

**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
MAY 9, 2013**

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 towards 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 Micheal 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, and 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, 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.

¹ 38 U.S.C. 1703, and 38 CFR §§ 17.52-17.56

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 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 benefitted 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 already 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 decision-making 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 publically 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 transitioning 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. 171437f(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 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

² 38 U.S.C. §§1803; 1821.

³ 38 U.S.C. §§1811; 1812; 1813.

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.

⁴ 76 Fed. Reg. at 26149

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 expanding 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 publically 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 service members, veterans and their families.

This concludes my testimony. I am happy to answer any questions Committee Members may have related to my statement.