regulations. For example, those regulations leave "appeal rights" unaddressed (including appeals from adverse determinations of law); set unduly strict criteria for determining a need for caregiving for veterans with severe behavioral health conditions; and invite arbitrary, inconsistent decisionmaking. Simply extending the scope of current law at this point to caregivers of other veterans would inadvertently signal to VA acquiescence in its flawed implementation of that law. We recommend that the Committee insist on VA's resolving these long-outstanding concerns as a pre-condition to extending the promise of this law to caregivers of pre-9/11 veterans.

PROSTHETICS AND ORTHOTICS

S. 522, the Wounded Warrior Workforce Enhancement Act, would direct VA both to establish a program to provide grants to institutions that provide or intend to provide graduate education in prosthetics and orthotics, and to award a grant to

[1] Final Report, White House Commission on Complementary and Alternative Medicine Policy (March 2002), accessed at http://www.whccamp.hhs.gov/pdfs/fr2002_document.pdf

[2] Id.

[3] Strauss, J. & Lang, A. Complementary and Alternative Treatments for PTSD. PTSD Research Quarterly (2012). Accessed at: http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v23n2.pdf

[4] Recent study found that ginko biloba, a widely-used herbal supplement, caused carcinogenic activity in mice. "New Doubts about Ginko Biloba," New York Times (April 30, 2013) accessed at http://well.blogs.nytimes.com/2013/04/29/new-doubts-about-ginkgo-biloba/

support the establishment of a center of excellence in orthotic and prosthetic education, and research into the skills and optimal training needed by clinical professionals in such fields.

WWP has had concerns regarding the VA's prosthetics and orthotics program. With its generally older patient population whose prosthetic needs are most often linked to diabetes and post-vascular disease, VA has faced a steep adaptation-curve as it relates to serving young warriors who have lost limbs in war.[5] War zone injuries that result in amputations are often complex and can prove difficult for later prosthetic fitting because of length, scarring, and additional related injuries such as burns.[6] VA has instituted an amputation system of care and initiated the development of amputee centers of excellence which can become important components of needed changes, but much more progress is needed to realize the underlying vision. Indeed the Department of Defense (DOD) has surpassed VA in providing state-of-the-art rehabilitation for this generation of combat-injured amputee servicemembers and veterans. Some have suggested that VA's leadership role in prosthetics has declined and that prosthetics no longer holds the priority for VA it did in the past.[7] VA prosthetics research, particularly—an area of real strength in the past and so important to serving wounded warriors tomorrow—has lagged, even as the numbers of new veteran-amputees climb steadily.

We do see a need for Congress to press VA to make these concerns a higher priority, and have urged such steps as the following:

- Ensure through ongoing oversight that the vision of a VA Amputee System of Care is realized; that VA meets its commitment to provide timely, needed prosthetics; and that it works to regain leadership in prosthetics research and service.
- Ensure that VA's amputee-registry is deployed and used to track amputee-care and outcomes, conduct longitudinal studies and other research, and—working in concert with DOD—expand understanding of best practices;
- Establish a steering committee of experts composed of academicians, clinicians, and researchers to oversee and provide guidance to VA on the direction and operation of its prosthetics and orthotics program; and
- Develop guidance to assist clinicians in more appropriately prescribing durable medical equipment (in particular, expanding clinical practice recommendations through the use of guidelines such as are commonly employed in other fields of medical practice).

With regard to S. 522, we would acknowledge that VA may well face challenges in filling future vacancies in prosthetics and orthotics. But it is not clear that S. 522, while authorizing grants to institutions for a wide range of uses relating to prosthetics and orthotics education, is sufficiently focused to meet VA's potential workforce needs.

REPRODUCTIVE ASSISTANCE

S. 131, the Women Veterans and Other Health Care Improvements Act of 2013, raises important issues in proposing that VA would provide reproductive services and adoption assistance to assist in helping severely wounded, ill or injured veterans who have service-incurred infertility conditions to have children.

The experience of our operations in Iraq and Afghanistan has heightened the importance of grappling with the issue of reproductive services. Blasts from widespread use of improvised explosive devices (IED's) in Iraq and Afghanistan, particularly in the case of warriors on foot patrols, have increasingly resulted not only in traumatic amputations of at least one leg, but also in pelvic, abdominal or urogenital wounds.[8] While not widely recognized, the number and severity of genitourinary injuries has increased over the course of the war, with more than 12% of all admissions in 2010 involving associated genitourinary injuries.[9] With that increase has come not only DOD acknowledgement of the impact of genitourinary in-

[5] Sigford BJ, "Paradigm Shift for VA Amputation Care," *J Rehabil Res Dev*; 47(4): (2010) xv-xx.

[6] Ibid.

[7] See Hearing, "Optimizing Care for Veterans with Prosthetics," Subcommittee on Health, Committee on Veterans Affairs, House of Representatives (May 16, 2012) accessed at http://veterans.house.gov/hearing/optimizing-care-for-veterans-with-prosthetics

[8] Dismounted Complex Injury Task Force, "Dismounted Complex Blast Injury: Report of the Army Dismounted Complex Injury Task Force," I (June 18, 2011) available at: http://www.armymedicine.army.mil/reports/DCBI%20Task%20Force%20Report%20%28Redacted%20Final%29.pdf.

[9] Id. at 16.

juries on warriors' psychological and reproductive health,[10] but recent adoption of a policy authorizing and providing implementation guidance on assisted reproductive services for severely or seriously injured active duty servicemembers.[11] DOD's policy, set forth in recent revisions to its TRICARE Operations Manual, applies to servicemembers of either gender who have lost the natural ability to procreate as a result of neurological, anatomical or physiological injury. The policy covers assistive reproductive technologies (including sperm and egg retrieval, artificial insemination and in vitro fertilization) to help reduce the disabling effects of the servicemember's condition to permit procreation with the servicemember's spouse.[12]

For veterans, however, VA coverage is very limited in scope. The regulation describing the scope of VA's "medical benefits package" states explicitly that in vitro fertilization is excluded[13] and that "[c]are will be provided only * * * [as] needed *to promote, preserve, or restore the health of* the individual * * * ."[14] Consistent with that limiting language, the VA's benefits handbook advises women veterans with regard to health coverage that " * * * infertility evaluations and limited treatments are also available."[15]

In a departure from longstanding policy, the VA stated last year that "[t]he provision of Assisted Reproductive Services (including any existing or future reproductive technology that involves the handling of eggs or sperm) is in keeping with VA's goal to restore the capabilities of Veterans with disabilities to the greatest extent possible and to improve the quality of Veterans' lives."[16] In its statement, the Department also expressed support in principle for legislation authorizing VA to provide assistive reproductive services to help a severely wounded veteran with an infertility condition incurred in service and that veteran's spouse or partner have children. It conditioned that support, however, on "assurance of the additional resources that would be required."[17]

Certainly the administration of a VA program that would assist wounded warriors and their spouses to conceive children would require careful attention to ethical[18] and regulatory[19] issues associated with providing advanced reproductive services. Economic considerations certainly can arise in that regard.[20] But while these advanced interventions can be quite costly, cost should not be a barrier as it relates to this country's obligation to young warriors who sustained horrific battlefield injuries that impair their ability to father or bear children.

WWP urges Congress to enact legislation that would enable couples who are unable to conceive because of the warrior's severe service-incurred injury or illness to receive fertility counseling and treatment, including assisted reproductive services, subject to the development of reasonable regulations.

BENEFICIARY TRAVEL

S. 633 would amend current law governing VA's "beneficiary travel" program to cover certain severely disabled veterans' travel in connection with care provided on an inpatient (or lodger-basis) through a special VA disability-rehabilitation program.

WWP works extensively across the country with wounded warriors, specifically veterans and servicemembers who were injured, wounded or developed an illness or disorder of any kind in line of duty during military service on or after September 11,

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[10] Id.

[11] Asst. Secretary of Defense (Health Affairs) & Director of TRICARE Management Activity, Memorandum on Policy for Assisted Reproductive Services for the Benefit of Seriously or Seriously Ill/Injured (Category II or III) Active Duty Servicemembers (April 3, 2012) available at: http://www.veterans.senate.gov/upload/DOD_reproductive_letter.pdf.

[12] Dept. of Defense, TRICARE Operations Manual 6010.56-M, Chapter 17, Section 3, para. 2.6 (Sept. 19, 2012).

[13] 38 CFR § 17(c)(2).

[14] 38 CFR § 17(b) (Emphasis added).

[15] Dept.of Veterans Affairs, "Federal Benefits for Veterans, Dependents and Survivors" available at http://www.va.gov/opa/publications/benefits—book/benefits—chap01.asp.

[16] *Health and Benefits Legislation Hearing Before the S. Comm. on Veterans Affairs*, 112th Cong. (2012).

[17] Id.

[18] See Meena Lal, "The Role of the Federal Government in Assisted Reproductive Technologies, 13 Santa Clara Computer and High Tech. L.J. 517 (1997).

[19] See Michelle Goodwin "A Few Thoughts on Assisted Reproductive Technology," 27 L. & Ineq. 465 (2009). Among these regulatory issues, VA would have to address the need for physicians providing advanced reproductive technologies to fully inform couples as to their risks, including greater health risks in children born through these technologies. See N.Y. State Dept. of Health Task Force on Life and the Law, Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy, available at: http://www.health.ny.gov/regulations/task—force/reports—publications/execsum.htm

[20] Id.

2001. Our warriors certainly encounter barriers to receiving needed VA services—barriers that include sometimes-rigid VA appointment-scheduling, long-distance travel, and instances of inflexible program requirements. We are not aware, however, of problems that warriors have encountered regarding receipt of beneficiary travel generally or with respect to travel to special disability-rehabilitation programs. As such, we have no position on S. 633.

Thank you for your consideration of WWP's views on these issues.

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