STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

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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 dialogue 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 assistance 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 section101(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, examination, 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 Worforce 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. Lastly, 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 access 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.