

**HEARING ON HEALTH AND BENEFITS
LEGISLATION**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ONE HUNDRED TWELFTH CONGRESS
SECOND SESSION

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JUNE 27, 2012
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Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.fdsys.gov>

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U.S. GOVERNMENT PRINTING OFFICE

76-283 PDF

WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
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HEARING ON HEALTH AND BENEFITS LEGISLATION

WEDNESDAY, JUNE 27, 2012

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

The Committee met, pursuant to notice, at 10:04 a.m., in room 124, Dirksen Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Burr, Isakson, Brown of Massachusetts and Boozman.

Also present: Senators Heller, Ayotte, Franken, Wyden, Boxer, and Portman.

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning. Thank you, and welcome all of you to this hearing of the Veteran Affairs' Committee this morning as we examine health and benefits legislation that is before our Committee.

We have a number of Senators who are here who want to testify about their legislation. I will make an opening statement, then Senator Burr, and if we have any other Committee Members we will allow them to give theirs, then turn to other Senators. So, thank you all for being here.

Like our hearing 2 weeks ago on economic opportunity and transition legislation, today's agenda is ambitious and reflects important work by the Members on both sides of the aisle. I wanted to briefly highlight two of my bills that are on the agenda.

The Mental Health ACCESS Act of 2012 is sweeping legislation that improves how VA provides mental health care. I think it is fitting actually that we are here considering this legislation on National PTSD Awareness Day.

Over the past year, this Committee has repeatedly examined the alarming rate of suicide and the mental health crisis in our military and veterans' populations. We know our servicemembers and veterans have faced unprecedented challenges, multiple deployments, difficulty finding a job when they come home, and isolation in their communities. Some have faced tough times reintegrating into family life, with loved ones trying to relate but not knowing how.

These are the challenges our servicemembers and veterans know all too well. But even as they turn to us for help, we are losing the battle. Time and time again, we have lost servicemembers and vet-

erans to suicide. We are losing more servicemembers to suicide than we are to combat, and every 80 minutes a veteran takes his or her own life. On average this year, we have lost a servicemember to suicide once every day.

But while the Departments of Defense and Veterans' Affairs have taken important steps toward addressing this crisis, we know there is a lot more that needs to be done. We know that any solution depends upon reducing the wait times and improving access to mental health care, ensuring proper diagnosis, and achieving true coordination of care and information between the Departments.

The Mental Health ACCESS Act would expand eligibility for VA mental health services to family members of veterans. It would require VA to offer peer support services at all medical centers and create opportunities to train more veterans to provide peer services, and this bill will require VA to establish accurate and reliable measures for mental health services.

This Committee has held multiple hearings on VA mental health care, and we heard repeatedly about the incredibly long wait times to get into care. It is often only on the brink of crisis that a veteran seeks care. If they are told "sorry, we are too busy to help you," we have lost the opportunity to help, and that is not acceptable.

Without accurate measures, VA does not know the unmet needs. Without a credible staffing model, VA cannot deploy its personnel and resources effectively.

The other bill I want to mention today is S. 3313. It is the Women Veterans and Other Health Care Improvement Act of 2012, which builds upon previous law to improve VA services for women veterans and veterans with families.

This bill will create a child-care pilot program for veterans seeking readjustment counseling at Vet Centers and increase outreach to women veterans. We know that as more of our men and women return from Afghanistan, the VA will be called upon to provide care for our most severely wounded veterans. After suffering life-changing injuries on the battlefield, these veterans now face a future forever changed.

Between 2003 and 2011, we know that more than 600 servicemembers experienced blast injuries that caused trauma to their reproductive or urinary tracts in Iraq and Afghanistan. Even more have experienced other injuries, like spinal cord injuries.

Many of these veterans dream of 1 day starting a family. But with the injuries they have sustained on the battlefield that may not be possible without some extra help. While the Department of Defense and TRICARE are now able to provide advanced fertility treatment to injured servicemembers, today the VA can only provide limited treatment. VA's services do not even begin to meet the needs of our most seriously injured veterans and their families.

So, my bill will help make real the dream of starting a family by authorizing the VA to provide advanced fertility treatment to severely wounded veterans. By authorizing these treatments, we will bring VA services in line with what DOD and TRICARE already provide. It is the right thing to do, and it is what our veterans deserve.

I look forward to our second panel today where we have some very compelling testimony from families that have been impacted by these injuries.

So, I look forward to hearing from our VA witnesses and all of our Committee Members and those Senators that are here today to talk about their legislation.

With that, I will turn it over to the Ranking Member, Senator Burr.

Senator BURR. Thank you, Chairman Murray; and I also welcome our witnesses today. I would also like to welcome Senator Wyden, who just introduced a bill in the last couple of weeks together, which he will testify on today. And I welcome the rest of my colleagues who are here that I expect to do a similar thing.

Before turning to today's agenda, I want to say a few words about the Caring for Camp Lejeune Veterans Act, which would provide health care for veterans and their families who were stationed at Camp Lejeune when the water was contaminated with known or probable known carcinogens.

I am very pleased that we have made progress on this bill in recent weeks, and I hope it will soon pass so that we can finally provide these veterans and their families with the care they need and deserve.

As we consider other bills today—particularly any that create or expand programs—we should start by looking at how well existing programs are working and identify any gaps and inefficiencies. That should help us focus on changes that are truly needed and avoid creating any more duplicative and overlapping programs that can end up frustrating veterans and their families.

Also, with the fiscal challenges facing our Nation, we need to know the cost of these bills; and for any that will move forward, we must find ways to pay for them.

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

One is S. 1707, which would end the unfair process that strips veterans and their families of the rights to own firearms if VA believes they need help with their finances.

Under this bill, the Second Amendment rights of a VA beneficiary could not be taken away unless a judicial authority finds that the individual is dangerous. This would put the decision about Constitutional rights in an appropriate forum and base it on relevant questions.

Another bill, S. 2045, would require judges of the Court of Appeals for Veterans' Claims to live within 50 miles of the Court's office, a requirement that already applies to other Federal judges.

This should increase the efficiency and effectiveness of the Court by encouraging the judges to be present and personally engaged on a daily basis. It would also emphasize that the judges must be totally committed to the Court's important work.

Then, S. 3084 would reform VA's Veterans' Integrated Service Networks or the acronym we all know, VISNs. In 1995, the veterans' health care system was divided into 22 geographic areas. It now is divided into 21 VISNs. Each VISN has its own headquarters with a limited management structure to support the medical facili-

ties in that region. Since then, there has been a huge growth in staff at the VISN headquarters and increasing duplication in the duties they carry out.

So, this bill would consolidate the boundaries of nine VISNs, move some oversight functions away from VISN management, and limit the number of employees at each VISN headquarters. All of this should make these networks more efficient and should allow resources to be reallocated to direct patient care.

One other, S. 3202, is a bill Chairman Murray and I introduced to give VA the tools to help ensure that veterans and servicemembers are laid to rest with dignity and respect. By granting VA the authority to purchase caskets or urns when they otherwise would not be provided, veterans buried in national cemeteries can be laid to rest in a manner befitting their service.

Finally, S. 3270 would create a "look-back" period so VA could consider whether someone applying for need-based pensions has recently transferred away assets. As the Government Accountability Office highlighted, there is an entire industry aimed at convincing veterans to move assets around in order to qualify for need-based pension benefits.

That practice not only undermines the integrity of the pension program but can leave elderly veterans without any adequate resources in their greatest time of need. So, this bill aims to strengthen VA's pension program, while discouraging companies from preying on elderly veterans.

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

Again, I want to stress how important this hearing is, and I want to thank you for your help with Camp Lejeune legislation.

Chairman MURRAY. Of course, thank you very much, Senator Burr. We have three Committee Members present. If any of you would like to offer an opening statement before we turn to our visiting Senators; Senator Isakson, Senator Brown, do you have an opening statements?

**STATEMENT OF HON. SCOTT P. BROWN,
U.S. SENATOR FROM MASSACHUSETTS**

Senator BROWN OF MASSACHUSETTS. Yes, I do.

Thank you, Madam Chair. I am bouncing back and forth between HSGAC and this. I appreciate the opportunity.

I want to say thank you, Senator Burr, for working on Camp Lejeune. It is something I am a cosponsor of. I have many Massachusetts families affected by that too. So, I appreciate your efforts and, Madam Chair, your willingness to move forward on that in a positive manner.

As we know, we introduced a bill last week with Senator Burr, Housing for Families of Ill and Injured Veterans. It is pretty simple. It gives the VA the authority to award grants to the Fisher House Foundation for the construction of additional temporary lodging facilities similar to the ones which currently exist and that many people are aware are.

There is even a Fisher House in Washington State, Madam Chair, as you are probably aware of, and today there are 21 States and additional projects are already planned in nine other States.

If you have been to Walter Reed or visited a VA medical center back home, you know the critical role that that facility plays in helping troops and their families navigate the difficult and often painful road to recovery.

Our Fisher Houses in Massachusetts are an incredible asset for the family seeking care in our State and thankfully these homes create, as you all know, an instant community of support for our families.

Unfortunately, the reality is that private and corporate charitable contributions are declining. There is a real concern about what is going to happen with a lot of the so-called deduction opportunities if charitable deductions is going to be one of those on the chopping block, and this has prevented Fisher House from producing the amount of homes required by VA for the foreseeable future even as demand continues to rise.

In fact, Secretary Shinseki identified 19 medical centers that desperately need a Fisher House. On the other hand, the DOD budget is about \$4 million annually to the Fisher House Foundation to cover the cost, and my point is I do think it is reasonable for the VA like DOD to put some skin in the game. Our bill gives the authority to do just that.

I would also like to just make a quick reference to the Women's Homeless Veterans Act that Senators Heller and Burr recently introduced, and I was proud to cosponsor as well.

This Committee held a hearing back in March to learn more about what the VA was doing on this epidemic, and we heard from Ms. Sandra Strickland and learned firsthand about her personal experiences. She testified that she was hung up on by folks at the VA and felt bad that VA did not go above and beyond to address their current needs. What is worse it is not an isolated case. We reference that from the GAO report.

So, I want to obviously thank those Senators Heller and Burr, and I am hopeful that we will be able to move these matters forward.

As I mentioned, I am back and forth between hearings, and I am going to hopefully come back and testify. If not, I will offer questions for the record.

Thank you, Madam Chair.

Chairman MURRAY. Thank you very much.

Senator Boozman.

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

Senator BOOZMAN. Thank you, Madam Chair, and thank you, Ranking Member Burr, for holding this important hearing regarding legislation to improve the health care and benefits that each individual of our all volunteer force has earned through their sacrifice.

I also appreciate that you have included several bipartisan bills in which we have been working to improve our veterans benefits

and quality-of-life. I would really like to just take a few minutes to say a few words about some of this.

First off, I want to thank Senator Franken for his hard work, and I want to say that I echo the sentiments that he is going to be expressing in a little bit.

With so many of our veterans living in rural areas, our Nation has seen fit to invest significant amount of money to improve the accessibility and quality of the health care that they receive. While the research of VA Office of Rural Health Strategic Plan is a little step in the right direction, I think it is so important for us to have a clear path forward to improve health care for our rural veterans.

So, I would associate again myself with Mr. Franken's sentiments and thank him for his continued partnership and hard work in addressing the issue.

Another important bill that we have been working on is S. 3206 to extend Paralympic Integrated Adaptive Sports Program. I would also like to take this opportunity to thank Senator Begich for his assistance and hard work with the bill and so many others, many of which we will hear today, that he has been such a great partner on the Committee and together we have been able to raise awareness about the several key issues to help our veterans and advance legislation through Congress. So again, thanks to him and his staff.

S. 3206 would reauthorize this program that despite only being operational for about 18 months is already serving wounded warriors in more than under 50 communities in 42 States and has collaborated with 53 VA medical centers to provide adaptive sports programs for our disabled veterans right in their communities. More than 500 partner organizations have come together to help provide this important service to thousands of our disabled veterans that have leveraged these Federal dollars with their own funds and expertise. This type of activity is so important to our wounded warriors in improving quality-of-life, health, self-esteem, socialization.

Now with our recent overseas engagements winding down, it is more important than ever that this valued program remain in place with no interruption in its authorization which would lapse at the end of the next fiscal year under current law.

Another bill that is important that I have been working with Senator Baucus on, to whom I am grateful for his efforts on this issue, is S. 1838. This is simple legislation, a nearly identical companion of which has already passed the full House is part of H.R. 2074.

It would create a pilot program in which the VA would examine the feasibility of the service-dog training activities as therapies in mental health rehab programs.

Too often many of our veterans must rely on pharmacological therapies for seen and unseen injuries. This is not all bad, but I think we need to examine alternatives to this, which is why I am being very supportive of programs like Rivers of Recovery, which recently expanded into Arkansas and that teaches recreational therapy through fly fishing.

This dog-training program could be a four-way win by providing therapy, teaching potential vocational skills as dog trainers, providing highly-trained service dogs for veterans in need, and pro-

viding a pathway for the rescue of shelter dogs that meet the criteria for the service.

For all of these reasons, I think that this modest pilot program is worthy of examination.

I have also been working with Senator Begich on S. 3094, which is a commonsense adjustment to the definition of homeless veterans so that it includes veterans who are fleeing domestic violence situations.

With such an increasing percentage of our veterans population being women, this Committee has been hard at work to improve programs and benefits to meet their needs; and while it is not only women who could fall under this adjustment, it is important that we get our veterans the benefits and assistance they need when they need them and this simple adjustment would help ensure that that happens.

Finally, I would like to express my strong support for S. 1707, the Veteran Second Amendment Protection Act. I have been strongly advocating for this legislation for the past few Congresses, and it is high time that we have got this done.

This bill would protect the Second Amendment rights of our veterans who served in uniform. Right now if a veteran is assigned a fiduciary to administer their benefits, they can be automatically deemed adjudicated as mentally defective by a nameless and faceless bureaucrat and be denied their Second Amendment rights.

There is nothing just about this. So this legislation would require that a judge or a magistrate make this determination. I think it is commonsense and Congress should move this bill forward.

So, again, thank you all very much for bringing all of these things forward. We appreciate your hard work.

Chairman MURRAY. Thank you very much. We do have a number of Senators who are here to testify about the legislation. We welcome all of them. I will call on them in order of their appearance beginning with Senator Heller.

**STATEMENT OF HON. DEAN HELLER,
U.S. SENATOR FROM NEVADA**

Senator HELLER. Good morning. Thank you, Madam Chairwoman and Ranking Member Burr, for the opportunity for me to introduce this legislation, Senate bill 3308, the Homeless Women's Veterans Act, before the Committee today; and I appreciate your hard work and effort on behalf of the Nation's veterans.

I know everybody here shares the same concerns about homeless veterans as I do. A couple of weeks ago I met with a constituent of mine, Dan Lyons, who walked from Reno, Nevada, to Washington, DC, to raise support for homeless veterans. A 6-month, 2800-mile journey.

He began walking on January 3, recording about 25 miles each day. This former Marine Corps veteran who served in Vietnam battled treacherous weather. He battled snakes and long, lonely miles just for the chance to sit down and ask that we do more to help struggling veterans.

All too often we see clearly what is wrong with this society, and I think Dan reminds us of all that is right, and I am proud to tell his story as we discuss legislation helping homeless veterans. I

commend his steadfast determination in raising awareness for those who keep us safe, and I share his commitment in helping veterans in need.

Too many of our Nation's heroes are coming home from overseas to their homes underwater and high unemployment in their communities. This economy has left far too many veterans without work and in too many instances without a place to live; and while a number of veterans have fallen on tough times financially, some have also had difficulty adjusting to civilian life.

Today there are over 100,000 veterans on America's streets, roughly 16 percent of the homeless adult population. Congress has established numerous programs to provide services to homeless veterans facing economic hardship.

One program, the Grant and Per Diem Program has provided construction costs, transportation costs, and counseling to thousands of veterans and has been successful in combating homelessness among veterans.

While these programs provide significant assistance to our Nation's veterans, there are still too many without a place to call home. Of particular concern is the growing number of homeless female veterans.

In 1990, women made up 4 percent of all veterans. Today that number has doubled to 8 percent, amounting to almost 1.8 million women. As the demographics of our Armed Services have changed throughout the years so too have the needs of homeless veterans.

Many homeless shelters today were never designed to serve the needs of female veterans or homeless veterans with children. The funding provided by Congress specifically dedicated to this growing population is simply not enough to ensure they have a safe and secure place to stay, nor do existing programs allow the VA to be reimbursed for services provided to children of homeless veterans.

Shelters should not have to make the untenable decision to either lose money or deny services to children. For these reasons, I join with Ranking Member Burr to introduce the Women's Homeless Veterans Act. I do appreciate the support of my friend, Senator Brown from Massachusetts, for his support on this legislation also.

This commonsense legislation increases the percentage of funding allocated for homeless women veterans as well as providing the VA with the ability to reimburse shelters for services provided to children.

Under this bill, at least 15 percent of funds allocated to the Grand Per Diem account must be directed to the special-needs program to greater meet the needs of homeless women veterans. The current program does not provide an amount that is reflective of this growing population.

The increased resources could be used to construct wings at homeless shelters that are designed specifically for the security and safety needs of women and children or provide more counseling or other rehabilitative services for female veterans.

The bill also clarifies that the VA can reimburse the cost of dependents of veterans, ensuring that shelters providing services will not have to turn children of veterans away. Ensuring that all of our veterans and their children have a safe and secure place to stay is the least that we can do.

I urge my colleagues to support this legislation to improve the lives of our Nation's bravest. When they have sacrificed so much for our country to preserve and protect our freedoms, we should at least ensure that their needs are met when they fall on hard times. I am proud that both The American Legion and the National Coalition of Homeless Veterans have joined in support of this legislation and ask that their letters of support be entered into the record.

[The letters are included in the Appendix.]

I thank Chairman Murray and Ranking Member Burr for holding this important hearing. I am deeply appreciative of the Committee's time and look forward to continuing this important discussion.

And as a finishing point, Dan Lyons, who walked for 6 months, did take the train home. [Laughter.]

Thank you.

Chairman MURRAY. Thank you very much, Senator Heller.
Senator Ayotte.

**STATEMENT OF HON. KELLY AYOTTE,
U.S. SENATOR FROM NEW HAMPSHIRE**

Senator AYOTTE. Thank you Madam Chair and Ranking Member Burr for convening this hearing today.

I appreciate the opportunity to testify before this distinguished Committee regarding the Remembering America's Forgotten Veterans Cemetery Act of 2012, which is S. 2320, which Senator Begich and I introduced earlier this year and which several Members of this Committee are cosponsoring. I would like to personally recognize and thank the Members of this Committee that are cosponsoring my bill who are Senators Akaka, Brown, Isakson and Wicker.

From Normandy to Panama, America's veterans' cemeteries serve as a reminder of the extraordinary sacrifice thousands of brave American men and women have made on distant battlefields to protect our country.

Maintaining America's veterans' cemeteries is a well-recognized responsibility of the Federal Government, and we have a moral obligation to make sure that these cemeteries are properly cared for.

One of those cemeteries is the Clark Veterans Cemetery in the Philippines which contains the remains of more than 8,300 United States servicemembers and their dependents.

In 1991, the United States abandoned Clark Air Force Base in the wake of a volcanic eruption; after 90 years of maintaining custodianship, the United States also unfortunately abandoned the graves of these brave Americans, leaving them unattended under a thick layer of ash.

Over the next few years, the condition of the cemetery worsened, leaving the graves of our courageous veterans in an unacceptable state. Before you and also on the Committee Members' iPads are pictures of what happened to the Clark Veterans Cemetery, and you can see from these pictures that no men or women or their dependents who have served our country admirably should they be left, their remains, in a cemetery that is in this condition and not cared for by our government.

Private volunteers became so concerned about the state of this cemetery that they volunteered and attempted to honor our servicemembers and their families buried there by maintaining the cemetery at their own expense, and I want to thank the Clark Veterans Cemetery Restoration Association and its president, Denis Wright, for volunteering their own time and resources to attempt to right this wrong and to give the servicemembers buried at Clark the dignity that they deserve.

While these private citizens deserve our gratitude, the United States government has a moral responsibility to care for our veterans' cemeteries that honor the remains of those who have bravely served our country.

For almost a century, the United States government cared for those buried at the Clark Veterans Cemetery in the Philippines. Now, it is time for the United States to resume its responsibilities.

Our legislation would accomplish this by requiring the American Battle Monuments Commission to restore, operate, and maintain Clark Veterans Cemetery to honor the courageous Americans that are buried there.

In fact, Senate Resolution 481, which passed the Senate by voice vote on June 5, concluded that the United States government should designate an appropriate United States entity to be responsible for the ongoing maintenance of Clark Veterans Cemetery.

Military cemeteries are managed by three Federal agencies, the American Battle Monuments Commission and the Department of Veterans Affairs National Cemetery Administration, and those in the United States and Puerto Rico that is the agency that maintains our cemeteries; and military departments also manage cemeteries that are located on military installations.

Of these three Federal agencies, the American Battle Monuments Commission, which is responsible for designing, constructing, operating, and maintaining permanent American cemeteries in foreign countries, is the most appropriate agency to assume responsibility for the Clark Veterans Cemetery because the Cemetery is a permanent American cemetery in a foreign country.

Although the American Battle Monuments Commission focuses much of its efforts on historical cemeteries and monuments in Europe, the Commission also maintains a Corozal American Cemetery in Panama, which is very, very similar to the Clark Veterans Cemetery.

I am very pleased that the military coalition, which represents 34 military veterans and uniformed services organizations totaling nearly 5.5 million members, and the National Military Veterans Alliance, which represents 3.5 million members in our country, as well as The American Legion, the Military Officers Association, and others have written endorsement letters or passed resolutions supporting this legislation. Millions of current and former servicemembers and dozens of service organizations have spoken.

They all agree. We must do the right thing for Clark Veterans Cemetery. Madam Chair, I would ask that these letters be submitted for the record.

Chairman MURRAY. The information will be included in the record.

Senator AYOTTE. The American veterans buried in Clark Veterans Cemetery deserve a dignified and well-maintained final resting place. There is no reason that the brave servicemembers buried at Clark should be deprived of the honor that they have earned and that veterans at other cemeteries are afforded. It is time for the United States government to fulfill its responsibility to care for this sacred ground.

Again, I would like to thank you, Madam Chair, and Ranking Member Burr, for agreeing to hold this hearing. I am optimistic that we can move forward on this legislation and ensure that the United States government fulfills its responsibility to honor the final resting ground of those who have sacrificed and made the alternate sacrifice many of them for our country.

Chairman MURRAY. Thank you very much for your statement.

[The letters are included in the Appendix.]

Chairman MURRAY. We will turn to Senator Franken.

**STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA**

Senator FRANKEN. Thank you, Madam Chairwoman.

Chairwoman Murray and Ranking Member Burr, Members of the Committee, thank you for the opportunity to testify on behalf of the Rural Veterans' Health Care Improvement Act.

I apologize. I am going to have to leave immediately following my testimony today.

I am very pleased to be working together with Senator Boozman on this legislation. His commitment to our Nation's veterans, like his unflappable disposition, is well known and undisputed. I am honored that he is the lead sponsor of this legislation which was considerably improved through his work on it.

The purpose of our legislation is very straightforward and very important: to improve access to quality health care for our Nation's veterans living in rural areas.

Like many States, Minnesota has a great many veterans who live in rural areas. Nationwide over 40 percent of all veterans enrolled in the VA system live in rural areas. That presents a challenge to accessing quality health care through the VA.

To address this challenge, the VA created the Office of Rural Health or ORH in 2007. Congress has provided over \$1 billion in support of ORH through fiscal year 2012. That is a significant investment.

But the reality and the results are not yet where they need to be. The funds that Congress has provided have enabled the Office of Rural Health to undertake hundreds of initiatives throughout the country.

Unfortunately, there has been no coherent strategic plan for those hundreds of initiatives, and I think this speaks to the Ranking Member's opening statement about making sure that we are not wasting money and that we are not having duplicative plans but we are having well-thought-out, strategically-thought-out responses to these needs.

As a result, improvements in veterans' access to health care in rural areas has been piecemeal and uneven. Last year, a VA Inspector General found that ORH lacked reasonable assurance that

a majority of its funds, this is amounting to \$273 million in fiscal years 2009 and 2010, actually no assurance that they actually improved access to and quality of care for rural veterans. That is a failure. It fails our veterans and it fails the public that funds VA's programs.

When we are talking about that much money and such an important mission, we are not going to let VA muddle through. We are going to demand that they get it right, and they get it right now.

The ORH has an essential goal, to bring quality health care to veterans in rural areas. To achieve that, the VA needs to undertake careful, strategic planning, including the careful stewardship of taxpayer resources. That is the purpose of our legislation, which requires the VA to produce a strong and comprehensive strategic plan for ORH.

Now, I appreciate that VA has taken some steps to address problems identified by the Inspector General's report, but these steps are simply not enough.

First, the strategic plan that the VA put out, which was already out when the IG made its findings does not move beyond the piecemeal approach ORH has been taking and does not develop a comprehensive strategy.

The research of the ORH plan, as Senator Boozman said in his opening, the research of the ORH plan that VA issued late last year was an improvement over the initial plan, but not yet enough of an improvement.

Second, while some of the features required by our legislation are included in the plan that VA put out others are not. If ORH is to be successful, it needs to address all of the important goals and objectives we have identified in the legislation.

The Disabled American Veterans in their testimony note a couple of these areas. The full and effective use of mobile outpatient clinics and the provision and coordination of care for women veterans in rural areas.

I will add another just by way of example. I believe you will not find the word emergency or emergencies in the VA's current plan. Yet, the VA Inspector General has again and again reported the difficulties that many veterans in rural areas face trying to get care in an emergency.

Understandably, many rural clinics are not equipped to handle many types of emergencies including heart attacks, strokes, and mental health emergencies. They simply go beyond the capacity of these relatively small clinics. But we know that emergencies will happen, and we need to be prepared.

To address this, our legislation will require VA to ensure that all rural health care providers are actually identifying their clinical capacity and have a contingency plan for how they handle emergencies that exceed that capacity.

That way, if a veteran shows up with a mental health emergency, for example, he or she will really get the best care possible in addressing that emergency. We cannot have veterans committing suicide or suffering intense psychological anguish because they could not get care.

I have also heard some Minnesota County veterans' services officers about veterans who get taken to a hospital for a heart attack

because the VA clinic does not have an emergency room and then have real trouble getting reimbursed, getting it covered. They have to pay for it themselves. The coordination of care that our bill promotes will also make that situation far less likely.

Finally, finally, our bill brings much-needed accountability to the VA's Office of Rural Health. I appreciate that VA wants ORH to achieve its mission. This legislation will make that happen and happen faster. I would also note that the Appropriations Committee in its report accompanying the military construction/VA appropriations express its belief, quote, that "the VA must do more to plan for and provide quality health care to veterans living in rural and highly rural areas."

ORH is dedicated to the provision of health care to rural veterans, and the Congress has provided substantial funds for that very important purpose. But thus far the results have not been good enough and this speaks so clearly, I think, to what the Ranking Member said in his opening.

Our legislation will ensure that the VA improves access to care for rural veterans so they can get the excellent health care that they deserve. We owe them nothing less. Thank you.

Chairman MURRAY. Thank you, Senator Franken.

With that, we will turn now to Senator Wyden.

**STATEMENT OF HON. RON WYDEN,
U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you, Madam Chair.

Madam Chair, I would ask first that my statement, my statement's entirety could be put in the record and perhaps I could just summarize. I know you have additional colleagues who are waiting to testify.

Chairman MURRAY. Absolutely. Every Senator's statement will be printed in the record.

Senator WYDEN. Thank you, Madam Chair, and first of all, Madam Chair, as your Pacific Northwest neighbor, let me just thank you for the extraordinary advocacy that you have brought to the cause of veterans. I get to see it, and most recently the work that you are doing now to up the ante in the fight against PTSD is extraordinarily important. I want you to know I appreciate it and want to help.

And to Senator Burr, my friend, we have worked together for a lot of years on these kinds of issues, and you have just been tireless and a terrific partner, and I thank you for it.

Madam Chair, what Senator Burr and I are sponsoring is S. 3270. This is a piece of legislation that comes about as a result of a lengthy undercover investigation done by the Government Accountability Office. It was done on behalf of Senator Burr, yourself, and several of us from the Senate Aging Committee.

So, lots of times around here you cannot get one Committee to agree. We have now been able to get two committees to work together in a bipartisan way.

The heart of the problem and what the GAO found, and I started looking at some of these senior abuses, you know, years ago when I was codirector of the Oregon Gray Panthers and the Senior Citizens Law Program, is they really uncovered some of the sleaziest

practices in terms of older veterans that I have seen in the years that I have spent working in this field.

What it essentially involves is a program called Aid and Attendance. This program is essentially a lifeline for the poorest and most vulnerable who have served our country. It is for very sick veterans, folks who are no longer able to care for themselves and do not have the resources to pay for their care.

What you have is essentially several hundred financial firms. They are called pension poachers, and we see them around the country basically trying to find ways to either talk these vulnerable veterans out all their resources or tie up their assets in a way that is good for the financial firm.

These case, just to highlight, that we saw in our hearings was one from Montana. A veteran there was referred by the management of the retirement home to one of these pension poaching companies from Mississippi for assistance with the Aid and Attendance benefit.

So, what the poachers did was charge the veteran a very substantial sum, \$2,500, to fill out the application paperwork that they essentially can get for free, and it was eventually filed with the VA but it was denied because the paperwork was never actually signed by the veteran.

What the poachers did, however, and this is a very common kind of practice, is to get the veteran's signature on a power of attorney and that way they can tie up their assets in one of these corporations that are located out of State.

That has been a special magnet for these pension poachers. They try to sell these inappropriate financial instruments, deferred annuity, certain types of trusts. That way they can, in effect, benefit while the veteran's money, in effect, becomes unusable during the veteran's lifetime.

So, what the Government Accountability Office recommended, you know, Madam Chair, was the establishment of a look-back approach similar to what has been used for years with Medicaid or Social Security.

This would take away the incentive for the pension poacher to target older veterans. Senator Burr and I have joined in sponsoring this bill. It is legislation that would, in effect, implement the recommendations from the Government Accountability Office that come from this undercover investigation.

For colleagues who would like to see the tapes of this undercover inquiry, Senator Burr and I can make it available to you. But I will tell you that having worked in this field now for many years and going back to the days with Gray Panthers and always watching how unfortunately there are some people out there who try to rip off older people and here they are ripping off older veterans.

This is some of the sleaziest stuff I have ever seen. We ought to take away the incentive to rip off the people who desperately need this benefit.

My sense is in this kind of financial climate, and the Chair of the Committee did important work on the Super Committee, if people keep ripping off this program, people are going to say, well, maybe this is something we should not have any longer.

Senator Burr and I want to make sure that this program remains for the most needy and most vulnerable and that is why I very much appreciate the chance to come here.

I know Senator Boxer and Senator Portman are waiting. If the rest of my remarks could be put into the record, I would very much appreciate it.

Chairman MURRAY. We will do that. Thank you very much, Senator Wyden.

Senator WYDEN. Thank you, Madam Chair, Senator Burr.
[The prepared statement of Senator Wyden follows:]

PREPARED STATEMENT OF HON. RON WYDEN, U.S. SENATOR FROM OREGON

Chairman Murray and Senator Burr, I want to thank you for allowing me the time to appear before the Committee on Veterans' Affairs today.

The legislation that I'm here today to discuss is the result of the great bipartisan efforts of the two of you and well as this Committee and the Senate Committee on Aging. I think this demonstrates the importance of this issue.

Senator Burr, you especially have been a relentless driving force behind this bill, and I'm honored to have introduced it with you.

As you'll recall, a few weeks ago the Senate Special Committee on Aging held an investigative hearing on scams targeting elderly veterans using a specific VA pension as a lure.

The Aging Committee found that some financial planners, lawyers and others are using the VA's "enhanced pension with aid and attendance," or simply, Aid and Attendance, to enrich themselves at our veterans' and taxpayers' expense.

What makes this even worse is the fact that Aid and Attendance was specifically designed to help infirm and impoverished elderly veterans, so many of the victims of these pension poachers are the ones who can afford it least.

At the hearing, the Government Accountability Office testified about the undercover investigation they conducted at the request of Senators Murray, Burr, Kohl and I. They found versions of this scam nationwide, with over two hundred pension poaching companies in operation.

GAO's recommendation to Congress was the establishment of a look-back period, similar to Medicaid or Social Security, to take away the incentive for the Pension Poachers to target elderly veterans, and preserve this benefit for the veterans it is intended to help.

This recommendation has been echoed by veterans' advocacy groups and the VA itself.

Senator Burr and I authored S. 3270, which would provide this look-back. We worked closely with the VA and other experts to ensure our bill fixes the problem, but does not create collateral damage like an increased backlog of claims.

We knew we had to drain the swamp and get rid of these pension poachers, but we also had to ensure the benefits our veterans need would be accessible quickly and without excessive red tape.

We also didn't want to inadvertently punish veterans who were misled by the false or inaccurate promises, so we've included specific waiver authority to address this.

"Aid and Attendance" is an invaluable lifeline for many veterans. This program is for the very sick—veterans who are no longer able to care for themselves and who do not have the resources to pay for care. It is a benefit intended to ensure that those who served their nation with honor can live out their final days in dignity.

I believe the bill that Senator Burr and I have introduced, which already has strong bipartisan support, will preserve the Aid and Attendance benefit, while protecting our veterans from pension poachers who are driven only by greed.

I'm pleased to announce we've received formal support from AMVETS, recognizing the importance of this legislation in protecting our veterans.

We've also received a letter from the Assisted Living Federation of America, supporting this bill and pledging to help in the development of industry best practices to further ensure veterans are treated with the integrity they deserve.

I hope that this Committee will support this legislation, and help put an end to the malicious practices of these pension poachers.

Chairman Murray, Thank you again for the time to speak this morning. I truly appreciate your consideration of such an important matter.

Chairman MURRAY. Senator Boxer.

**STATEMENT OF HON. BARBARA BOXER,
U.S. SENATOR FROM CALIFORNIA**

Senator BOXER. Madam Chairman, Ranking Member Burr, and Members of the Committee, my friends, you know, I am in the middle of some very interesting negotiations right now that are looking good; but even though that is the case, I want you to know how honored I am to be sitting here listening to my colleagues come forward with such good ideas, and to have this forum is such an honor.

I just want to say, I am in awe of the Chairman for the work she is doing and the Ranking Member beside her, and to serve with the Ranking Member as the Chair of the Military Families Caucus is a great honor.

So, I come here and I will stick within the time limit because I know how much work you have to do, and that you have to hear from a lot of people. I came here to talk to you about the epidemic of veteran homelessness and to offer an idea that does not cost any money that I think would be terrific involving the American people in fighting this epidemic.

You know, I would say probably all of those in this room—I certainly hope all of us in this room—have safe, comfortable, permanent homes to live in, and we take it for granted. Yet every night 67,500 of our Nation's veterans are homeless. Again, 67,500 of our veterans are homeless. This is inexcusable because no veteran should ever have to spend the night on the streets, and I know we all agree with that.

Ensuring that our veterans have safe, stable housing is also a smart thing to do because research has shown that a home is the very foundation on which a veteran can build and sustain a successful life.

In my homestate of California I met a veteran, Holbert Lee. When Mr. Lee returned home from Vietnam, he ended up addicted to drugs and homeless on the streets of San Francisco.

We have an organization there called Swords to Plowshares, and they helped him turn his life around, Madam Chairman. With the help of a housing voucher and VA support services, Mr. Lee now has a home to call his own; and today as a vocational specialist at the San Francisco VA. He is working to assist other veterans.

Holbert Lee is a success story and proof of what can happen when we end a cycle of homelessness. But there are too many more men and women who we have not reached.

Now, our government announced a goal to end veterans' homelessness by 2015, and I would like to think when we announce a goal like that we mean it. This is not just something we throw out but yet Secretary Shinseki admitted, quote, while we are not where we need to be just yet, we have movement, but it is too early to begin high-fiving one another.

It is clear from those words that we have a long way to go. So, I introduced S. 1806, the Check the Box for Homeless Veterans' Act of 2011. Very straightforward. It creates a check-off box on the annual Federal tax return. Taxpayers can decide to make a voluntary contribution of one dollar or more to support programs that prevent and combat veterans' homelessness.

The donations are deposited in a new homeless veterans' assistance fund established at the Treasury that can only be used to supplement Congressionally appropriated funds for these various programs to help veterans.

Now, let me be very clear. These funds in the check-off box will not be allowed by law to replace any budgeted dollars. There needs to be a maintenance of effort but they would be used to supplement those dollars.

So, colleagues, I want to say, well, before I do my real close, I want to place in my record with your permission, Madam Chair, letters of support from the Veterans Foreign Wars, from the National Coalition for Homeless Veterans, from Team AMVETS, from the Center for American Homeless Veterans, Inc., and from the California Association of Veterans Services, and Swords to Plowshares. Might I put those in the record?

Chairman MURRAY. We will do that.

[The letters are included in the Appendix.]

Senator BOXER. And I think if you read these letters, they strongly support this approach.

So, in conclusion, I would say that our veterans have given so much. You are dealing with this every day and a lot of them suffer and they suffer mightily and having a home is the least we can do, and I think that all Americans want a chance to help. They feel sometimes helpless but with a dollar and a check off if every American paying, you know, their taxes did that we could do something special.

I hope you will consider this. I will work with you to make it happen. I thank you for your dedication.

Chairman MURRAY. Thank you very much.

We will turn to Senator Portman.

**STATEMENT OF THE HON. ROB PORTMAN,
U.S. SENATOR FROM OHIO**

Senator PORTMAN. Thank you, Madam Chair, I appreciate it. I got used to calling you Madam Chair in another little Committee we served on.

Chairman MURRAY. I remember it.

Senator PORTMAN. This one is more super than that one was.

[Laughter.]

Chairman MURRAY. And I agree.

Senator PORTMAN. Thank you what you do every day for our veterans, and Ranking Member Burr, I was just with him in North Carolina recently, another champion for our veterans. Senator Isakson and Senator Boozman who testified on the floor last night about veterans.

I am here to ask you to support this bill, S. 2244, the Veterans Missing America Act. It has been a privilege to work with my colleague, Senator Begich, on this, and it helps bring light to a critical issue that many of us are becoming aware of.

At funeral homes and mortuaries all across this great country, thousands of veterans ashes and remains go abandoned, unclaimed; and in response to these unfortunate circumstances, a handful of veterans service volunteers began this project called Missing in America Project. It is a terrific group of volunteers who

have been very active in my homestate of Ohio, and I am sure in many of your States.

Regrettably, when individuals pass away, and there is no next of kin identified, the remains sometimes stay at funeral homes or mortuaries, without anyone laying them to rest, indefinitely.

Of the hundreds of thousands of unclaimed remains in this country, it is estimated that over 10,000 are remains of our veterans. The Missing America Project tries to identify anyone who is a veteran among those unclaimed remains and then provide a proper burial and funeral.

Sometimes these dedicated volunteers have run into bureaucracy and complications because they tried to do that. It is a noble cause but, due to limitations on third-party involvement, it has become difficult for them.

So, this legislation attempts to address these complications, recognizing their tireless work and dedication and in cooperation with numerous veterans service organizations have put together a legislative approach here that we think will help identify unclaimed remains and ensure that the Department of Veterans Affairs will work with these volunteers to see every veteran receives the respect that they deserve.

As I mentioned, in Ohio we have taken a leadership role on this. Despite some of these roadblocks we are talking about we are trying to fix today, the Department of Veterans Affairs in Ohio, along with these volunteers from the Missing America Project, have had an initial burial of 10 veterans at the Dayton National Cemetery in May of this year.

These were veterans of World War I, World War II, and Korea; and in this case, the remains had been at funeral homes for between 15 and 25 years.

It was a very moving ceremony. There were a few hundred people who showed up to pay their respects, none of whom knew the veterans but they were there to pay their respects for their service to our country.

Although we have had some successes like those, the work of these volunteers is encumbered by the Department of Veterans Affairs next-of-kin requirements. The bill, therefore, directs the Secretary of Veterans Affairs to work with veterans service organizations to assist entities in identifying veterans eligible for burial in a national cemetery.

If the remains are of an eligible veteran, the Secretary of the Department of Veterans Affairs is then required to provide the burial benefits already authorized to that veteran.

It is important to note to this Committee that since we introduced the legislation with Senator Begich in March and along with our counterparts in the House, there is companion legislation in the House, we have worked closely with the Department of Veterans' Affairs to ensure the measure is appropriately worded to meet the sheer intent that we have; and through those discussions and their technical suggestions, we have amended the language including refining the burial eligibility criteria to ensure that benefits are provided to qualifying veterans.

We stand ready to submit these technical amendments and refinements to the Committee during your markup of the bill. Our

intent is to add no new spending through this provision and we will work with the Committee very closely and, of course, with the Department to achieve that goal.

I am proud to say that the National Association of State Directors of Veterans Affairs has expressed support for the Missing America Project and has urged our Nation's leaders to take action. Additionally, this effort has the support of the National Funeral Directors Association and The American Legion.

Those who gave their life in service to our country deserve an honorable burial, and this bill is a step toward ensuring that eligible veterans do receive that burial in a national cemetery given the respect that they rightly deserve.

Thank you very much for the opportunity to testify on that this morning, and I look forward to working with the Committee on this going forward along with all of the other good work that you are doing.

While I am here, Madam Chair, I would also like to thank you for having S. 3238 on the docket this morning. This measure would designate the Department of Veterans Affairs Community Based Outpatient Clinic in Mansfield, Ohio, in the name of Private First Class David F. Winder. I am pleased to cosponsor this measure along with Senator Sherrod Brown as we seek to honor this Metal of Honor recipient from Vietnam who provided medical aid to his soldiers in Vietnam and died in doing so.

So again, thank you for your help on both of these important pieces of legislation, and I look forward to working with the Committee further.

Chairman MURRAY. OK. Thank you very much.

I will just let all the Senators know who have been testifying today that we are going to be working with them and their staff and the Administration on all of these bills.

As Senator Burr mentioned, we do have to pay for all of the legislation that comes before this Committee. So, we have a lot of work to do, but we will be scheduling a markup on all of these pieces of legislation toward the middle of July, and I will be working with Senator Burr on that. So, thank you very much.

At this time then, I would like to welcome and introduce our first panel. From the Department of Veterans Affairs, we have Dr. Madhulika Agarwal, the Deputy Under Secretary for Health Policy and Services at the Veterans Health Administration.

Also joining us today from the VA is Thomas Murphy, Director of the Compensation Service at the Veterans Benefits Administration. Accompanying Dr. Agarwal and Mr. Murphy is Deputy Under Secretary for Health for Operations and Management at the Veterans Health Administration William Schoenhard, as well as Jane Claire Joyner and Richard Hipolit from the Office of General Counsel.

We appreciate all of you being here today.

The Department's full statement will be entered into the record and, Dr. Agarwal, please begin.

STATEMENT OF MADHULIKA AGARWAL, DEPUTY UNDER SECRETARY FOR HEALTH POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. AGARWAL. Chairman Murray, Ranking Member Burr, and other Members of the Committee, thank you for the opportunity to address the health care bills on today's docket.

My colleague, Mr. Murphy, will address the VBA bills under consideration. I will highlight some of the critical issues that are themes of many of the bills on the agenda and a detailed discussion of these bills can be found in my written statement.

First, Chairman Murray, thank you for your continued efforts to emphasize the health care needs of women veterans. I am proud of VA's efforts in improving women's health, and I know we can make further enhancements working with the Committee.

Your bill, S. 3313, the Women's Veterans Health and Other Care Improvement Act, among other features includes reproductive health issues. The VA's goal is to restore the capabilities of veterans with disabilities to the greatest extent possible. VA does not yet have a position on S. 3313 but we have had productive discussions with your staff which we look forward to continuing.

Second, several bills address programs for rural veterans. VA is committed to improving access and quality of health care for this population. My written testimony outlines what VA is doing to meet this challenge, including greater use of telehealth technologies and collaboration with other Federal and State agencies and community providers to provide more points of care.

This work is especially important to increase access to mental health services for veterans in rural areas. We note in our testimony that some features of the bills would overlap with our current efforts. We will be glad to discuss how we can best advance the goals of the legislation before us.

Third, while we do not have views today on S. 3340 regarding the Mental Health ACCESS Act of 2012, we will follow-up with the Committee as soon as possible.

We fully recognize there is no more critical need than effective and timely mental health care. We strive to improve all facets of mental health services. To increase our capacity to meet current and future demand, we have launched a new hiring initiative to increase staff, and we will continue our efforts to increase access to quality mental health care.

Fourth, we regret we do not have a position this morning on S. 3049 which expands the definition of homelessness. We will provide information on that to the Committee as soon as possible.

Let me assure the Committee that whatever the technical considerations may be on a statutory definition, VA never would and never will turn away a homeless veteran who finds themselves on the street because they are fleeing domestic violence.

Finally, turning to Ranking Member Burr's legislation on VISN reorganization, we have been working for the past year to review VISN operations.

My written testimony describes these ongoing efforts, and we would like to brief the Committee in greater detail on these plans. We believe S. 3804 is too prescriptive in legislating particular

boundaries and structures and Mr. Schoenhard will be glad to discuss this issue.

Madam Chairman, this concludes my statement. Mr. Murphy will now address the pending VBA legislation and we will then be ready to answer your questions.

Chairman MURRAY. Mr. Murphy.

STATEMENT OF THOMAS MURPHY, DIRECTOR, COMPENSATION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION; JANE CLAIRE JOYNER, OFFICE OF GENERAL COUNSEL; AND RICHARD HIPOLIT, OFFICE OF GENERAL COUNSEL

Mr. MURPHY. Chairman Murray, Ranking Member Burr, and other Members of the Committee, thank you for the additional time to comment on the extensive agenda before us today. As Dr. Agarwal did, I will only touch on a few highlights, as you have our detailed testimony for the record.

VA wholeheartedly supports Senate Bill 2259, the Veterans Cost of Living Adjustment Act. It would express in a tangible way this Nation's gratitude for the sacrifices made by our service-disabled veterans and their surviving spouses and children and would ensure that the value of their well-deserved benefits will keep pace with the increased cost of living.

Two bills on the agenda concern the burial needs of the indigent veterans whose remains are unclaimed. Senate Bill 2244, the Veterans Missing in America Act and Senate Bill 3202, the Dignified Burial of Veterans Act.

VA appreciates the Committee's continued attention to ensure that these veterans, including, no doubt, homeless veterans, are honored and are not forgotten. We look forward to continuing to work with you to ensure that all veterans receive dignified and respectful burials, which they earned through our service to our Nation.

We are supportive of these efforts and welcome discussions with the Committee on those few points in the testimony where he recommend improvements in the bill.

For Senate Bill 1707, the Veterans Second Amendment Protection Act, we appreciate the objectives of this legislation to protect the firearms rights of veterans determined by VA to be unable to manage their own financial affairs.

VA determinations of mental incompetency are based generally on whether a person lacks the mental capacity to manage his or her own financial affairs due to injury or disease. We believe that there are adequate protections in the law now such that a veteran with a determination of incompetency has two procedures available to make a showing to restore his or her ability to purchase a firearm.

In the interest of time, I will then herein refer the Committee to my written statement. I would be happy to answer any questions you or the Members of the Committee may have.

[The prepared joint statement of Dr. Agarwal and Mr. Murphy follows:]

PREPARED STATEMENT OF DR. MADHULIKA AGARWAL, DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Murray, Ranking Member Burr, and other Members of the Committee, I am pleased to provide the views of the Department of Veterans Affairs (VA) on pending legislation. Joining me today are Tom Murphy, Director, Compensation Service, Veterans Benefits Administration; William Schoenhard, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration; Jane Clare Joyner, Deputy Assistant General Counsel; and Richard Hipolit, Assistant General Counsel.

VA regrets not having sufficient time to formulate views for S. 1391; S. 3049; S. 3206; S. 3270; S. 3238; S. 3282; S. 3308; S. 3309; S. 3313; S. 3316; S. 3324; S. 3336; a draft bill to amend title 38, United States Code, to improve the multi-family transitional housing loan program of the Department of Veterans Affairs; and a draft bill entitled the “Mental Health Access to Continued Care and Enhancement of Support Services Act of 2012” or “Mental Health ACCESS Act of 2012.” VA will provide views for these bills at a later date.

S. 1264—VETERAN VOTING SUPPORT ACT OF 2011

VA has a tradition of successfully supporting and facilitating Veteran voting, without disrupting the delivery of health care and services to Veterans. Facilities use posters and flyers to emphasize the issue of voting to patients and visitors, and VA volunteers assist Veterans in registering to vote. VA facilitates transportation to the polls for Veterans to vote, using VA resources and volunteers. VA tracks these voter registration and facilitation activities.

The Department’s voter assistance policy (VHA Directive 2008–053) focuses on Veterans who are inpatients at VHA facilities. Under this directive, Veterans staying at VA facilities are currently provided the same type and level of assistance and support that would be required under the bill. During the 2008 election cycle more than 9,000 posters were placed at VA facilities, more than 225,000 flyers were provided to new inpatients through their welcome packets and comfort kits, and 1,100 volunteers were recruited specifically to provide voter information and assistance to Veterans. VA also partnered with non-partisan groups to conduct more than 80 informational “voter drives.” As a result, close to more than 5,900 inpatients received assistance in registering to vote. While not a principal focus, voter assistance does reach Veterans using outpatient services as well.

Section 3 of this bill would require VA to provide a “mail voter registration application” to each Veteran seeking enrollment in VA health care and to all enrolled Veterans any time there is a change in enrollment status or address. It would also require VA to provide assistance with voter registration to Veterans unless they refuse such assistance, and would require VA to accept completed voter registration forms and transmit them to the appropriate state election official within 10 days of receipt (unless they are received within 5 days of the registration deadline, in which case they must be sent within 5 days). Section 3 also would prohibit VA from influencing Veterans or displaying any political preference and would prohibit VA’s use of this information for any purpose other than voter registration. The bill would allow anyone aggrieved to provide notice of the violation to the facility director or the Secretary and would require the director or the Secretary to respond within 20 days. If a violation is not corrected within 90 days, the aggrieved person may provide written notice to the Attorney General and Election Assistance Commission. Section 3 also authorizes the Attorney General to bring a civil action for violations.

Section 4 would require VA, consistent with state and local laws, to assist Veterans residing in VA facilities with absentee balloting. Section 5 would require the Secretary to permit nonpartisan organizations to provide voter registration information and assistance at Department health care facilities, subject to reasonable limitations.

Section 6 would similarly prevent VA from prohibiting any election-administration official from providing voter information to Veterans at any VA facility. Moreover, it would require VA to provide reasonable access to VA health care facilities to state and local election officials for providing nonpartisan voter registration services. Section 7 would require VA to submit an annual report to Congress on the agency’s compliance with this Act as well as the number of Veterans served by VA’s health care system, the number of Veterans who requested information or assistance with

voter registration, the number who received information or assistance, and information regarding notices of violations.

As noted previously, VA is committed to helping Veterans exercise their right to vote, and, especially in recent years, has increased the non-partisan assistance provided to Veterans. While VA applauds the bill's goals, it opposes S. 1264 as it is overly burdensome and, in some respects, duplicates the agency's existing voter assistance efforts.

As described above, Section 3 of the bill would require VA to provide a voter registration application form to each Veteran who seeks to enroll, and to enrolled Veterans any time there is a change in the enrollment status of that Veteran, or a change in the address of the Veteran. As VA facilities treat patients from multiple jurisdictions under a national system, implementing these requirements would be extraordinarily complicated. Under this national system, Veterans have the ability to use VA facilities not necessarily in their home jurisdiction. It would require VA to keep and apply authoritative information on elections, voter registration deadlines, and voter registration requirements in all 50 states.

The multi-jurisdictional nature of VA also creates complications for providing the assistance with absentee ballots outlined in Section 4 of S. 1264; however, Section 4 is limited to Veteran inpatients, those residing in Community Living Centers, and domiciliaries.

This bill would also require the Secretary to permit nonpartisan organizations to provide voter assistance at facilities of the VA health care system. In addition, S. 1264 provides that the Secretary shall not prohibit any election official from providing voting information to Veterans at any facility of the Department of Veterans Affairs. Though the legislation allows VA to set reasonable time, place and manner restrictions on visits by election officials and nonpartisan groups, it is not clear that VA could entirely exclude election officials from certain facilities. There are some places within VA, such as National Cemeteries, psychiatric facilities, and Vet Centers, which are not appropriate locations for voter information and assistance activities from outside entities. Moreover, the definition of election official is overly broad as it could be interpreted to include volunteer "election judges" or "election monitors" who are assigned by campaigns or political parties to watch polling locations for irregularities on the day of an election. Directive 2008-053 currently provides nonpartisan organizations and election officials access to VA health care facilities for the purpose of providing voter information and assistance.

The costs for the requirements of this bill are significant. They include an initial mail-out to approximately 8.2 million enrollees at a cost of \$5.3 million and estimated recurring costs of \$1.2 million annually. VHA would have to create a Voter Assistance Program in VA Central Office and in the field to support the proposed legislation. VA estimates the entire cost of implementing S. 1264 would be \$26.0 million in FY 2013, \$6.1 million in FY 2014, \$113.3 million over 5 years, and \$242.4 million over 10 years.

S. 1631—A BILL TO AUTHORIZE THE ESTABLISHMENT OF A CENTER FOR TECHNICAL ASSISTANCE FOR NON-DEPARTMENT HEALTH CARE PROVIDERS FURNISHING CARE TO VETERANS IN RURAL AREAS

Section 1(a) of S. 1631 would authorize the Secretary of Veterans Affairs to establish a center responsible for providing technical assistance to non-VA health providers who furnish care to Veterans in rural areas. Were the Secretary to exercise this authority, section 1(b) of the bill would permit VA to refer to the center as the "Rural Veterans Health Care Technical Assistance Center" (the "Center"). It would also require the Secretary to appoint a Director for the Center from candidates who are qualified to carry out the duties of the position and who possess significant knowledge and experience working for, or with, a non-VA health care provider that furnishes care to Veterans in rural areas.

Section 1(c) of S. 1631 would require the Secretary of Veterans Affairs to select the location of the Center and, in doing so, to give preference to a location that meets a set of detailed criteria relating to available infrastructure and a high number of Veterans in rural and highly rural areas, among other factors.

Section 1(d) of S. 1631 would require the Center to carry out the following tasks:

- Develop and disseminate information, educational materials, training programs, technical assistance and materials, and other tools (1) to improve access to health care services for Veterans in rural areas and (2) to otherwise improve health care provided to Veterans by non-VA health care providers;
- Improve collaboration on health care matters, including the exchange of health information, for Veterans receiving health care from both VA and non-VA providers serving rural populations;

- Establish and maintain Internet-based information on mechanisms to improve health care for Veterans in rural areas (including practical models, best practices, research results, and other appropriate information);
- Work with existing Government offices and agencies, including those specified in the bill, on programs, activities, and other mechanisms to improve health care for rural Veterans;
- Track and monitor fee expenditures incurred by VA in using non-VA health care providers to serve rural populations; and
- Evaluate the Center through the use of an independent entity that is experienced and knowledgeable about rural health care matters, non-VA providers serving rural populations, and VA programs and services.

Finally, section 1(e) of S. 1631 would authorize the Center, in discharging its functions, to enter into partnerships with: (1) persons and entities that have demonstrated expertise in the provision of education and technical assistance to Veterans in rural areas; (2) health care providers serving rural populations; and (3) persons and entities seeking to enter into contracts with the Federal Government in matters relating to functions of the Center (including the provision of education and technical assistance relating to telehealth, reimbursement for health care, improvement of quality of care, and contracting with the Federal Government).

VA appreciates the aims of this legislation, but does not support S. 1631. VA's Office of Rural Health (ORH) currently supports a number of programs and initiatives that are accomplishing many of the activities proposed for the Center for Technical Assistance. Specifically, ORH currently funds "The Health and Resource Initiative for Veterans Everywhere (THRIVE) On-Line," a collaboration with Stanford University School of Medicine, eCampus Rural Health, and VA Palo Alto Health Care Systems. THRIVE also partners with multiple VA services and community agencies. Participating VA staff are from a number of complementary Department programs, such as mobile medical, homeless outreach, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), women's outreach, and incarcerated Veterans re-entry teams. Successful partnerships have been established with local homeless shelters, employment agencies, and county health clinics. THRIVE On-Line also provides technical assistance, materials, and other tools to VA and non-VA providers alike, to improve the health care of our Veterans in rural areas.

In addition, ORH currently funds three Veterans Rural Health Resource Centers (VRHRCs). These centers function as field-based clinical laboratories for demonstration projects. A number of these projects are focused on developing models of care as well as innovative clinical practices and systems of care for rural Veterans. The VRHRC—Western Region is located in Salt Lake City, Utah. Much of the work of this center focuses on outreach, access issues, and the special needs of Native American Veterans and aging Veterans. One of its major efforts has been to establish an outreach program to build partnerships with community agencies and organizations that serve rural communities. Through these partnerships, rural Veterans receive information about, and assistance in identifying, VA benefits for which they may be eligible. The VRHRC—Central Region is located in Iowa City, Iowa. This center focuses on evaluating rural health programs and piloting new strategies to help Veterans overcome identified barriers to access to (quality) care. The VRHRC—Eastern Region has three locations: Gainesville, Florida; Togus, Maine; and White River Junction, Vermont. Their collective focus is on developing models to deliver specialty care and services to rural areas and on educating and training VA's next generation of rural health care providers. VRHRC staff members also serve as rural health experts for VA providers Nation-wide, and they provide training and education services to both VA and non-VA providers caring for rural Veterans.

ORH also funds and oversees Veterans Integrated Service Network (VISN) Rural Consultants (VRCs). There is a VRC in each VISN that serves as the primary interface for ORH, the VISN, and the community regarding rural activities. The VRCs work closely with internal and external stakeholders to introduce, implement, and evaluate ORH-funded projects. The VRCs are also instrumental in conducting outreach to develop strong partnerships with community members, state agencies, rural health providers, and special interest groups. Since being established, ORH has funded well over 500 projects across the VA health care system. These projects cover a myriad of areas, such as education, home-based primary care, long-term care, mental health, case management, telehealth, primary care, and specialty care. ORH also funds "Project Access Received Closer to Home (ARCH)," which is a 3-year pilot program to provide health care services to rural Veterans through contractual arrangements with non-VA care providers.

VA has also recently drafted a memorandum of understanding (MOU) between the Department of Veterans Affairs (VA's Office of Rural Health) and the Depart-

ment of Health and Human Services (Offices of the National Coordinator for Health IT and Rural Health Policy) to ensure interoperability between VA and rural health care providers to allow and promote the effective exchange of health information.

Information on practical models, best practices, research results, and other appropriate information on mechanisms to improve health care for Veterans in rural areas, is already available on the ORH Web site at <http://www.ruralhealth.va.gov/>, at THRIVE On-Line, <http://ruralhealth.stanford.edu/>, and on the VA Internet at <http://www.va.gov/>.

As to the bill's requirement to monitor and track fee expenditures in this area, the VHA Support Service Center (VSSC) already tracks all fee expenditures down to the Veterans' Zip Code in the "Non-VA Care Cube."

In sum, S. 1631 is duplicative of VA's on-going efforts to improve access to quality health care for Veterans residing in rural areas. VA has committed considerable resources not only to ORH and other affected VA program offices but also to our collaborative projects with other Government Departments and Agencies. To date, these and related efforts have proven, and continue to prove, successful in developing models of care, providing education to VA and non-VA providers through the Internet, establishing an MOU for health information exchange, and developing innovative clinical activities and systems of care. As we continue to monitor, expand, and improve our efforts in this area, we will be glad to keep the Committee advised of our activities and progress.

VA estimates the costs associated with enactment of S. 1631 to be \$2.1 million for FY 2013, \$11.7 million over a 5-year period, and \$25.8 million over a 10-year period.

S. 1705—TO DESIGNATE THE DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CENTER IN SPOKANE, WA

S. 1705 would designate the Veterans Affairs Medical Center in Spokane, Washington as the "Mann-Grandstaff Department of Veterans Affairs Medical Center." VA defers to Congress in the naming of this facility.

S. 1707—VETERANS SECOND AMENDMENT PROTECTION ACT

S. 1707, the "Veterans Second Amendment Protection Act," would provide that a person who is mentally incapacitated, deemed mentally incompetent, or unconscious for an extended period will not be considered adjudicated as a "mental defective" for purposes of the Brady Handgun Violence Prevention Act in the absence of an order or finding by a judge, magistrate, or other judicial authority that such person is a danger to himself, herself, or others. The bill would have the effect of excluding VA determinations of incompetency from the coverage of the Brady Handgun Violence Prevention Act.

We understand and appreciate the objective of this legislation to protect the firearms rights of veterans determined by VA to be unable manage their own financial affairs. VA determinations of mental incompetency are based generally on whether a person because of injury or disease lacks the mental capacity to manage his or her own financial affairs. We believe adequate protections can be provided to these veterans under current statutory authority. Under the NICS Improvement Amendments Act of 2007 (NIAA), there are two ways that individuals subject to an incompetency determination by VA can have their firearms rights restored: First, a person who has been adjudicated by VA as unable to manage his or her own affairs can reopen the issue based on new evidence and have the determination reversed. When this occurs, VA is obligated to notify the Department of Justice to remove the individual's name from the roster of those barred from possessing and purchasing firearms. Second, even if a person remains adjudicated incompetent by VA for purposes of handling his or her own finances, he or she is entitled to petition VA to have firearms rights restored on the basis that the individual poses no threat to public safety. Although VA has admittedly been slow in implementing this relief program, we now have relief procedures in place, and we are fully committed going forward to implement this program in a timely and effective manner in order to fully protect the rights of our beneficiaries.

We also note that the reliance on an administrative incompetency determination as a basis for prohibiting an individual from possessing or obtaining firearms under Federal law is not unique to VA or veterans. Under the applicable Federal regulations implementing the Brady Handgun Violence Prevention Act, any person determined by a lawful authority to lack the mental capacity to manage his or her own affairs is subject to the same prohibition. By exempting certain VA mental health determinations that would otherwise prohibit a person from possessing or obtaining firearms under Federal law, the legislation would create a different standard for

veterans and their survivors than that applicable to the rest of the population and could raise public safety issues.

The enactment of S. 1707 would not impose any costs on VA.

S. 1755—COVERAGE UNDER DEPARTMENT OF VETERANS AFFAIRS BENEFICIARY TRAVEL PROGRAM OF CERTAIN DISABLED VETERANS FOR TRAVEL FOR CERTAIN SPECIAL DISABILITIES REHABILITATION.

S. 1755 would amend VA's beneficiary travel statute to ensure beneficiary travel eligibility for Veterans with vision impairment, Veterans with spinal cord injury or disorder, and Veterans with double or multiple amputations whose travel is in connection with inpatient care in a VA special disabilities rehabilitation program.

This legislation could be construed to apply for travel of specified Veterans only in connection with their inpatient care in special rehabilitation program centers, and would apply only to Veterans with the specified medical conditions who are not otherwise eligible for beneficiary travel under 38 U.S.C. § 111. VA provides rehabilitation for many injuries and diseases at numerous specialized centers, including programs for Closed and Traumatic Brain Injury (CBI+TBI), Post Traumatic Stress Disorder (PTSD), other mental health issues, Parkinson's Disease, Multiple Sclerosis, Epilepsy, War Related Injury (WRIIC), Pain Management, and various addictions. In addition, many of VA's specialized treatment centers, including blind, SCI, and amputee centers, provide rehabilitation—both initial and ongoing—on an outpatient basis using on and off-station lodging. This legislation clearly would not apply to travel for those specified Veterans receiving care on an outpatient basis and thus would provide disparate travel eligibility to a limited group of Veterans. Therefore, VA does not support S. 1755 as written.

VA does support expansion of travel benefits to a larger group of Veterans (including blind, SCI, and amputees) and those with other 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.

VA estimates that the total cost for S. 1755 would be \$3 million during FY 2013, \$17.6 million over 5 years and \$43.1 million over 10 years. This estimate is based on workload projections for inpatient services at specialized SCI, Blind, and Amputee centers.

S. 1799—ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2011

S. 1799 would amend the definition of "preventive health services" in 38 U.S.C. 1701 to include the term "recommended adult immunization schedule" and define it to mean the schedule established by the Advisory Committee on Immunization Practices (ACIP). S. 1799 would also amend section 1706 of title 38, to require the Secretary to develop quality measures and metrics to ensure that Veterans receive immunizations on schedule. These metrics would be required to include targets for compliance and, to the extent possible, should be consistent and implemented concurrently with the metrics for influenza and pneumococcal vaccinations. The bill would require that these quality standards be established via notice and comment rulemaking. S. 1799 would also require that details regarding immunization schedules and quality metrics be included in the annual preventative services report required by 38 U.S.C. 1704. VA notes that the effective dates under this proposal would be retroactive to July 1, 2011 for the publication of the proposed measures and metrics and January 1, 2012 for the implementation of the measures and metrics.

VA does not support this legislation, as VA now provides prevention immunizations at no cost to the Veteran. In addition, VHA is represented as an ex-officio member of the ACIP and follows its recommendations. VHA is also an ex-officio member of the Department of Health and Human Services (HHS) National Vaccine Advisory Committee.

VA develops clinical preventive services guidance statements on immunizations in accordance with ACIP recommendations (VHA Handbook 1120.05). All ACIP-recommended vaccines are available to Veterans at VA medical facilities. These vaccines currently include: hepatitis A, hepatitis B, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, tetanus/diphtheria, varicella, and zoster. As the recommendations change, VHA policy reflects those changes. The delivery of preventive care that includes vaccinations has been well established in the VHA Performance Measurement system for more than 10 years with targets that are appropriate for the type of preventive service

or vaccine. VA updates the performance measures to reflect changes in medical practice over time.

Adding the statutory requirement for regulations to the development of targets would be burdensome and lengthy. Moreover, the process does not allow for nimble and quick changes as new research or medical findings surrounding a vaccine come to light. Because the clinical indications and population size for vaccines vary by vaccine, blanket monitoring performance of all vaccines can be cost prohibitive and may not have a substantial positive clinical impact at the population level.

VA estimates the costs associated with enactment of S. 1799 to be as follows: \$654,000 for FY 2013; \$3.5 million over a 5-year period; and \$7.7 million over a 10-year period.

S. 1806—DESIGNATION OF CONTRIBUTIONS TO THE HOMELESS VETERANS ASSISTANCE FUND

S. 1806 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, as provided in appropriations Acts, to supplement funds appropriated to the Department of Veterans Affairs [(VA)], the Department of Labor [(Labor)] Veterans Employment and Training Service, and the Department of Housing and Urban Development [(HUD)] for the purpose of providing services to homeless veterans.” S. 1806 would require that in the President’s annual budget submission for fiscal year 2013 and each year thereafter, VA, Labor, and 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.

While S. 1806 is well-intended, VA is opposed to its enactment. 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 could lead some to see these obligations as a discretionary charity. VA does involve charities and community organizations in its work, and they are vital. But VA prefers that all Federal funding come from affirmative appropriations taken by the Congress, rather than voluntary apportionments through the tax code.

S. 1838—DEPARTMENT OF VETERANS AFFAIRS PILOT PROGRAM ON SERVICE DOG TRAINING

S. 1838 would require the Secretary, within 120 days of enactment, to commence a pilot program for a 3-year period to assess the feasibility and advisability of using service-dog training activities to positively affect Veterans with post-deployment mental health and Post Traumatic Stress Disorder (PTSD) symptoms and produce specially trained service dogs for Veterans. The bill would require the Secretary to conduct the pilot program at one Department of Veterans Affairs (VA) medical center other than in the Department of Veterans Affairs Palo Alto health care system.

The bill requires that the VA medical center selected as the program site have an established mental health rehabilitation program that includes a clinical focus on rehabilitation treatment of post-deployment mental health disorders and PTSD and a demonstrated capability and capacity to incorporate service dog training activities into the rehabilitation program. In addition, the Secretary would be required to review and consider using recommendations published by experienced service dog trainers with regard to space, equipment and methodologies. In selecting the program site, the Secretary must give special consideration to Department of Veterans Affairs’ medical centers located in States that the Secretary considers rural or highly rural. The pilot program must be administered through VA’s Patient Care Services Office as a collaborative effort between the Rehabilitation Office and the Office of Mental Health Services. The national pilot program lead must be from Patient Care Services and have sufficient administrative experience to oversee the pilot program site.

The bill also includes provisions concerning the service dogs themselves. The bill requires VA to ensure that each service dog in training is purpose-bred for this work with an adequate temperament, has a health clearance, and is age appropriate. Dogs in animal shelters or foster homes are not to be overlooked as candidates, but only if such dogs meet the service-dog candidate selection criteria under the bill. The Secretary must also ensure that each service dog in training is taught all basic

commands and behaviors required of service dogs, that the service dog undergo public access training and receives additional training specifically tailored to address the mental health conditions or disabilities of the Veteran with whom the dog will be paired. In other words, that VA independently and internally train or produce service dogs for Veterans with mental health conditions or disabilities.

Other provisions of the bill concern participation in the pilot and the actual instruction of the service dogs. Veterans diagnosed with PTSD or other post-deployment mental health conditions would be eligible to volunteer to participate. The Secretary would be required to give a hiring preference for service-dog training instructor positions to Veterans who have PTSD or some other mental health condition. The bill would also require the Secretary to provide or refer participants to business courses for managing a service-dog training business. In addition, the bill contemplates the Secretary providing "professional support for all training under the pilot program."

VA would be required to collect data on the pilot program and determine the effectiveness of the program in positively affecting Veterans with PTSD or other post-deployment mental health condition symptoms. The data must also indicate the feasibility and advisability of expanding the pilot program to additional VA medical centers. VA would be required to submit an annual report to Congress following the end of the first year of the pilot program and each year thereafter to inform Congress about the details of the program and its effectiveness in specific areas. At the conclusion of the pilot program, the Secretary must submit to Congress a final report that includes recommendations with respect to the extension or expansion of the program.

VA is not opposed to Veterans diagnosed with PTSD, or other post-deployment mental health conditions, training service-dog candidates for persons with disabilities as a component of a treatment plan, so long as the determination of placement with a particular Veteran is made by the service-dog training program that acquires the VA service-dog-in-training candidate and completes the final service-dog training.

However, VA cannot support S. 1838 because as written the bill focuses on training of the dog as opposed to the therapeutic activities that such Animal Assisted Therapy or Animal Facilitated Therapy may provide the Veteran if appropriately administered as a component of a comprehensive mental health treatment program. It is also VA's opinion that a pilot is unnecessary as current efforts at the Palo Alto program focus on the training activity as part of the comprehensive treatment program which incorporates the training of dogs in basic obedience and preparing the dogs to complete the Canine Good Citizen (CGC) test. Establishing another pilot in addition to the existing Palo Alto program would be duplicative, unnecessary and fiscally inefficient.

While excepted from consideration as the pilot program site in S. 1838, the Service Dog Training Program initiated in July 2008 at the Palo Alto Veterans Healthcare System (Menlo Park Division), in collaboration with Bergin University, is an example of a program where Veterans diagnosed with PTSD participate in the training of dogs as one activity in their comprehensive recovery program. The training of these dogs by Veterans participating in the PTSD Treatment Program includes basic obedience training, and the participation is designed to provide the Veterans with opportunities in skills development and community reintegration. The program provides a bridge to community involvement as a component of the dog-training activities. After completion of the basic obedience training program, the dogs that complete training are transitioned to an external Assistance Dogs International (ADI)-accredited organization where they complete a rigorous training regimen to become service dogs and are paired with disabled Veterans.

The Palo Alto program is not an example of VA independently training or producing service dogs for Veterans through all phases of training. The dogs involved in the Palo Alto program were actually trained to become service dogs by an external ADI-accredited organization, over an extended period of time and subject to ADI standards as adopted and applied by that organization. The Palo Alto program training focuses on basic obedience (e.g., commands such as "sit," "stay," and "heel") and public access skills (sensitizing dogs to different environments) to prepare the dogs to become service dogs for disabled persons. That is because VA does not have the expertise, experience, or resources to develop independent training criteria or otherwise train or produce safe, high quality service dogs for Veterans. Such training is highly specialized and includes the training of the Veteran who is to receive the service dog. VA requires that a service dog candidate that is found to have the requisite ability to behave and learn skills at the service dog level, be "given" to a service dog training organization that has the personnel, skills, and specialized abilities to pair the dog with a disabled person (in this case a disabled Veteran) and

train the dog and Veteran on the specific tasks that the dog will perform for that individual Veteran. VA believes its reliance on the recognized expertise of a public or private organization is well-reasoned.

It is unclear in S. 1838 whether subsection 1(d)(5)(C) is concerned with the volunteer Veteran participants who are training the dogs or the Veteran recipients of the dogs. Either interpretation is problematic. If subsection 1(d)(5)(C) is interpreted to refer to the Veterans with whom the dogs are paired to provide actual service dog services, rather than targeting the act of training as therapy and a component of a treatment plan for a particular Veteran, it would require VA to focus on determining what the dog's specialty will be or which category of disabled Veteran it will serve. In other words, the specialized training requirement shifts the goal to the successful training of the service dogs instead of the therapeutic benefit to the Veteran derived from the act of training the dog. Veterans would only be qualified to provide basic training. The advanced stages of specialized training must be turned over to accredited service dog training experts. The dogs' eventual roles or skills will depend on the outcome of this specialized training. If subsection 1(d)(5)(C) is intended to refer to the volunteer Veteran participants with whom the dogs are paired, it is equally inappropriate, as the dogs are not paired with a specific Veteran in the training process, but will almost certainly be trained by several Veterans who are participating in the residential program and who will work with the dogs as a team. Patients come and go based upon their individual clinical indications, and it is unlikely that all volunteer Veteran participants in the treatment/rehabilitation program will be there for the length of time it takes to train a dog to enter a service-dog training program.

Subsection 1(d)(6) states that in designing the program, the Secretary must provide professional support for all training under the pilot program. It is not clear whether this is a mandate that third party organizations actually conduct the training and that Veterans assist or that the bill allows for Veterans to in fact act as "owner-trainers" with assistance of third parties.

The requirement to give a hiring preference to Veterans who have PTSD or other mental health conditions may be counterproductive to the goals and objectives of the pilot program. VA understands the pilot is aimed at creating a therapeutic treatment modality that will help patients currently suffering from and in treatment for PTSD and post-deployment mental health conditions. VA interprets the primary goal of the pilot to be finding better ways to improve the health of this Veteran population by exploring treatments, specifically Animal Assisted Therapy or Animal Facilitated Therapy that will prepare dogs to become service dogs for Veterans. For these reasons, it is critically important that the trainers selected be experts at their job, which is to train Veterans to train dogs as a component of treatment and as a member of the treatment team. It would be beneficial if they also appreciated the importance of serving Veterans and possessed a working knowledge of the needs of this Veteran population, but it is necessary not to confuse the role of the clinical staff with the role of the trainer which is that of training the Veteran to train the dog. The bill also envisions VA hiring trainers as employees. Allowing VA to contract for these services would afford VA more flexibility and access to already available training experts, particularly as there is no Government Service (GS) occupation training service dogs for disabled individuals. Although on the surface this sounds reasonable, should the program prove to be inappropriate for expansion/spread there would be no position available for a dog trainer in the system.

VA is highly doubtful that the requirements of the bill can be accomplished within 120 days of the enactment. VA would have to establish selection criteria, advertise for sites (through a Request for Proposal), evaluate candidates and make selections. We are available to work with the Committee to provide advice on the components of what could be a workable program, and an appropriate mechanism to evaluate the current programs as to whether training service dogs is a clinically appropriate form of treatment based on information gleaned from the Palo Alto program and other related animal therapy programs currently in place within the VA.

VA estimates the cost for the 3-year period of the pilot as follows: \$635,281 in FY 2013; \$658,151 in FY 2014; and \$682,502 in FY 2015 for a total of \$1,975,934.

S. 1849—RURAL VETERANS HEALTH CARE IMPROVEMENT ACT

Section 2(a) of S. 1849 would require VA's Director of the Office of Rural Health (ORH) to develop a 5-year strategic plan for improving access to, and the quality of, health care services for Veterans in rural areas. In developing this plan, the Director would be required to consult with the Director of VA's Health Care Retention and Recruitment Office, VA's Office of Quality and Performance, and VA's Office of Care Coordination Services. It would also require the Director to develop this plan

not later than 180 days after the date of enactment, with the 5-year period beginning on the date of the plan's issuance.

Section 2(b) of the bill would require the strategic plan to include the following elements:

- Goals and objectives for the recruitment and retention of VA health care personnel in rural areas;
- Goals and objectives for ensuring timeliness and improving quality in the delivery of VA health care services furnished to Veterans in rural areas through the use of contract providers and fee-basis providers;
- Goals and objectives for the implementation, expansion, and enhanced use of VA telemedicine in rural areas (through coordination with other appropriate VA offices);
- Goals and objectives for ensuring the full and effective use of mobile outpatient clinics to provide health care services in rural areas;
- Procedures for soliciting from each VA facility that serves a rural area a statement of the facility's clinical capacity; its procedures in the event of a medical, surgical, or mental health emergency outside the scope of the facility's clinical capacity; and its procedures and mechanisms to provide (and coordinate) health care for women Veterans (including procedures and mechanisms for coordination with local hospitals and facilities, oversight of primary care and fee-basis care, and management of specialty care);
- Goals and objectives for modifying funding allocation mechanisms of the ORH to ensure that it distributes funds to Departmental components, to best achieve its goals and objectives in a timely manner;
- Goals and objectives for the coordination and sharing of resources between VA and the Department of Defense, Department of Health and Human Services, Indian Health Service, and other Federal agencies, as appropriate and prudent, to provide health care services to Veterans in rural areas;
- Specific milestones for the achievement of the goals and objectives developed for the plan; and
- Procedures for ensuring the effective implementation of the plan.

Section 2(c) of the bill would require, not later than 90 days after the date of the plan's issuance, that the Secretary transmit the strategic plan to Congress (along with any comments or recommendations that the Secretary considers appropriate).

VA does not believe that S. 1849 is necessary. VA's past and continuing efforts already provide a comprehensive approach to ensuring access to quality health care for Veterans in rural areas. Specifically, in 2010, VHA's ORH produced a 5-year strategic plan for fiscal years (FY) 2010–2014 to ensure that ORH programs and initiatives meet the health care needs of rural Veterans. That plan was refreshed in FY 2011, for FY 2012–2014, to better align ORH's resources with identified health care needs, especially in light of new technologies and delivery systems for rural Veterans.

The plan was updated by a committee of stakeholders comprised of the following members: Veterans Rural Health Advisory Committee; Veterans Integrated Service Network (VISN) rural consultants; Veterans Rural Health Resource Centers; ORH; VA Medical Center Directors; VA's Office of Telehealth Services; VA's Office of Mental Health Services; VA's Office of Geriatrics and Extended Care, State VA Offices; VA's Office of Health Informatics; VA's Office of Academic Affiliations; VA Employee Education System; and VA's Healthcare Retention and Recruitment Office.

The Committee updated each of the six ORH strategic goals in line with broadly agreed-upon initiatives (and associated action items) that respond to the specific findings of ORH's Nation-wide assessment to identify gaps in care at rural VA facilities and unmet clinical needs of rural Veterans. Input obtained at numerous town hall meetings and listening sessions also helped the Committee to better understand the perspective of rural Veterans and in particular the barriers that prevent them from accessing VA health care.

The new initiatives included in the revised strategic plan include: an action plan to improve communications and outreach to rural areas; continued support of community-based outpatient clinics and outreach clinics; developing, implementing, and evaluating new models of specialty care; implementing and evaluating rural women's health care initiatives, increased collaboration and partnership with non VA community networks and providers, increasing student training opportunities in rural health; enhancing telehealth capabilities in rural areas; and increasing training for rural providers. We will continue to monitor implementation of these initiatives under the plan and revise them as necessary. ORH will also continue to evaluate its on-going programs, especially the host of pilot and demonstration projects that ORH currently funds across the VA health care system, to assess their effec-

tiveness in delivering quality care to rural Veterans and improving those individuals' access to care.

One ORH initiative is the "Rural Health and Education Training Initiative." It will provide infrastructure support for up to five VA sites of care to establish rural health training and education programs for medical residents, dental, nursing, and allied health professions students from affiliated institutions. Under the program, these trainees will receive particular instruction on providing care to Veterans residing in rural areas. This will include instruction on the special challenges associated with providing health care in rural areas and how VA is working to overcome these challenges. Once they complete their training, VA hopes to recruit and retain them in rural VA health care positions throughout the country.

ORH is also supporting an initiative to provide rural clergy with both information on VA benefits and services and local VA contact information. This initiative will also educate clergy-participants about post-deployment readjustment challenges, the spiritual and psychological effects of war-trauma on survivors, and the important role that religious institutions can play in helping to reduce the societal stigma associated with mental illness and to assist Veterans in their parishes and communities to obtain care and services for their mental health issues. It will also address other ways in which they, as vital community partners, can help support Veterans and their families.

Finally, as discussed in connection with S. 1631, VA and the Department of Health and Human Services (HHS) are working on a memorandum of understanding (MOU) to address shortages in the rural Health IT workforce and the need for the effective exchange of health care information between VA providers and rural providers furnishing care to Veterans. The MOU will serve to:

- Increase the number of trained health IT and health information management professionals;
- Diversify training programs to meet a wider range of training needs;
- Reach out to potential workers and employers to inform them about career pathways in health information management and technology;
- Support employers in staffing health IT positions; and
- Examine ways to leverage existing resources to develop potential pilot sites for Health Information Exchange between rural providers and VHA.

As indicated above, the 2010–2014 ORH strategic plan refresh will be re-evaluated periodically but at least on an annual basis to determine if additional initiatives or actions are needed. At the end of FY 2014, ORH will draft a new strategic plan based on its evaluations of the success of projects undertaken to date and updated assessments of the health care needs of Veterans residing in rural areas.

VA estimates the costs associated with enactment of S. 1849 to be as follows: \$215,000 for FY 2013; \$368,000 over a 5-year period; and \$768,000 over a 10-year period.

S. 2045—TO REQUIRE JUDGES ON THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS TO RESIDE WITHIN 50 MILES OF THE DISTRICT OF COLUMBIA

S. 2045 would amend 38 U.S.C. 7255, to require that active judges of the U.S. Court of Appeals for Veterans Claims reside within 50 miles of the District of Columbia. This bill also would amend section 7253(f)(1) to provide that violation of this residency requirement may be grounds for removal of a judge from the court. The absence of such a residency requirement in current law has not created difficulties for VA. Thus, VA perceives no need for this legislation.

If enacted, S. 2045 would result in no costs or savings for VA.

S. 2244—VETERANS MISSING IN AMERICA ACT OF 2012

S. 2244, the "Veterans Missing in America Act of 2012," would direct the Secretary to cooperate with Veterans Service Organizations to assist entities in possession of unclaimed or abandoned human remains in determining whether such remains are those of Veterans or other persons eligible for burial in a national cemetery. If unclaimed remains are identified as those of Veterans or other eligible persons, VA would provide for burial of the remains in a national cemetery and would cover the cost of preparation, transportation, and burial of the remains. The bill would further direct VA to establish a publicly accessible national database of such identified individuals.

VA strongly supports the goal of ensuring that those who have earned the right to burial in a national cemetery are accorded that honor. VA commends organizations and volunteers who work to ensure that unclaimed and abandoned remains of our Nation's Veterans are identified and if eligible, receive a proper burial in a national cemetery. To ensure eligible Veterans receive burial in a national cemetery,

VA currently works with States, counties, municipalities and private organizations to determine the eligibility of unclaimed and abandoned remains that are held at funeral homes or coroner's offices. In this regard, VA's National Cemetery Scheduling Office (NCSO) located in St. Louis, Missouri coordinates with Federal, State and local agencies to verify a deceased individual's military service and identity. NCSO also provides eligibility review assistance to entities such as the Missing In America Project (MIAP), to identify unclaimed remains and inter all eligible individuals. In FY 2011, NCSO processed 663 requests for burial eligibility determinations that were submitted by the MIAP, which works on behalf of entities, such as city and county coroners' offices, to ensure eligible Veterans receive proper burial. Currently, NCSO is working with the State of Oregon to identify unclaimed remains recently found in that state and determine eligibility for burial in a national cemetery.

VA does not, however, support this bill in extending existing funeral and transportation benefits to certain non-Veterans and placing no cap on the amount of such payments. Section 3(b) would require VA to pay the cost of the burial, preparation, and transportation of the unclaimed or abandoned remains of any individual who is eligible for national cemetery burial when there are insufficient alternative resources to cover such expenses. Under current law, VA provides reimbursement benefits, up to maximum amounts specified by statute, for funeral and transportation costs associated with the burial of certain Veterans. However, not all Veterans who are eligible for burial in a national cemetery qualify for these benefits; for example, Veterans who were not in receipt of disability compensation at the time of death generally do not qualify for reimbursement of funeral or transportation costs. VA would support extending current funeral and transportation benefits under sections 2302(a)(2) and 2308 of title 38, United States Code, to all unclaimed remains of Veterans, subject to the same monetary caps generally applicable to such payments. However, VA does not support the current bill insofar as it would provide benefits for non-Veterans that are unavailable for many Veterans eligible for burial in a national cemetery and would lift the generally applicable monetary caps for this benefit.

Section 3(c) of S. 2244 would direct VA to establish a database of the names of any Veterans or other individuals who are determined, under the identification process described in this bill, to be eligible for burial in a national cemetery. We believe this provision is unnecessary. Currently, VA maintains a publicly-accessible database, commonly known as the National Gravesite Locator (NGL), which already performs the functions proposed in the bill. The public can use the NGL to search for burial locations of Veterans and other individuals interred in VA National Cemeteries, State Veterans cemeteries, and various other military and Department of the Interior cemeteries. The NGL also provides information about Veterans buried in private cemeteries when the grave is marked with a Government-furnished headstone or marker. Names of Veterans or other individuals who are eligible for burial and whose remains are unclaimed or abandoned would be made available to the public through the NGL once they are interred. NCA continues to work to make this database even more accessible by implementation of a mobile application.

S. 2244 would impose recurring costs on VA by extending entitlement to burial and transportation reimbursement benefits for a new category of individuals, without a monetary limit on the amount of such reimbursement. At this time, VA is unable to estimate the likely extent of those costs.

S. 2259—VETERANS' COMPENSATION COST-OF-LIVING ADJUSTMENT ACT OF 2012

S. 2259, the "Veterans' Compensation Cost-of-Living Adjustment Act of 2012," would require VA to increase, effective December 1, 2012, the rates of disability compensation for service-disabled Veterans and the rates of dependency and indemnity compensation for survivors of Veterans. Current estimates suggest that the consumer price index will increase by 1.9 percent. This bill would increase these rates by the same percentage as the percentage by which Social Security benefits are increased effective December 1, 2012.

VA wholeheartedly supports this bill, which is consistent with the President's FY 2013 budget request. It would express, in a tangible way, this Nation's gratitude for the sacrifices made by our service-disabled Veterans and their surviving spouses and children and would ensure that the value of their well-deserved benefits will keep pace with the increased cost of living.

VA estimates that this bill would result in first-year benefit costs of \$772 million in FY 2013, 5-year benefit costs of \$4.9 billion, and 10-year benefit costs of \$10.9 billion. However, as annual cost-of-living adjustments are assumed in the baseline

for the Disability Compensation program, no PAYGO costs are associated with this proposal.

S. 2320—REMEMBERING AMERICA’S FORGOTTEN VETERANS CEMETERY ACT OF 2012

S. 2320, the “Remembering America’s Forgotten Veterans Cemetery Act of 2012,” would direct the American Battle Monuments Commission to restore, operate, and maintain Clark Veterans Cemetery in the Republic of the Philippines, subject to the availability of appropriations. This bill would make Clark Veterans Cemetery a permanent cemetery under the auspices of the American Battle Monuments Commission, pursuant to section 2104 of title 36, United States Code.

Because S. 2320 pertains to the American Battle Monuments Commission’s authority under current chapter 21 of title 36 to allocate resources for the care and maintenance of military cemeteries and monuments in foreign countries, VA defers to the views of that Commission on this bill.

S. 3052—NOTICE TO VETERANS OF AVAILABILITY OF SERVICES FROM VSOS

S. 3052 would amend title 38 to require the Secretary of Veterans Affairs to provide Veterans who electronically file claims for VA benefits with notice that relevant services are available from Veterans’ Service Organizations (VSOs). The bill would require the Veterans Benefits Administration (VBA) to notify each claimant who files a claim for benefits electronically that VSOs are available to provide services, and to provide a list of VSOs, and their Web site and contact information.

S. 3052 is unnecessary, as VBA already provides notice to Veterans who file claims electronically that VSO representation is available. In addition, links to VSOs and private attorneys who offer representation on claims for VA benefits are currently available on VA’s eBenefits Web site, which also contains a directory of all recognized VSOs with their contact information.

S. 3052 would not impose any costs on VA.

S. 3084—VISN REORGANIZATION ACT OF 2012

Section 2 of S. 3084 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 VA medical center, and would limit the number of employees at each VISN headquarters to 65 FTE. VA does not support section 2 for a number of reasons. By increasing the scope of responsibility and span of control of each VISN headquarters while reducing the number of employees at each, the legislation would impede VA’s ability to implement the national goals of the Department. 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 sometimes essential service.

VHA has already reviewed each VISN headquarters and is in the process of working with each to streamline operations, create efficiencies internal to each VISN, and to realign resources to facilities. This will achieve savings while not creating the negative outcomes of the restructuring and new organizations proposed in S. 3084. Current VHA plans are to reduce VISN staffing levels.

VA currently maintains close relationships with other health care organizations, including those from other governmental, public, and private health care entities, when appropriate. The language appears to require VA to create new alliances with entities which may not be available or appropriate. VA’s health care system has benefited from developing an expertise in the clinical and cultural needs and demands of Veterans. Requirements to further partner with other organizations could lead to distractions and unintended outcomes.

This section’s requirement that VISN budgets be balanced at the end of each fiscal year may have other unintended consequences. Currently, at the end of each fiscal year, each VISN’s accounts must be balanced, and this is sometimes achieved by providing additional resources from VHA Central Office. Additional 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. By codifying a requirement that the VISN budget be balanced at the end of each fiscal year, VA may lose this flexibility to supplement VISNs with additional resources, and Veteran patient care would suffer as a result.

Section 2 also requires the Department 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. Furthermore, while section 2 describes how the VISNs should

be consolidated, it fails to clearly articulate the flow of leadership authority. In fact, by moving certain oversight responsibilities to regional centers, S. 3084 would create no clear lines of authority from VHA Central Office, regions, VISNs, to medical centers, actually producing less oversight and more confusion.

Additionally, the proposed combination of VISNs simply combines VISNs to arrive at a reduction in the total number of Networks and employees without considering the underlying referral patterns within each VISN. The original VISN boundaries were drawn based upon local population health needs. Each VISN is charged with managing quality and access of health care while increasing the efficient delivery of population health. S. 3084 fails to take this into account in aligning VISN boundaries. For example, it is unclear why VISNs 19 and 20 should be consolidated, which 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, which oversees three states and eight health care systems or medical centers, remains its own entity. VA would appreciate the opportunity to review the Committee's criteria for determining these boundaries.

Last, Section 2 of S. 3084 seems to assume that locating the management function off campus from a medical center represents an inefficient organizational approach. We believe that assumption is not valid for all cases. Currently, six VISNs (1, 2, 3, 20, 21, and 23) are co-located with a VA medical center; the legislation's requirement for co-location with a VA medical center 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 space for VISN staff in at least nine VISNs given the bill's proposed realignment of VISNs 1, 2, and 3, as well as 20 and 21.

As a result of this legislation, Veterans may be forced to travel to different locations for services that were previously available at the new host facility, or may 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 of the bill 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 logistical reality of required co-location with medical centers would necessitate this result.

VA also does not support section 3 of S. 3084. 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 centers including:

- financial quality assurance;
- OEF/OIF/OND outreach;
- homelessness effectiveness assessments;
- women's Veterans programs assessments;
- energy assessments; and
- such other functions as the Secretary deems appropriate.

This would present several challenges, as certain services are more appropriately organized as fully consolidated national functions instead of regional ones. The functions identified for homelessness and women Veterans would create capabilities that duplicate existing national services. The current structure (VISN accountability and national oversight) is directly linked with ensuring accountable leadership oversight that is much more proximate to health care services provided to Veterans in facilities. The proposed structure creates two national-level entities competing for oversight analysis relationships with facilities. Furthermore, the proposed functions may not be the most appropriate ones to offer for consolidation into four centers. 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. These types of functions are more appropriate to move off-station without damaging the necessary management/accountability relationship between leadership, line management, and staff. The rationale behind the selected functions does not appear to have been based on a thorough analysis of the types of functions best suited to consolidation.

S. 3084 appears to propose a reduction in the FTE associated with regional management, but the proposed regional service centers are likely to increase the overall staffing requirement. We believe this actually will result in a diversion of resources away from critical patient care. The proposed legislation would result in VISN management staff of roughly 780 persons. If each of the four regional centers is just 110 FTEE, a not unrealistic assumption given the scope of responsibilities identified in

the legislation, then the proposed model would result in overall growth of regional staff compared with VHA's current plans.

It is not possible currently to identify costs for the proposed legislation but it is expected that the requirement to co-locate functions with medical centers would result in costlier clinical leases or additional construction. Additionally, the proposed VHA Central Office, Regional Center, and VISN structure would require increased staff.

S. 3202—DIGNIFIED BURIAL OF VETERANS ACT OF 2012

S. 3202, the "Dignified Burial of Veterans Act of 2012," would amend section 2306 of title 38, United States Code, to authorize VA to furnish a casket or urn, of such quality as the Secretary considers appropriate for dignified burial in a national cemetery, of the remains of a Veteran for whom the Secretary is unable to identify next of kin, if there are not otherwise sufficient resources available to furnish a casket or urn. The bill would also require VA to submit a report to the Senate and House Committees on Veterans' Affairs within 180 days of enactment, to describe industry standards for caskets and urns, and assess compliance with such standards at VA national cemeteries.

VA does not object to enactment of the main feature of S. 3202, provided Congress identifies appropriate cost offsets, but believes its reporting requirement is unnecessary. Section 2 of the bill, would assist in ensuring that a suitable casket or urn is provided for interment in a national cemetery of the remains of any Veteran without family and necessary resources. This legislation is consistent with VA's continued efforts to address the needs of homeless Veterans—many of whom die as unclaimed and indigent individuals. Section 3 of the bill, requiring a report on industry standards for caskets and urns and VA's compliance with such standards at national cemeteries, is unnecessary. Currently, NCA relies upon licensed funeral directors who prepare remains to comply with relevant Federal, State, and local laws regarding the preparation of Veterans' remains. When caskets or urns are presented for burial, NCA cemetery directors assess containers to determine any possible health or safety risks and whether the caskets or urns are sufficiently constructed to allow for necessary handling for burial. On rare occasions when caskets or urns do not meet these standards, NCA instructs the funeral director to return to the cemetery with remains in a proper container to facilitate burial. For the remains of Veterans with next of kin, NCA respects the wishes of families regarding their choice of containers so long as there are no public health or safety concerns.

VA recognizes that S. 3202 complements other bills recently introduced in Congress that seek to address issues relating to the unclaimed remains of Veterans.

S. 2244 and H.R. 2551, both titled the "Veterans Missing in America Act," generally propose to expand VA's authority to provide an allowance to those who assist with the transportation and interment of unclaimed remains of Veterans. VA will continue to provide technical assistance to the Committees on these bills.

At this time, VA is unable to estimate the extent of costs that would result from enactment of S. 3202 because it is difficult to project the number of unclaimed Veteran remains that may be affected by this legislation. In 2009, the National Funeral Directors Association projected that the average cost for a metal casket was \$2,295.

Chairman Murray, this concludes my statement. I would be happy to answer any questions you or the other Members of the Committee may have.



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 12, 2012

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

Dear Madam Chairman:

This letter is in response to your invitation to submit for the record the Department's views on thirteen bills: S. 1391, S. 3049, S. 3206, S. 3270, S. 3238, S. 3282, S. 3308, S. 3309, S. 3313, S. 3316, S. 3324, S. 3336, and S. 3340. Thank you for giving us this valuable opportunity to submit our views before you close the record of the hearing held on June 27, 2012.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Eric K. Shinseki".

Eric K. Shinseki

Enclosure

ENCLOSURE

VA VIEWS

S. 1391—IMPROVING THE DISABILITY COMPENSATION EVALUATION PROCEDURE FOR VETERANS WITH POST TRAUMATIC STRESS DISORDER OR MENTAL HEALTH CONDITIONS RELATED TO MILITARY SEXUAL TRAUMA, AND FOR OTHER PURPOSES

S. 1391 would amend 38 U.S.C. §1154, Consideration to be accorded time, place, and circumstances of service, by adding a new subsection (c) that would liberalize the standard of proof for service connection of Post Traumatic Stress Disorder (PTSD) and a new subsection (d) that would lower the standard of proof for service connection of "covered mental health conditions" related to military sexual trauma.

Proposed new section 1154(c) would require the Department of Veterans Affairs (VA) to accept as sufficient proof of service connection for PTSD alleged to have been incurred or aggravated by military service: (1) a diagnosis of PTSD by a "mental health professional;" (2) written testimony by the Veteran that the PTSD was incurred or aggravated during service; and (3) a written statement by the mental health professional relating the PTSD to the claimant's service, if the claimed occurrence or aggravation of PTSD is consistent with the circumstances, conditions, or hardships of the Veteran's service.

Proposed new section 1154(d) would similarly require VA to accept as sufficient proof of service connection for covered mental health conditions-defined as PTSD,

anxiety, depression, or “other mental health conditions the Secretary determines to be related to military sexual trauma”-when the condition is claimed to result from military sexual trauma during active service: (1) a diagnosis of the covered mental health condition by a “mental health professional;” (2) written testimony by the Veteran of the alleged trauma; and (3) a written statement by the mental health professional relating the mental health condition to the claimed trauma, if the claimed trauma is consistent with the circumstances, conditions, or hardships of the Veteran’s service.

Proposed sections 1154(c) and (d) would require departure from current practice for adjudicating both PTSD claims and claims based on other covered mental health conditions. In the case of PTSD claims, current procedures under 38 CFR § 3.304(f) require credible supporting evidence that an in-service stressor occurred in order to establish that current PTSD symptoms are related to an event in service. This generally means objective and verifiable documentation that the stressor actually occurred.

Section 3.304(f) currently provides particularized rules for establishing stressors related to combat, former prisoner-of-war (POW) status, fear of hostile military or terrorist activity, and personal assault. These particularized rules are based on an acknowledgement that certain circumstances of service may make the claimed stressor more difficult to corroborate. At the same time, they require threshold evidentiary showings designed to ensure accuracy and fairness in determinations as to whether the claimed stressor occurred. Evidence of a Veteran’s service in combat or as a prisoner of war generally provide an objective basis for concluding that claimed stressors related to such service occurred. Evidence that a Veteran served in an area of potential military or terrorist activity may provide a basis for concluding that stressors related to fears of such activity occurred. In such cases, VA also requires the opinion of a VA or VA-contracted mental health professional, which enables VA to ensure that such opinions are properly based on consideration of relevant facts, including service records, as needed. For PTSD claims based on a personal assault, lay evidence from sources outside the Veteran’s service records may corroborate the Veteran’s account of the inservice stressor, such as statements from law enforcement authorities, mental health counseling centers, family members or former servicemembers, as well as other evidence of behavioral changes following the claimed assault.

S. 1391 would require VA to accept as proven the occurrence of military sexual trauma or a PTSD stressor without even the minimal threshold evidence currently required in most compensation claims to support a Veteran’s account of events in service. The claimant would be required merely to state that PTSD was incurred or aggravated in service or that a military-sexual-trauma stressor or event occurred in service. As long as there was a current diagnosis of PTSD, or other covered mental health condition, and a mental health professional offered a medical opinion that the symptoms were related to military service, service connection would be granted. This would occur whether the mental health professional had access to the Veteran’s service records or not or was otherwise able to evaluate the veracity of the claimant’s statements regarding the occurrence of the claimed in-service stressor or event.

The regulatory provisions at 38 CFR §§ 3.303 and 3.304(f) have established equitable standards of proof and the evidence for corroboration of an in-service injury, disease, or event, for purposes of service connection. Further, 38 U.S.C. § 1154 properly requires consideration of the time, place, and circumstances of service when evaluating disability claims and provides for acceptance of lay statements concerning combat-related injuries, provided evidence establishes that the Veteran engaged in combat. S. 1391 would expand section 1154 to require VA to accept lay statements as sufficient proof of in-service events in all PTSD claims and military sexual trauma claims involving covered mental health conditions, based solely on the nature of the claim and without requiring the objective markers, such as combat service, that are essential to the effective operation of section 1154. Without the requirement of any evidentiary threshold for the mandatory acceptance of a lay statement as sufficient proof of an occurrence in service, this legislation would eliminate, for discrete groups of Veterans, generally applicable requirements that ensure the fairness and accuracy of claim adjudications.

VA is committed to serving our Nation’s Veterans by accurately adjudicating MST claims in a thoughtful and caring manner, while fully recognizing the unique evidentiary considerations involved in such an event. The Under Secretary for Benefits has spearheaded the efforts of the Veterans Benefits Administration (VBA) to ensure that these claims are adjudicated compassionately and fairly, with sensitivity to the unique circumstances presented by each individual claim.

VA is aware that, because of the personal and sensitive nature of the MST stressors in these cases, it is often difficult for the victim to report or document the event when it occurs. To remedy this, VA developed regulations and procedures specific to MST claims that appropriately assist the claimant in developing evidence necessary to support the claim. As with other PTSD claims, VA initially reviews the Veteran's military service records for evidence of MST. VA's regulation also provides that evidence from sources other than a Veteran's service records may corroborate the Veteran's account of the stressor incident, such as evidence from mental health counseling centers or statements from family members and fellow Servicemembers. Evidence of behavior changes is another type of relevant evidence that may establish occurrence of an assault, such as a request for transfer to another military duty assignment. Veterans are provided notification regarding the types of evidence that may establish occurrence of an in-service personal assault and are requested to submit or identify any such evidence.

VBA has also placed a primary emphasis on informing VA regional office personnel of the issues related to MST and providing training in proper claims development and adjudication. VBA developed and issued Training Letter 11-05, Adjudicating Posttraumatic Stress Disorder Claims Based on Military Sexual Trauma, in December 2011. This was followed by a nationwide Microsoft Live Meeting broadcast on MST claims adjudication. The broadcast focused on describing the range of potential markers that could indicate occurrence of an MST stressor and the importance of a thorough and open-minded approach to seeking such markers in the evidentiary record. In addition, the VBA Challenge Training Program, which all newly hired claims processors are required to attend, now includes a module on MST within the course on PTSD claims processing. VBA also provided its designated Women Veterans Coordinators with updated specialized training. These employees are located in every VA regional office and are available to assist both female and male Veterans with their claims resulting from MST.

VA believes these actions ensure that MST claimants are given a full and fair opportunity to have their claim considered, with a practical and sensitive approach based on the nature of MST. VA believes that processes and training in place now provide MST claimants a full and fair opportunity to present their claim. VA has recognized the sensitive nature of MST-related PTSD claims and claims based on other covered mental health conditions, as well as the difficulty inherent in obtaining evidence of an in-service MST event. Current regulations provide multiple means to establish an occurrence, and VA has initiated additional training efforts and specialized handling procedures to ensure thorough, accurate, and timely processing of these claims.

In summary, VA opposes S. 1391 because we believe it would go too far in relaxing standards requiring service connection for a current disability to be based on credible supporting evidence of an injury, disease, or event in service.

Benefit costs are estimated to be \$137.1 million during the first year, \$2.0 billion for 5 years, and \$7.1 billion over 10 years. Costs for general operating expenses are estimated to be \$5.0 million during the first year, \$24.1 million for 5 years, and \$52.5 million over 10 years. IT costs are estimated to be \$196 thousand during the first year, \$531 thousand for 5 years, and \$967 thousand over 10 years.

S. 3049—EXPANDING THE DEFINITION OF HOMELESS VETERAN

S. 3049 would broaden the definition of "homeless veteran" found in 38 U.S.C. § 2002(1) to include "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing." It would do this by adding to the Title 38 definition a reference to an additional subsection of the general definition of homeless individual found in the McKinney-Vento Homeless Assistance Act, at 42 U.S.C. § 11302.

VA supports the intent of S. 3049. VA understands that the Department of Housing and Urban Development (HUD) uses the definition found in 38 U.S.C. § 2002(1) in the application of some of its programs. Therefore, we suggest the Committee consult with HUD regarding any changes to that definition.

VA has taken steps to address the critical issue of domestic violence. In recognition of the unique and emerging health challenges posed by victims of domestic violence, the Deputy Under Secretary for Health for Policy and Services recently chartered a Domestic Violence Task Force to "develop a national plan/policy on domestic violence to address identification of domestic violence and access to services for Veterans, who need help planning for and achieving physical, emotional, and psycho-

logical safety and well being; and define the scope of domestic violence to be addressed.” As evidenced by this task force, VA intends to study this population and VA’s options for serving this population; however, at this time, VA lacks subject matter experts to implement programming directly targeted at victims of domestic violence. Furthermore, in the event VA would be expected to reach and target this population, VA needs time and resources to implement systems, protocol, and policies to ensure timely interventions and meet the needs of this vulnerable population. Domestic violence is a complex health issue and addressing it involves collaboration between many programs and external local, State and Federal agencies to address identification, prevention, provision of safety supports, treatment, and legal consequences.

VA is not able to provide an accurate cost estimate for S. 3049 since we currently lack information regarding the size and characteristics of the potential population. For example, VA’s estimates of the homeless population do not include individuals fleeing domestic violence. Many VA providers have only minimal training on domestic violence. S. 3049 would likely require additional training for VA employees and providers, which may have some costs, depending upon the scope of the training.

S. 3206—MONTHLY ASSISTANCE ALLOWANCE TO DISABLED VETERANS TRAINING OR COMPETING FOR THE PARALYMPIC TEAM AND ASSISTANCE TO UNITED STATES PARALYMPICS, INC.

Section 1 of S. 3206 would extend the authority for appropriations to fund the payment of the monthly monetary allowance under 38 U.S.C. § 322(d) (to Veterans training for or selected to compete on the U.S. Paralympic team) for a period of 5 years (through FY 2018). VA supports such an extension.

By its own terms, the cost of enactment of this section would be \$2 million in FY 2014, with a total 5-year cost (FY 2014 through FY 2018) of \$10 million.

Section 2 of S. 3206 would extend (through FY 2018) VA’s authority to award grants to United States Olympic Committee (USOC) for its U.S. Paralympics Integrated Adaptive Sports Program. Under current law, VA has provided grants totaling \$7.5 million to the USOC in each FY 2010 and FY 2011. Due to identified need, VA currently is processing an \$8.0 million USOC grant request in FY 2012. VA supports extending the authority for this program, which has positively impacted the lives of thousands of Veterans.

S. 3270—PENSION AMENDMENTS

Section 1(a) of S. 3270 would amend the net worth limitations applicable to Veteran’s pension in 38 U.S.C. § 1522 to provide that when a Veteran (or Veteran’s spouse) disposes of “covered resources” for less than fair market value (including transfers to annuities or trusts) on or after the beginning date of a 36-month look-back period, the disposal may result in a period of ineligibility for pension. In addition, section 1(a) would provide a method for calculating the period of ineligibility for pension resulting from a disposal of covered resources at less than fair market value. The period of ineligibility, expressed in months, would be determined by dividing the total value of all applicable covered resources disposed of by the Veteran (or the Veteran’s spouse) by the amount of pension that would have been payable to the Veteran under 38 U.S.C. §§ 1513 or 1521 without consideration of the transferred resources.

Section 1(b) of S. 3270 would amend 38 U.S.C. § 1543 to apply to a surviving spouse’s or surviving child’s pension the same restrictions pertaining to disposal of covered resources at less than fair market value as would apply to Veterans under subsection (a).

Section 1(c) of S. 3270 would specify the effective date and applicability of the amendments made by section 1(a) and (b). Section 1(d) of S. 3270 would require VA to provide annual reports to Congress regarding: (1) the number of individuals who applied for pension during the period covered by the report; (2) the number of individuals who received pension during that period; and (3) the number of individuals whose pension payments were denied or discontinued during that period because covered resources were disposed of for less than fair market value.

Currently, if a pension claimant (or the spouse of a Veteran pension claimant) disposes of assets before the date of the pension claim, VA does not consider those assets as part of the claimant’s net worth, so long as the transfer was not a gift to a relative living in the same household as the claimant. S. 3270 would provide that such disposals of “covered resources” for less than fair market value during a 36-month look-back period may result in a period of ineligibility for pension.

VA supports the objectives of S. 3270 to provide for consideration of recent asset transfers for less than fair market value in evaluating a pension claimant’s net

worth and to impose a period of ineligibility for pension where such transfers occur. The bill would clarify current law by prescribing that pension applicants cannot create a financial need, qualifying them for VA pension, by disposing of assets that the applicant could use for the applicant's own maintenance. It would also clarify that an applicant cannot create pension eligibility by restructuring assets during the 36-month period preceding a pension application through transfers to certain financial products or legal instruments, such as annuities and trusts. A recent Government Accountability Office study found that there is a growing industry that markets these products and instruments to vulnerable Veterans and survivors and potentially causes them harm. The amendments contemplated by S. 3270 would enable VA to implement necessary program integrity measures.

However, VA is concerned that the provisions of S. 3270 specifying how the period of ineligibility will be calculated would be unnecessarily complex and burdensome to administer. The provisions of section 1(a) of S. 3270 to be codified at 38 U.S.C. § 1522(a)(2)(E)(ii) would require VA to divide the total value of all applicable covered resources disposed of by the Veteran (or Veteran's spouse) by "the amount of the monthly pension that would be payable to the veteran under section 1513 or section 1521 of this title without consideration of such resources under paragraph (1)." Sections 1(a) and 1(b) of S. 3270 would provide for similar calculations under 38 U.S.C. §§ 1522(b)(2)(E)(ii), 1543(a)(4)(E)(ii), and 1543(b)(2)(E)(ii). It appears that the divisor used to calculate the ineligibility period under these provisions would require VA to develop for and adjudicate up to 3 years' worth of countable income. Such a complex calculation would significantly increase VA's adjudicative burden and, as a result, delay the payment of pension claims to eligible Veterans.

VA suggests modifying this calculation method. The goals of S. 3270 could be achieved more efficiently by revising the language describing the divisor to refer to "the monthly amount a claimant would have received based on the maximum annual pension rate including any amount of increased pension payable on account of family members, but not including any amount of pension payable because a person is in need of regular aid and attendance or is permanently housebound." It would be burdensome and inefficient to require VA to develop income and expense information to determine up to 3 years' worth of countable income in a decision that would deny pension in any event. By using less claim-specific criteria tied to the maximum annual pension rate, VA would be able to quickly determine the length of the penalty period and conserve adjudication resources for expeditious processing of claims.

The use of such less-specific criteria is not without precedent. Congress used similar language in 38 U.S.C. § 1503(a)(8) in establishing the rule for calculating the 5-percent threshold for medical expense deductions in VA pension, which is based on the maximum annual pension rate including increased pension payable on account of family members, but without regard to special monthly pension.

At this time, VA has no objection to this section but is unable to estimate the costs or savings associated with this proposal because sufficient data is not available.

S. 3238—A BILL TO DESIGNATE THE DEPARTMENT OF VETERANS AFFAIRS COMMUNITY BASED OUTPATIENT CLINIC IN MANSFIELD, OHIO, AS THE DAVID F. WINDER DEPARTMENT OF VETERANS AFFAIRS COMMUNITY BASED OUTPATIENT CLINIC, AND FOR OTHER PURPOSES

S. 3238 would designate the Department of Veterans Affairs community based outpatient clinic located in Mansfield, Ohio, as the "David F. Winder Department of Veterans Affairs Community Based Outpatient Clinic." VA defers to Congress in the naming of this facility.

S. 3282—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO REAUTHORIZE THE VETERANS' ADVISORY COMMITTEE ON EDUCATION, AND FOR OTHER PURPOSES

S. 3282 would amend 38 U.S.C. § 3692 to extend the expiration date of the Veterans Advisory Committee on Education (Committee) to December 31, 2014. It would also change the composition of the Committee to include representatives of institutions and establishments furnishing education or vocational training to eligible Veterans or persons enrolled under chapter 31 of Title 38 (Training and Rehabilitation for Veterans with Service-Connected Disabilities) while removing those providing training to Veterans or persons enrolled under chapter 32 of that title (Post-Vietnam Era Veterans' Educational Assistance).

Further, S. 3282 would require the composition of the Committee, to the maximum extent practicable, to include:

- Veterans who served on active duty and were deployed in connection with a contingency operation,
- at least one Veteran who is a student currently enrolled in a program of education and receiving assistance for the pursuit of such program of education under chapters 30, 31, 33, or 35 of Title 38,
- at least one representative from the American Council on Education or an affiliated organization,
- at least one representative from an organization that represents Veterans,
- a representative of a State Approving agency, and
- at least two school certifying officials from different regions of the country.

The Committee would be required to seek feedback on the policies of VA relating to the administration of chapters 30, 31, 33, 35, and 36 of Title 38 and chapter 1606 of Title 10 from students who are currently training under such chapters or Veterans seeking to enroll for training under such chapters.

At least twice each year, the Committee would be required to submit to VA and Congress a report on the administration of chapters 30, 31, 33, 35, and 36 of Title 38 and chapter 1606 of Title 10, including recommendations for legislative and administrative action to improve educational assistance under such chapters.

VA supports this legislation. If reauthorized, VA would be able to continue to receive recommendations and seek advice from the Members of the Committee with regard to the administration and proposals to enhance VA education benefit programs. VA estimates that S. 3282 would have insignificant costs associated with its enactment.

S. 3308—A BILL TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE FURNISHING OF BENEFITS FOR HOMELESS VETERANS WHO ARE WOMEN OR WHO HAVE DEPENDENTS, AND FOR OTHER PURPOSES

Section 1(a) of S. 3308 would amend 38 U.S.C. § 2012(a) to permit a grantee receiving per diem payments under VA's Homeless Providers Grant and Per Diem Program (GPD Program) to use part of those 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.

Section 1(b)(1) of the bill would amend 38 U.S.C. § 2061(c) to require the Secretary to ensure that the total amount of grants awarded in any year under VA's Grant Program for Homeless Veterans with Special Needs is not less than 15 percent of the total amount of grants awarded under the GPD Program under 38 U.S.C. § 2011. This would ensure a level of minimum funding for grants targeted to assist homeless populations with special needs, such as women, including those with minor dependents, frail elderly, etc. Section 1(b)(2) would amend 38 U.S.C. § 2061 to authorize for appropriation such sums as may be necessary for the purposes of this program for FY 2013 and each fiscal year thereafter. The law currently authorizes for appropriation \$5 million to conduct the program through FY 2012.

VA supports the intent of section 1(a) of S. 3308. We feel that this authority is needed to fully reach the entire homeless population. However, full implementation of the legislation would require additional funding to avoid diminished services for homeless Veterans. At the current level of funding VA would be unable to provide grants to current grant recipients as well as Veterans with dependants.

VA does not support Section 1(b) for two reasons. First, it fails to take into account that entities receiving grants under 38 U.S.C. § 2011 become eligible, subject to the availability of appropriations, to receive per diem payments subsequently under 38 U.S.C. § 2012. This means that VA may award per diem payments to current grant recipients in lieu of awarding new grants under section 2011. Indeed, VA conducted its last capital grant Notice of Funding Availability in FY 2010. Since then, VA has offered a Special Needs grant round pursuant to 38 U.S.C. § 2061 and a GPD "Per Diem Only" grant round pursuant to 38 U.S.C. § 2012 (see also 38 CFR part 61.33).

Second, funding for Special Needs Grant Program is not a separate, line-item budget item. Funds designated for this program are included in the general allocation for the entire GPD program and come out of VA's Medical Services account. With competing priorities for Medical Service dollars, VHA currently funds the GPD Programs at the levels that are authorized to be appropriated to for these programs. Were the mandate in section 1(b) enacted, it would dramatically disrupt GPD Program operations and force the closure of current GPD projects. To illustrate, within the GPD Program's current budget of approximately \$224 million for FY 2012, VA expects to support approximately 15,000 operational GPD beds with per diem payments in the amount of approximately \$164 million (80 percent bed occupancy rate),

and support GPD Liaison positions in the amount of approximately \$29 million. Additionally, there are approximately 1,900 capital beds in development from past capital grant rounds. VA estimates these capital beds could require an additional \$21 million in per diem grant support. Were the requirements of section 1(b)(1) in place, VA would be required to spend at least \$33 million on GPD Special Needs grants. This would be a dramatic increase in Special Needs funding—far above the current mandated spending level of \$5 million. Such an increase would have to be absorbed from the GPD Program budget, and, to do that, the GPD Program would be forced to close existing and proven GPD projects.

This concern is heightened by the fact that under existing law the total amount authorized for appropriation for the GPD program will drop from \$250 million in FY 2013 to \$150 million in FY 2014 and every fiscal year thereafter. For FY 2012, approximately \$164 million is slated to cover per diem payments to approximately 15,000 Veteran beds. In FY 2014, the required funding for per diem payments will exceed the amounts authorized to be appropriated for the GPD's programs. VA will then be forced to close GPD projects or reduce per diem rates for all beds to remain within those authorization limits. In other words, without a corresponding provision in 38 U.S.C. § 2013 to authorize appropriations in such sums as are needed to carry out the purposes of the GPD for FY 2014 and thereafter, the effect of the mandate in section 1(b)(2) will be meaningless.

VA estimates the costs associated with enactment of S. 3308 to be \$25.5 million for FY 2013, \$137.3 million over 5 years, and \$302.5 million over 10 years.

S. 3309—HOMELESS VETERANS IMPROVEMENT ACT OF 2012

S. 3309 is a comprehensive bill to continue and improve VA's provision of benefits to homeless Veterans and their families. Key provisions of the bill are targeted at addressing specific problems identified in recent reports by VA's Office of Inspector General and the Government Accountability Office, e.g., current barriers to access to care and services faced by both homeless women Veterans and homeless Veterans with children, the need for infrastructure improvements to ensure the privacy and security of women Veterans receiving services under VA or VA-sponsored programs, etc.

Section 2 of S. 3309 would amend current law to prohibit the Secretary from making a grant for a project under VA's Homeless Providers GPD Program unless the applicant also agrees in its grant application to meet the physical privacy, safety, and security needs of homeless Veterans receiving services through the project.

VA supports Section 2. This new requirement would help reinforce the GPD Program's inspection efforts and also ensure that GPD grantees comply with VA's ongoing efforts to ensure the privacy, safety, and security needs of Veterans participating in the GPD Program. We note as a practical matter that current GPD grantees would be required to absorb the costs of making these improvements as VA lacks authority to offer grants to existing GPD providers to renovate or remodel existing GPD facilities. (38 CFR part 61.10.3) To help current grantees recover these unanticipated costs, VA would need authority similar to that specified in 38 U.S.C. § 2012(c), wherein all GPD grantees were required to comply with the Life Safety Code. In section 2012(c), Congress authorized a five-year period during which VA offered grants to GPD grantees to assist the grantees in meeting the new requirements of the Life Safety Code. Regardless, future grant rounds for new grantees would incorporate this requirement as part of the application process.

VA does not support Section 3 of S. 3309, which would amend current law to require the Secretary, when awarding grants under the GPD Program, to assist eligible entities not only in establishing, but also in maintaining programs to furnish services for homeless Veterans (i.e., outreach services; rehabilitative services; vocational counseling and training; and transitional housing assistance). VA does not support this legislative measure because it would likely result in substantial costs that are not contemplated in the GPD Program's budget or in long-term financial planning for the GPD Program. VA believes that most, if not all, GPD projects would request grant funding for repairs and/or remodeling, but for the reasons previously explained, it is unlikely there would be sufficient funds available to cover repairs and/or remodeling of grantees' facilities.

The GPD Program was, in part, conceived to help save the Federal Government such costs, especially given the fact that such services can generally be obtained at lower cost in the community. Were VA to provide grants to cover the costs of maintaining grantees' infrastructures, the overall cost-effectiveness of the GPD Program would be reduced, and, more importantly, fewer funds would be available for the provision of direct services to homeless Veterans. As an administrative matter, VA

would have to amend its GPD regulations before such maintenance grants could be awarded.

VA estimates the cost of Section 3 of S. 3309 to be \$29.0 million in FY 2013; \$68.4 million over 5 years; and \$115.5 million over 10 years.

Section 4 of the bill would amend 38 U.S.C. §2044(e) to require that, of the amounts required to be made available for conduct of VA's Financial Assistance Program for Supportive Services for Very Low-Income Veteran Families in Permanent Housing (referred to below as the "SSVF" Grant Program), at least 1 percent of such funding must be made available for the furnishing of legal services to assist Veteran families with issues that interfere with their ability to obtain or retain housing or supportive services.

VA does not support Section 4 because it duplicates existing authority. Grants awarded under the SSVF Program already require grantees to assist participants with obtaining legal services for issues that interfere with their ability to obtain or retain permanent housing or supportive services. See 38 CFR §62.33(g), implementing 38 U.S.C. §2044(b)(1)(D)(vii). Some grantees have identified creative no-cost options for providing such legal services, relying on area law school clinics and local bar associations' pro bono initiatives. Such a spending-minimum for legal services would likely discourage grantees from cultivating local networks of legal service providers who will provide participants services at no cost. Beyond discouraging or providing a disincentive for the development of no-cost options for providing legal services, VA is also concerned that this provision would not be an efficient use of resources inasmuch as the mandated level of funding could well exceed the grantee's actual costs of obtaining legal services for participants. Yet, even in such cases, grantees would still have to slate the mandated-minimum amount for this purpose, using funds that could otherwise be expended to furnish other needed supportive services to participants.

Our non-support for section 4 is not meant to discount the central role that legal services play in preventing and ending homelessness among Veterans. Garnering adequate resources or partnerships for the provision of legal services to homeless Veterans and those who are at risk of becoming homeless is absolutely key to this effort. Veterans accessing services in our homeless health care programs often have multiple unmet legal needs ranging from criminal matters (e.g., unresolved warrants) to civil matters (e.g., child support arrears and landlord-tenant disputes). While SSVF grants can be targeted at helping address their participants' legal needs, those participants constitute only part of the homeless Veteran population in need of such services. We are heartened by the growing level of interest among lawyers and law students in serving homeless Veterans, as evidenced by an increasing number of Veteran-focused law school clinics and pro bono initiatives. Still, far more legal resources are needed to build a national practice community of attorneys who have the expertise and dedication needed to effectively serve this population. Outside of awarding grants under section 2044, VA's ability to help non-profits provide or coordinate the provision of legal services to homeless Veterans is hamstrung by limits on our legal authority. We are currently exploring ways to leverage other existing Federal resources to deliver legal services to both homeless and at-risk Veterans, and we would be happy to discuss these efforts with the Committee.

VA estimates the cost of Section 4 of S. 3309 to be \$3 million in FY 2013; \$15 million over 5 years; and \$30 million over 10 years.

Section 5(a) of S. 3309 would amend 38 U.S.C. §2012(a) to permit per diem payments made by the Secretary to grantees under VA's GPD Program to include payments for furnishing care for a dependent of a homeless Veteran, but only while the Veteran is receiving services from the grantee under such grant.

Section 5(a) of S. 3309 is identical to section 1(a) of S. 3308, discussed above. VA supports this section, but we refer you to our earlier comments, which identify some concerns we have with its enactment. VA estimates the cost of \$25.5 million for FY 2013; \$137.3 million over 5 years; and \$302.5 million over 10 years.

Section 5(b)(1) of S. 3309 would require the Secretary to make funds available for per diem payments under VA's GPD Program to grant recipients or eligible entities that are considered to be "non-conforming." Non-conforming recipients or entities fall into three categories: (1) those that meet each of the transitional and supportive services criteria prescribed by the Secretary and furnish services to homeless individuals of which not less than 75 percent are Veterans; (2) those that meet at least one but not all of criteria prescribed by the Secretary and furnish services to homeless individuals of which not less than 75 percent are Veterans; and (3) those that meet at least one but not all of the criteria prescribed by the Secretary and furnish services to homeless individuals of which less than 75 percent are Veterans. Currently, the Secretary's authority to make per diem payments to these non-conforming recipients and entities is discretionary. Section 5(b)(2) of the bill would re-

quire the Secretary to prescribe such regulations as may be necessary to implement this change.

VA does not support Section 5(b). The number of eligible conforming entities seeking to receive GPD funds already far exceeds the resources of the GPD Program.

For example, from 1994 through 2010, VA received 3,252 applications from conforming eligible entities for grant funding under the GPD Program. These applications included capital grant funding, per diem only funding, and GPD special needs funding. Out of the 3,252 applications from conforming eligible entities, VA could only fund 1,115 of these applications. Similarly, from 1994 through 2010, VA received applications requesting almost \$1.4 billion in capital grant funding, but VA could only fund approximately \$197 million in GPD capital grants. It is highly unlikely that funding will ever be available for nonconforming entities, rendering this mandate ineffectual and generating false expectations on the part of non-conforming entities who would seek such assistance. We are more concerned that changing the discretionary language in 38 U.S.C. §2012(d)(1) to mandatory language would remove needed discretion and produce the undesired result of non-conforming entities receiving grants over conforming entities solely because of this requirement.

There are no additional costs associated with section 5 because costs would come from those funds already slated to be awarded under the GPD.

Section 6(a) would authorize the Secretary, subject to the availability of appropriations, to award grants to cover the operational expenses of grant recipients' comprehensive service centers that are not otherwise covered by per diem payments made under the GPD Program. Section 6(b) would limit the aggregate amount of all such grants awarded in any Fiscal Year to \$500,000. Section 6(c) would require the Secretary to promulgate regulations not later than one year after the date of the Act's enactment to carry out this new authority.

VA does not support Section 6 of S. 3309. VA does not believe this measure would be an effective use of VA's resources and the GPD Program's budget. VA funds would likely be put to better use funding traditional outreach in the community or Community Resource and Referral Centers (CRRCs). Historically, it has been difficult for service centers to remain viable for several reasons. VA's statutory authority is limited to paying "per diem" to service center providers, and the service centers have difficulty in providing the federally-required information under Office of Management and Budget (OMB) Circulars and other Federal standards needed to accurately reflect the services they provide, to determine in a timely manner the eligibility of the individuals receiving those services, and to determine the amount of time actually spent with the individuals served. Given GPD grantees' difficulties in accounting for services provided in service centers, VA does not believe service centers are an effective outreach model for VA homeless programs and services, especially given VA has more effective and proven methods of reaching the homeless Veteran population. For instance, VA excels at traditional outreach in the community and is introducing CRRCs throughout the country. VA estimates the cost associated with enactment of section 6 could be \$500,000 per any fiscal year these operational grants are awarded. VA is unable, however, to estimate costs with greater specificity given the disparate operational needs of each GPD service center.

Section 7 of S. 3309 would extend dental benefits under 38 U.S.C. §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."). It would also amend current law to permit the Secretary to disregard breaks in the continuity of assistance or care for which the Veteran is not responsible. VA supports the intent of section 7 of S. 3309, 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. Indeed, increasing access to dental care for Department of Housing and Urban Development VA Supportive Housing (HUD-VASH) Veterans is an important step in VA's Plan to End Veteran Homelessness. Severe dental disease plagues the majority of Veterans experiencing homelessness, particularly the chronically homeless Veterans participating in HUD-VASH. Severe dental disease seriously impacts physical health as well as self esteem and mental health.

Under Directive 2007-039, homeless Veterans participating in the GPD Program, Domiciliary Residential Rehabilitation Program, Health Care for Homeless Veterans (HCHV) contract residential treatment program, Community Residential Care Program, and Compensated Work Therapy-Transitional Residence (CWT-TR) program are eligible for a one-time course of focused dental care. (38 U.S.C. §1712(a)(1)(H); 38 U.S.C. §2062). Section 7 would expand dental eligibility to Veterans participating in the HUD-VASH Program Veterans.

While VA is committed to ensuring eligible Veterans receive patient-centered, cost-effective, evidence-based care, we acknowledge that current resources are inadequate to provide these dental benefits to a new cohort of Veterans and to accommodate the related increase in workload. An expansion of the eligible dental population without a corresponding expansion of resources would severely limit VA's ability to deliver dental care to Veterans already receiving VA dental care benefits.

Finally, as a technical matter, the language proposed for section 2062 refers in error to subsection "(a)" when it should instead reference subsection "(b)." That is, it should be amended in relevant part to read: "(b) ELIGIBLE VETERANS." VA further notes that while Section 7 of S. 3309 would amend the current structure of 38 U.S.C. §2062, the only substantive change would be the inclusion of HUD-VASH Veterans.

VA estimates that there would be significant costs in the first years of operation as thousands of HUD-VASH Veterans become eligible for dental care. However, after the first few years of operation, the cost of providing dental care to Veterans in HUD-VASH would drop dramatically because the dental needs of this population would be satisfied or stabilized. VA would avoid new costs because VA expects a 10 percent turnover in HUD-VASH vouchers in each fiscal year. Specifically, VA estimates the total cost associated with enactment of section 7 for FY 2013 to be \$75.9 million; \$123.0 million over a five-year period, and \$182.3 million over a 10-year period. (These estimates are comprised of the separate amounts estimated for direct patient care as well as projected increases in administrative costs.) VA's cost estimate for this provision only focused on HUD-VASH vouchers and Veterans participating in the HUD-VASH program. It is possible that Veterans eligible for VA health care reside in Section 8 housing that is unaffiliated with the HUD-VASH program. As presently drafted, Section 7 could further increase the cost of this bill.

Section 8 of S. 3309 includes a series of extensions to reauthorize VA's benefits programs for homeless Veterans. VA supports Section 8 and notes that, if enacted, these extensions would not result in any additional costs beyond those contemplated in VA's FY 2013 budget request. Each provision of Section 8 is discussed below in greater detail.

Section 8(a) would authorize to be appropriated \$250,000,000 for FY 2013 and \$150,000,000 for FY 2014 and each fiscal year thereafter for the conduct of VA's GPD Program.

VA supports Section 8(a). Under current law, the amount authorized to be appropriated for the GPD Program for FY 2013 will be reduced from \$250,000,000 to \$150,000,000 and it remains the same for each subsequent fiscal year. We support section 8(a) to the extent that it would retain the program's current level of authorization for FY 2013. We have concerns, however, about the terms that would drop the authorization level to \$150,000,000 for FY 2014 and each fiscal year thereafter. Such a decrease would be highly problematic. GPD expenditures will far exceed the amount authorized to be appropriated for the program for FY 2014 and in following fiscal years. VA would require additional funding to support the existing projects at anticipated per diem and occupancy rates in FY 2014 and beyond. Otherwise, VA would be forced to either cut per diem payments to GPD community providers or summarily terminate operational GPD projects presently serving homeless Veterans.

Section 8(b) would authorize to be appropriated \$50,000,000 for FY 2013, for the conduct of the U.S. Department of Labor's (DOL) Homeless Veterans Reintegration Programs. We defer to the views of the Secretary of Labor on this provision.

Section 8(c) would extend VA's general treatment and rehabilitation authority (codified at 38 U.S.C. §2031(a)) for seriously and mentally ill Veterans from December 31, 2012 to December 31, 2014. VA supports this legislative measure, which would reauthorize the VA's Health Care for Homeless Veterans Program (consisting of VA's premier outreach program and a program offering contract therapeutic housing).

Section 8(d) would extend VA's operation of comprehensive service centers for homeless Veterans (under 38 U.S.C. §2033) from December 31, 2012 to December 31, 2014. VA supports section 8(d), which would re-authorize VA's Community Resource and Referral Centers.

Section 8(e) would extend, through December 31, 2013, the Secretary's authority under 38 U.S.C. §2041 to sell, lease, or donate properties to nonprofit organizations that provide shelter to homeless Veterans. Under current law, the authority will expire on December 31, 2012. VA supports the extension, as it will help VA meet its goal of ending Veteran homelessness by 2015. We note, however, that the five-year extension that the Administration proposed would better enable VA to achieve our goal. While any extension of authority under 38 U.S.C. §2041 would result in a re-

duction in property sales proceeds, neither a one-year, nor a five-year extension would result any significant loan subsidy costs.

Section 8(f) would require VA to make available (from amounts appropriated for Medical Services) \$300,000,000 for FY 2013 to carry out the Department's Financial Assistance Program (required by 38 U.S.C. § 2044). VA supports section 8(f), which would re-authorize appropriations for the SSVF Program, VA's premier prevention and rapid re-housing program. VA has already budgeted \$300 million for the SSVF Program in FY 2014.

Section 8(g) would extend VA's Grant Program for Homeless Veterans with Special Needs through 2015. VA supports this measure.

Section 8(h) would extend VA's Advisory Committee on Homeless Veterans from December 31, 2012, to December 31, 2014. VA supports this provision.

S. 3313—WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2012

Section 2 of the bill would add a new section 7330B to Title 38, 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 Director of the National Institutes of Health" 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 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 73308 that may be useful for other activities of the Veterans Health Administration (VHA) is disseminated throughout VHA. No later than three years after enactment, VA would be required to report to Congress on the research activities conducted under section 7330B.

VA supports section 2 of S. 3313. Generally, VA supports implementing research findings for the benefit of 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 Director of the National Institutes of Health. 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 3 of S. 3313 would include fertility counseling and treatment, including assisted reproductive technology, among those things that are considered to be "medical services" under chapter 17 of title 38, U.S.C., as provided in 38 U.S.C. § 1701(6).

VA supports the intent of section 3 of S. 3313, 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 in keeping with VA's goal to restore the capabilities of Veterans with disabilities to the greatest extent possible and to improve the quality of Veterans' lives. For many Veterans, having children is an important and essential aspect of life, and 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.

VA estimates the cost of providing these new benefits to all Veterans would be \$59 million in FY 2013, \$37 million in FY 2014, \$232 million over 5 years, and \$529 million over 10 years. The cost estimate is higher in the first year than in subsequent years because VA assumes that existing demand would result in immediate utilization of this benefit, but that demand would decline after these services were provided.

Section 4 would add a new section 1787 to Title 38 that would require VA to furnish fertility counseling and treatment, including assisted reproductive technology, to a spouse or surrogate of a severely wounded enrolled Veteran who has an infertility condition incurred or aggravated in line of duty, if the spouse 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. Section 4 would require VA to prescribe regulations to carry out section 1787 no later than 1 year after enactment.

VA supports section 4 in part, but must condition this support on assurance of the additional resources that would be required were this provision enacted. While VA supports providing infertility services including Assisted Reproductive Technology (ART) to severely wounded Veterans described in section 4 and their spouses or partners, VA does not support coverage of surrogates. 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. Moreover, the complex legal, medical and policy arrangements of surrogacy vary from state to state due to inconsistent local regulations. VA acknowledges that surrogacy may offer the only opportunity for Veterans and their 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 clarification of the phrase, “a severely wounded veteran who has an infertility condition incurred or aggravated in line of duty in the active military, naval, or air service” in subsection (a) of proposed section 1787 in section 4. The current language is unclear as to whether this benefit would be available to the spouses and surrogates of enrolled Veterans that have suffered loss or loss or use of creative organs, or if the eligible population would be more limited based on certain conditions of such Veterans (e.g. those with SCI, polytrauma, genitourinary injuries). VA also recommends clarification of the terms “fertility counseling and treatment” and “assisted reproductive technology.” In addition, the meaning and scope of the coordination contemplated under proposed section 1787(b) (which would authorize VA to “coordinate fertility counseling and treatment” for the spouses and surrogates of other Veterans not described in section 1787(a)) is unclear, and could potentially account for spouses and surrogates of all other Veterans. VA recommends that this be clarified as well.

VA recommends that this legislation be consistent with DOD’s 2012, “Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Servicemembers.” As such we recommend this legislation account for both severe injury and illness. VA cannot separate the costs of illness and injury. In the context of reproductive health, the distinction between illness and injury often is not a clearly defined boundary.

VA also 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 1787 (e.g. to include both spouses and partners of Veterans).

The bill does not state whether maternity services would be covered for a female spouse of a Veteran once infertility treatment is provided and pregnancy is established. These benefits typically would be provided in the private sector following successful fertility treatment. If the Committee intends that these benefits be included, we recommend that be made clear in the bill language.

VA also notes that the timeline to implement regulations for this program within one year of enactment is unrealistic given the complexity of issues involved.

VA’s cost estimates for care provided under this section do not account for maternity services for a female partner or spouse of a Veteran with infertility because the bill does not state that maternity services would be covered for a female partner or spouse of a Veteran once infertility treatment is provided and pregnancy is established. Potential costs for surrogates are also not reflected in this analysis because VA has no reliable way to predict how many surrogates would be utilized and cannot project the costs to cover the full range of legal and medical issues arising from surrogacy. This analysis accounts for the following infertility services, and includes the costs of providing in vitro fertilization to the proposed eligible population: advice/office visits, testing, drug therapy, surgery or treatment for blocked tubes, tubotubal anastomosis (reversal of tubal ligation), vasovasotomy (reversal of vasectomy), varicocele repair (repair of varicose veins around scrotum), artificial insemination (AI)/intrauterine insemination (IUI), assisted reproductive technologies (ART), and ART with donated egg/sperm, ART with frozen embryo, and ART with host uterus. VA’s cost estimates also assume there is pent-up demand for these services, so first year costs are expected to be significantly higher as Veterans and their families would immediately utilize these treatment options. The estimates reflect only the cost of services and do not reflect any potential costs associated with additional enrollment or additional utilization. VA’s cost estimate is based on the assumption that the benefits under section 4 would be extended to the spouses of Veterans with SCI, polytrauma, or genitourinary injuries, or other creative organ loss. VA is unable to differentiate between creative organ loss that is a result of injury and that which is a result of illness. Therefore, this analysis includes spouses

and partners of Veterans with creative organ loss which could be a result of illness or injury.

VA estimates the total cost to provide care under section 4 for spouses and partners of severely injured Veterans (those with polytrauma, genitourinary injuries, and spinal cord injuries, as well as creative organ loss, which could result from both injury or illness) to be approximately \$77 million in FY 2013, \$36 million in FY 2014, \$252 million over 5 years, and \$590 million over 10 years. As with section 3, VA anticipates a greater cost in FY 2013 as existing demand for these services is addressed.

Section 5 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 5 of S. 3313, and VA believes the most effective means of implementing this section would be to establish an inbound calling system specifically for women Veterans. By building on capabilities within the WVCC, an incoming call center would allow women Veterans to call the WVCC, and VA to connect them to resources, assist with specific concerns, and provide information on services and benefits. Many Veterans call 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 discussion of benefits available to them. Calls could also be transferred to the appropriate medical center to assist eligible Veterans with obtaining a health care appointment. Once a woman Veteran is connected to VA health care services, the Women Veterans Program Manager could also assist her in finding community resources that may not be provided by VA.

VA estimates section 5 would cost \$1.2 million in FY 2013, \$6.4 million over 5 years, and \$14.1 million over 10 years.

Section 6 of S. 3313 would expand the locations and duration of the pilot program required by section 203 of Public Law 111-163. Section 203 required VA to carry out a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services in group retreat settings to women Veterans recently separated from service after a prolonged deployment. Section 6(a) would increase the number of locations at which VA is required to carry out the pilot program from three to fourteen locations. Section 6(b) would extend the duration of the pilot from 2 years to 4 years.

VA supports section 6 of S. 3313. VA is currently in the final year of the original 2-year pilot program, authorized by section 203 of Public Law 111-163. These retreats under the pilot program focus on building trust and developing peer support for the participants in a therapeutic environment. In FY 2011, VA provided three retreats to women Veterans with three more retreats scheduled for FY 2012. VA could benefit from additional retreats as a greater number of women Veterans will be able to participate. These additional participants will also provide more data for VA to make a determination as to the appropriateness of these retreats during the final reporting phase. Initial reports provided after the completed retreats show favorable results with supplying participants with tools needed to make a successful reintegration into civilian life.

While VA supports section 6, we note that there may not actually be fourteen distinct geographic locations that offer the level of service the program requires. Therefore, we recommend that section 6(a) be amended to require VA to carry out the pilot program in up to fourteen locations. VA would continue to look for new locations to hold these retreats if section 6 were enacted, but previously used facilities may need to be reused due to the shortage of potentially qualifying locations based on the retreat requirements, specifically the need for specialized locations to complete outdoor team building exercises and other conditions.

Because VA will have completed retreats at six locations by the end of FY 2012, section 6 would require VA to schedule retreats at an additional eight locations before entering the final reporting phase. VA estimates that the cost of implementing this pilot program at an additional eight locations for an additional 2 years of the pilot program would cost \$335,640 in FY 2013 and \$348,000 in FY 2014, for a total of \$683,640.

Section 7(a) would modify the duration of the pilot program required by section 205 of Public Law 111-163. Section 205 required VA to carry out a 2-year pilot program at no fewer than three VISNs to furnish child care services to eligible Veterans as a means of improving access to mental health care and other health care services. Section 7(a) would extend the duration of the pilot such that "[a] child care center that is established as part of the pilot program may operate until the date

that is 2 years after the date on which the pilot program is established in the third Veterans Integrated Service Network.”

VA supports section 7(a). Currently, VA has two operational sites for the pilot program required by section 205 of Public Law 111-163: the first site established in Buffalo in October 2011, and the second site established in Northport in April 2012. The third identified site, in American Lake, WA, began offering services in the community in August 2012, and is expected to open its program on its VA campus in late 2012. This amendment would extend the authorization to execute currently planned programs and consequently would result in no additional cost to VA.

Section 7(b) would require VA to carry out a pilot program to assess the feasibility and advisability of providing assistance to qualified Veterans to obtain child care during the period such Veterans are receiving readjustment counseling and related mental health services at a Vet Center. The pilot program would be carried out in at least three Readjustment Counseling Service Regions selected by VA, for a 2-year period beginning when the last pilot location established under this section is initiated. VA would be required to report to Congress on the pilot program not later than 180 days after completion of the pilot program, which would include findings and conclusions, as well as recommendations for continuation or expansion of the pilot program. Paragraph (8) of section 7(b) would authorize the appropriation of \$1,000,000 for each FY 2014 and FY 2015 to carry out the pilot program. This section would define “Vet Center” as “a center for readjustment counseling and related mental health services for veterans under section 1712A of title 38, United States Code.”

VA supports section 7(b). Some Veterans who use Vet Center services, especially those who have served in either Iraq or Afghanistan, have voiced concerns that the lack of available child care has impacted their ability to consistently use Vet Center services. Vet Center staff members are constantly searching for new initiatives that have the potential to increase Veteran access to services. This pilot program could help to identify the scope of these concerns within the Vet Center program and determine the effectiveness of potential interventions. However, we have identified some concerns about confidentiality under the proposed pilot program, as VA’s Vet Centers currently maintain a separate set of records to preserve Veteran information. There is a possibility that Veterans participating in the program would need to consent to a verification process that could lead to a child care provider knowing that the Veteran is using Vet Center services. The pilot program could allow us to determine whether this has an impact on utilization of Readjustment Counseling Services.

VA is not able to provide an accurate cost estimate for section 7(b), as VA has no experience in predicting the potential use of such child care programs by Veterans who use Vet Center services. It is not viable to use cost estimates from the VA Child Care Pilot Program required by section 205 of Public Law 111-163, as this pilot is providing additional services through onsite child care and Vet Centers do not have space to accommodate such additional services. Further, usage comparisons with this pilot are not viable, as Vet Centers provide services during non-traditional hours, including after normal business hours and on weekends when requested by the Veteran. Depending upon how the program is executed, the \$1 million that would be authorized to be appropriated under paragraph (8) of section 7(b) may not be adequate to support a pilot program offering child care services at three Vet Center locations.

S. 3316—A BILL TO REQUIRE THE SECRETARY OF LABOR TO CARRY OUT A PILOT PROGRAM ON PROVIDING VETERANS WITH ACCESS AT ONE-STOP CENTERS TO INTERNET WEB SITES TO FACILITATE ONLINE JOB SEARCHES, AND FOR OTHER PURPOSES.

Section 1 of S. 3316 would require the Secretary of Labor to commence a pilot program to assess the feasibility and advisability of providing Veterans seeking employment with access to computing facilities to facilitate the access of such Veterans to Internet Web sites. The bill requires commencement of the pilot program not later than 90 days after the date of the enactment of this Act. VA defers to the DOL on section 1 of the bill.

Section 2 of this bill would repeal 38 U.S.C. § 7324, which requires the Secretary of VA to submit to Congress an annual report on the use of authorities to enhance retention of experienced nurses. VA supports this proposal. This reporting requirement has been provided annually to Congress since 2002. The Veterans Health Administration (VHA) is very interested in retaining experienced nurses, and this report has demonstrated for 10 years how VHA utilizes its authorities to enhance retention. Given that VHA intends to continue its retention efforts, as the report has

demonstrated over the last 10 years, there is minimal value in resubmitting the same data, with slight variation, annually. There would be a cost savings associated with the bill. Annually, VA spends \$4,082 to prepare this report. VA estimates cost savings of \$20,400 over 5 years and \$40,820 over 10 years.

S. 3324—GRANTS TO NONPROFIT ORGANIZATIONS FOR THE CONSTRUCTION OF FACILITIES FOR TEMPORARY LODGING

S. 3324 would authorize VA to award grants to the Fisher House Foundation, Inc. for the construction, furnishing, and decorating of Fisher Houses to be used by VA to provide temporary lodging under 38 U.S.C. § 1708(a). This bill would also authorize VA to accept, use, and dispose of gifts of services or property for purposes of awarding these grants or for operating and maintaining Fisher Houses. Finally, the bill would authorize the appropriation of \$4,000,000 for FY 2013 and each fiscal year thereafter.

VA Fisher Houses improve access to care for Veterans by providing a supportive environment for family members and caregivers to stay during the course of medical treatment. Veterans are more likely to travel long distances to receive care if their families and caregivers can accompany them without bearing the burden of costs associated with hotel lodging. VA supports the Fisher House and other similar foundations. We note that the bill would set a new precedent in allowing funding for Fisher House construction, where previously VA only provided operation and maintenance funding. Further, the bill limits these grants to only the Fisher House Foundation. Other community organizations have provided funding for the construction of temporary lodging at VA medical centers. For example, Lilly Endowment, Inc., in collaboration with other community organizations, funded a grant to construct the “Veterans House,” which opened in 2011, and is located on the grounds of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana.

VA estimates the cost of this bill to be \$4.2 million in the first year, \$20.9 million over 5 years and \$41.9 million over 10 years.

S. 3336—A BILL TO AUTHORIZE THE SECRETARY OF VETERANS AFFAIRS TO CARRY OUT A MAJOR MEDICAL FACILITY PROJECT LEASE FOR A DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC AT EWA PLAIN, OAHU, HAWAII, AND FOR OTHER PURPOSES

S. 3336 would authorize the Secretary of VA to carry out a major medical facility project lease for an outpatient clinic at Ewa Plain, Oahu, in an amount not to exceed \$16,453,300.

VA supports the bill, but as written it does not fully describe the project. Because the outpatient clinic will be co-located with the Department of Defense, VA suggests modifying the language as set forth below.

“The Secretary of Veterans Affairs may carry out a major medical facility lease for a Department of Veterans Affairs outpatient health care access center, to include a co-located clinic with the Department of Defense and the co-location of the Veterans Benefits Administration Honolulu Regional Office and the Kapolei VA Vet Center, in an amount not to exceed \$16,453,300.”

S. 3340—MENTAL HEALTH ACCESS TO CONTINUED CARE AND ENHANCEMENT OF SUPPORT SERVICES ACT OF 2012

Title I

With regard to sections 101 through 103 and sections 107 through 113 of S. 3340, VA defers to the views of the Department of Defense (DOD), as these sections primarily affect DOD programs.

Section 104 of S. 3340 would limit disclosure by DOD medical and mental health care providers of a mental health condition of a member of the Armed Forces, treatment of a member for a mental health condition, or a member’s request for treatment of a mental health condition. Under this section, a DOD medical or mental health care provider could only make such a disclosure if:

- (1) The disclosure is to another covered entity (as defined for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) and is necessary;
- (2) The member concerned requests the disclosure;
- (3) The member concerned does not meet the minimum standards for deployment prescribed under section 1 074f(f) of Title 10, United States Code, at the time of the disclosure, regardless of the deployment status or plans of the member; or
- (4) The disclosure is necessary in an emergency to protect the life or safety of the member concerned or others.

While VA supports the goal of limiting unnecessary disclosures of Servicemembers' mental health records, we do not support section 104 because its provisions would complicate and delay the delivery of benefits to which Veterans are entitled. Currently, the Veterans Benefits Administration (VBA) is authorized to request and receive mental health treatment records from DOD without requiring the Veteran to sign a medical release for such disclosure. However, because VBA is not a "covered entity" under HIPAA, section 104 would require that a Servicemember or Veteran specifically request that VBA obtain the protected records. Thus, the provisions of section 104 would add an additional administrative burden for VBA in adjudicating claims for mental disorders that would potentially operate to the detriment of Veterans in need of compensation benefits by delaying the adjudication of their claims.

There are no mandatory or significant discretionary costs associated with section 104. However, the proposed provision would likely delay claims processing for Veterans seeking compensation for mental health conditions by imposing the additional requirement that VA obtain from every Veteran claiming compensation for a mental health condition a specific release of information to forward to DOD. This additional step could ultimately delay the delivery of benefits, or possibly result in a denial of benefits otherwise warranted if the Veteran failed to provide the necessary authorization.

Section 105 would require DOD and VA to enter into an MOU governing the sharing of examination results and other records retained under DOD's medical tracking system for members of the Armed Forces deployed overseas.

VA does not support the proposed provision. Current agreements between DOD and VA already permit the sharing of information contained within medical tracking systems for members deployed overseas. The current agreements enable VA to procure such records for purposes of VA health care and benefits claims. For example, DOD and VHA share information from DOD's Pre-and Post-Deployment Health Assessment surveys and the Post-Deployment Health Reassessments surveys by utilizing the Federal Health Information Exchange (FHIE) and Bidirectional Health Information Exchange systems. DOD sends data on separated Servicemembers to VA on a monthly basis, and weekly for individuals referred to VA for care or evaluation. Because VA and DOD already share this information pursuant to an MOU governing health information sharing, this provision is unnecessary. It is unclear whether this provision would require an additional MOU to replace or supplement the existing memorandum covering the same subject. There would be no costs associated with enactment of this provision.

Section 106 would require DOD and VA to enter into an MOU providing for participation of members of the Armed Forces in VA peer support counseling programs and would require VA to provide training to Servicemembers who will perform peer support counseling duties under those programs. VA has no objection to this section of S. 3340. VA already is undertaking actions consistent with the objective of section 106 without the use of a memorandum of understanding. VA currently has a peer support specialist position in development for which active duty Servicemembers would be eligible to apply. All VA peer support counselors receive training. In addition to the formal peer support training program, a volunteer position description has also been developed expressly to provide volunteer support to those Veterans in the suicide prevention program. While VA does not consider these volunteers to be "peer specialists" and would not expect or want these volunteers to provide counseling services, there are a variety of ways that they can provide support to fellow Veterans, such as companionship. VA encourages and supports this engagement through the suicide prevention volunteer program. VA estimates the cost of this provision would be \$32.4 million for FY 2013; \$167.5 million over 5 years; and \$349.8 million over 10 years.

Title II

Section 201(a) would require that VA, no later than December 31, 2013, develop and implement a comprehensive set of measures to assess mental health care services furnished by VA. These measures must provide an accurate and comprehensive assessment of the timeliness of the furnishing of VA mental health care, the satisfaction of patients who receive VA mental health care services, the capacity of VA to furnish mental health care, the availability and furnishing of evidence-based therapies by VA. Section 201(b) would require VA, not later than December 31, 2013, to develop and implement guidelines for the staffing of general and specialty mental health care services, including at community-based outpatient clinics. Such guidelines must include productivity standards for providers of mental health care.

VA has no objections to Section 201(a), although it is partially duplicative of current processes in place by the VHA Office of Mental Health Operations (OMHO) and

Office of Mental Health Services (OMHS). OMHO and OMHS have partnered to develop four separate work groups to address access measurement in response to the recent review by the Office of the Inspector General. VHA leadership has put forth both temporary and long-term proposals addressing access measurement. VHA is currently reviewing patient satisfaction using the Survey of Healthcare Experiences of Patients survey tool, and conducting meetings with Veterans at every OMHO site visit scheduled this year and on a recurring 3-year basis to provide feedback from Veterans on mental health services. VHA has also developed a specific survey to obtain Veteran feedback about mental health care and will be implementing the survey in FY 2013. Capacity to furnish mental health care is measured by the Comprehensive Mental Health Information System (MHIS), which allows VHA to review the amount of mental health services provided per unique Veteran at a facility and compare results across facilities. Likewise, VHA is able to partially monitor the availability and furnishing of evidence-based psychotherapies (EBP) using the Comprehensive MHIS, which provides an overall measure for psychotherapy implementation as well as specific metrics related to the provision of such services for Veterans with PTSD, Depression, Substance Use Disorders, and Serious Mental Illness (SMI). VHA anticipates the implementation of the templates for the EBP notes in FY 2013 will provide more specific information for analysis.

VA has no objections to section 201(b), OMHO is partnering with OMHS to further develop the mental health staffing model. A pilot is currently underway in (Veterans Integrated Service Networks (VISN) 1, 4, and 22, the results of which will help further guide implementation to all VISNs in FY 2013. Productivity standards for mental health providers have been drafted and are being reviewed internally by VHA before final approval. There are no additional costs involved for these subsections if efforts are covered by current VHA staff.

Section 201(c) would require VA seek to enter into a contract with the National Academy of Sciences to create a study committee to consult with VA on VA's development and implementation of the measures and guidelines required by subsections (a) and (b); and to conduct an assessment and provide an analysis and recommendations on the state of VA's mental health services. The contract must require the study committee to assess certain issues, conduct surveys, and make recommendations to the Secretary on certain issues. Any subcommittee that assists the study committee must include at least one former VHA official and two former VHA employees who were providers of mental health care. The study committee would be required to submit periodic reports to VA and provide other consultation to VA. Not later than 30 days after receiving a report from the Committee, VA would be required to submit to the Congressional Veterans' Affairs Committees a report on VA's plans to implement each recommendation in the report.

Section 201(c) appears to be duplicative of processes already in place within OMHO. However, VA does not object to the provision because a contract might be beneficial for consultative purposes to augment current internal efforts.

VA has no objection to this subsection. VHA has already reviewed barriers to mental health services using focus groups with mental health provider staff as well as through OMHO site visits at every facility this fiscal year. Comprehensive site visits have been conducted during which OMHO reviewed the implementation of the Uniform Mental Health Services Handbook at each facility. VHA could further modify these ongoing site visits to review implementation of early interventions services for hazardous drinking and relationship problems for Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans, as proposed in section 201(c). A survey of Veterans and clinical providers is also currently being finalized for distribution to the field and will include Veterans from OEF/OIF/OND. Follow-up analyses of both the surveys and the site visits will be submitted to upper management detailing overall concerns. Individual facilities are submitting action plans based on each site visit report. These actions plans are monitored by OMHO and a follow-up action plan will be developed based on the survey summary. It should be noted that site visit teams are also comprised of facility mental health providers and leaders. A compiled report can be made regularly to the Secretary for distribution to Congress as desired.

Section 201(d) would require VA to make available to the public on a VA Internet Web site the measures and guidelines developed and implemented under this section and an assessment of the VA's performance using such measures and guidelines. VA would be required to update the measures, guidelines, and assessment made available to the public not less frequently than quarterly.

VA has no objection to this provision. VHA could publish its measures and guidelines along with an assessment of VA's performance that is based on these metrics. This would be placed on an Internet Web site for public awareness. However, it

should be noted that such assessments cannot always be updated quarterly, as some metrics may be updated at various points of the year.

Section 201(e) would require VA to submit to the Congressional Committees on Veterans' Affairs a report on the Secretary's progress in developing and implementing the measures and guidelines required by section 201 no later than June 30, 2013, and no less frequently than twice each year thereafter. This subsection specifies what the report must include.

VA has no objection to providing reports to the Senate Veterans' Affairs Committee (SVAC) and House Veterans' Affairs Committee (HVAC) to report on progress on the implementation of the measures and guidelines from above. However, to reduce the burden of report preparation, we recommend this provision be modified to require reports annually or as needed.

Section 201(f) would require VA to submit to the Congressional Committees on Veterans' Affairs a report on the Secretary's planned implementation of such measures and guidelines not later than 30 days before the date on which the Secretary begins implementing the measures and guidelines required by this section. This subsection sets forth the required elements of this report.

VA has no objection to this provision. While VHA already has measures in place, OMHO could submit a report to the Secretary that outlines descriptions of each measure and current vacancies. Prior to submitting an assessment of how many additional positions may be needed to meet demand for services, VHA would need to complete the staffing model pilot and incorporate revisions to the staffing model based on the outcome of the pilot.

For those subsections of section 201 with costs, VA estimates the cost of Section 201 provisions to be \$2.3 million in FY 2013; \$7.7 million over 5 years; and \$9.1 million over 10 years.

Section 202 would limit the individuals who can receive readjustment counseling from VA, including at Vet Centers, to the following:

(1) Individuals (Veterans and members of the Armed Forces) who served on active duty in a theater of combat operations or an area at a time during which hostilities occurred in that area.

(2) Individuals (Veterans and members of the Armed Forces) who provided direct emergency medical or mental health care, or mortuary services to the casualties of combat operations or hostilities, but who at the time were located outside the theater of combat operations or area of hostilities.

(3) Individuals (Veterans and member of the Armed Forces) who engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle, notwithstanding whether the physical location of such Veteran or member during such combat was within such theater of combat operations or area.

(4) Individuals who previously received readjustment counseling.

(5) Individuals who are family members of a member of the Armed Forces who is serving on active duty in a theater of combat operations or in an area at a time during which hostilities are occurring in that area.

(6) Individuals who are family members of a Veteran or member of the Armed Forces described above.

With respect to individuals described in (1) through (4) above, VA would be authorized to provide counseling to assist in readjusting to civilian life. For individuals described in (5) and (6) who are family members of a member who is deployed in a theater of combat operations or an area at a time during which hostilities are occurring in that area, VA may provide counseling during such deployment to assist them in coping with the deployment. For individuals who are family members of a member or Veteran who is readjusting to civilian life, VA may provide counseling to them to the degree that counseling furnished to them is found to aid in the readjustment of the Veteran or member to civilian life.

Section 202 also would permit licensed and certified mental health care providers to determine that mental health services are needed to facilitate a Veteran's successful readjustment to civilian life. Currently, the law only permits physicians or psychologists to do this.

Section 202 would define the term "Vet Center" as a facility which is operated by VA for the provision of services under this section and which is situated apart from VA general health care facilities.

Section 202 would define the term "family member" to mean an individual who is a member of the family of the Veteran or member of the Armed Forces, including a parent, a spouse, a child, a step-family member, or an extended family member;

or an individual who lives with the Veteran or member of the Armed Forces, but is not a member of the family of the Veteran or member of the Armed Forces.

Finally, section 202 would authorize VA to provide for and facilitate the participation of VA employees who provide services under this section in recreational programs that are designed to encourage the readjustment of Veterans eligible for counseling under this section; and operated by organizations named in or approved by VA to prepare, present, and prosecute claims for Veterans' benefits.

VA supports this section, which would expand readjustment counseling services to two new cohorts: (1) Medical, Mental Health, and Mortuary Professionals who deal with the casualties of war; and (2) Servicemembers and Veterans who served in positions within unmanned aerial vehicle crews. Both of these groups represent individuals that may not have necessarily deployed to combat theaters or areas of hostilities though still experience firsthand the reality of war and have their own unique readjustment to civilian life.

There would be no cost associated with this section. These two cohorts represent a relatively small number of Veterans and Servicemembers. Furthermore, VA will be augmenting Vet Center staff around Active Duty military bases, where many of these individuals are stationed, as a part of the implementation of Section 401, Public Law 111-163 which expands Vet Center eligibility to active duty Servicemembers who served in OEF/OIF/OND.

Section 203 would authorize VA, subject to the availability of appropriations, to furnish mental health care to immediate family members of members of the Armed Forces who are deployed in connection with a contingency operation through VA medical facilities, telemental health modalities, and such community, nonprofit, private, and other third parties as the Secretary considers appropriate. Family members would not be eligible for VA payments for beneficiary travel as part of this care.

VA does not support this provision. These services are currently provided to family members of deployed Servicemembers by TRICARE or at a DOD medical facility. It is unclear what additional services would be offered by VA that are not already provided by TRICARE or DOD.

VA estimates the cost of the provision to be \$1.1 billion in FY 2013; \$7.6 billion over 5 years; and \$19 billion over 10 years.

Section 204 would amend Subchapter 1 of Chapter 73 of title 38 of the United States Code, to add a new section 7309, which would restructure the Readjustment Counseling Service (RCS) as a distinct organization within VHA, and add a new position of Chief Officer with direct authority over RCS staff and assets, including Vet Centers, who would report directly to the Under Secretary for Health. It would establish qualifications standards for Chief Officer, including, in part, combat Veteran status, psychological doctorates and internships approved by the American Psychological Association (APA), and minimum amount of required experience in administering and providing direct counseling or outreach services. This new section would fund the activities of RCS, including Vet Centers, through VHA's Medical Care appropriations, but prohibit allocation of the funds through the Veterans Equitable Resource Allocation system. Section 7309 also would require an annual report to Congress on the activities of RCS, including each Vet Center's workload, additional treatment capacity, and ratio between FTE employees and individuals served, and detailed analysis of demand and unmet need for readjustment counseling services and the plan for meeting such need.

VA does not support this section, which would reorganize RCS within VHA. RCS is an independent organizational unit within VHA that provides unique services in a safe and confidential environment not provided at VA medical center facilities. Its current organizational placement under the Deputy Under Secretary for Policy and Services allows RCS to interact with all other clinical programs at the national level, while maintaining independence at the operational level. This alignment provides a conduit for coordination and collaboration where services are similar (e.g. policy development for mental health services that are common to both RCS and other facilities); it also supports the alignment of patient needs when primary care or specialty services are identified.

Section 204 would also establish the statutory qualifications in the new section 7309 for the Chief Officer position. These include combat Veteran status, psychological doctorates and internships approved by the APA, and minimum years of experience in administering or providing direct counseling and outreach services. Qualification requirements for VA's organizational Chief Officers are generally not set forth in statute. For example, Title 38 does not recognize specific professional associations for other health care professionals. In addition, the APA would have the sole authority to determine satisfactory doctorates and internships. This would conflict with the Secretary's authority under 38 U.S.C. § 7402(b)(8) to determine, by pol-

icy, whether a particular psychological doctorate or internship is “satisfactory,” and would require a statutory amendment before VA could accept doctorates or internships from other psychological professional associations. Finally, new section 7309 would establish the minimum amount of experience required to qualify for the Chief Officer position. There is no evidence to support that any set time makes a person more or less qualified to apply for the position. These provisions could limit VA’s ability to recruit and appoint qualified candidates and result in an unintentional limitation on the sources of qualified individuals.

There are no costs associated with this section.

Section 205 would require the Secretary to establish a national program of outreach to societies, community organizations and government entities in order to recruit qualified mental health providers on a part-time, without compensation basis under 38 U.S.C. § 7405. Section 205 would enable VA to partner with or assist in developing a community entity, including through use of a sharing agreement under 38 U.S.C. § 8153 that provides strategic coordination to the societies, community organizations, and government entities in order to maximize the availability and effective delivery of their mental health services to Veterans. In carrying out the national outreach program, VA would train mental health professionals on military and service specific culture, combat experience, and other factors unique to Veterans who served in OEF/OIF/OND.

This section would require VA to participate in outreach to recruit Without Compensation (WOC) Mental Health providers to provide mental health services on VA’s behalf. VA currently has provisions for woe Employees that require mandatory credentialing and privileging procedures to assure competency and safety. VHA wants to ensure it has the ability to set recruitment targets and approve only those individuals who are qualified to provide mental health services. This summer VHA will release an accredited Military Culture Training program that will be available to all community providers, including those who provide care in the community for Veterans and Servicemembers.

We do not believe that this legislation is needed and we do not support the widespread recruitment of WOC mental health providers who are not credentialed and privileged to provide services under our guidelines. However, VA supports the goal of conducting outreach to mental health providers who are appropriately qualified to treat our Nation’s Veterans. VA is well positioned to set the appropriate recruitment and training guidelines that will maintain the integrity and safety of VA mental health care.

VA estimates costs of \$32.4 million for FY 2013; \$167.5 million over 5 years; and \$349.8 million over 10 years. Other costs may be needed, e.g., to run EES training programs for such WOC employees, but those cannot be estimated at this time.

Section 206 would amend 38 U.S.C. § 7411 to authorize reimbursement to full-time board-certified physicians and dentists for certification, recertification, or continuing professional education (CME) expenses up to \$1,000 per year or, in the case of full-time psychiatrists, up to \$4,000 per year.

VA does not support this section, which would create an inequity among other professionals subject to similar continuing education and certification obligations.

VA estimates costs for the provision at \$24.6 million in FY 2013; \$132 million over 5 years; and \$292 million over 10 years.

Section 207 of S. 3340 would require (as opposed to merely authorize) the Secretary to establish and carry out the peer support counseling program as provided for in 38 U.S.C. § 1720F(j). Section 207 would also require that the training provided to peer counselors include the training carried out under a contract with a national not-for-profit mental health organization for Veterans of OEF and OIF to provide peer outreach and peer support services. This program would need to commence at each VA medical center no later than 270 days after enactment of the Act.

VA does not support this provision. Currently, peer services are being provided at VA medical centers. In addition, the President recently signed an Executive Order to improve access to mental health services for Veterans, Servicemembers and military families. The Order requires VA to hire and train 800 peer-to-peer counselors to empower Veterans to support other Veterans and help to meet mental health care needs by December 31, 2013. Toward this end, new peers will be hired this fiscal year and throughout the coming fiscal year to enable VHA to provide these services at all VA medical centers and very large community-based outpatient clinics (CBOC). VA has developed the national training program and is currently soliciting bids for implementation. It is expected that an award will be made this summer and training will begin this fall.

VA estimates that this provision will cost \$27.8 million in FY 2013; \$249.4 million over 5 years; and \$567.3 million over 10 years.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO
MADHULIKA AGARWAL, M.D., M.P.H., DEPUTY UNDER SECRETARY FOR HEALTH FOR
POLICY AND SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Last Congress, we created a pilot program to provide child care at several VA medical centers for veterans who were coming in for health care services. I understand that the first site opened in October 2011, but that the third site is not open for business yet. Please provide any preliminary assessment of the program, or lessons learned from the implementation to date.

Response. In October 2011, the Department of Veterans Affairs (VA) began carrying out a 2-year pilot program to provide child care services to eligible Veterans at the Buffalo VA Medical Center (VAMC), and expanded this program to the Northport VAMC in April 2012. The third selected site, at American Lake, WA, a Division of the VA Puget Sound Health Care System, is scheduled to open in early fiscal YEAR (FY) 13. Preliminary information from this program reveals that Veterans are overwhelmingly supportive of the program and report that it has made health care more accessible for them. In FY 2012, VA projects it will spend a little more than \$1 million to support the program. Data from the Buffalo program covers 10 months (October 2011-July 2012), and Veteran utilization has steadily increased. Buffalo cared for 108 children in the month of July. The overall monthly average for the number of children cared for is 61. The program operates 5 days a week at both the Buffalo and Northport VAMCs. The Northport VAMC has 3 full months of data available (May 2012-July 2012), and has experienced high utilization since opening, providing care to 130 children in the month of July. The overall monthly average for the number of children cared for is 92.

We have identified contracting and construction issues as challenges to timely implementation. For example, the Buffalo VAMC operated under a monthly purchase order until VA awarded a contract on June 22, 2012. Other delays with construction and contracting have pushed back the opening of the American Lake site until early FY 2013.

VA officials have learned several valuable lessons from this pilot. Perhaps most important is that an implementation team comprised of individuals from General Counsel, Contracting, Public Affairs, and other offices is essential to timely implementation. The requirement for an integrated implementation team will be added as experience has indicated significant delays occurred as each office dealt with issues such as outreach and contracting sequentially rather than concurrently.

We also receive valuable feedback from Veterans concerning hours of operation, logistics, implementation, and other elements of the program via our approved satisfaction survey. Suggestions for improvement are carefully considered and implemented as appropriate. As the pilot progresses, we anticipate other lessons learned will be more readily identified, and we will include this information in our report to Congress after the completion of the pilot program.

VA has determined that its authority to execute the pilot program will expire on October 2, 2013, 2 years after the first pilot site opened in Buffalo. Because not all facilities began providing these services at the same time, under the current authority, Northport and American Lake will not be able to operate for a full 2 years. Section 7(a) of S. 3313, the Women Veterans and Other Health Care Improvements Act of 2012 which currently resides in the Committee, would provide a technical amendment authorizing the program to run for a period of 2 years beginning on the date the third site is activated. If such an amendment were made, VA would expand the pilot to additional locations in FY 2013 to obtain more, valuable information on the costs and benefits. These sites would be selected based upon interest by facility leadership, availability of resources, need for child care services among the Veteran population, and other relevant factors. These additional locations would provide VA with more data, thereby allowing VA to provide a better recommendation to Congress on whether the pilot should be continued or expanded.

Question 2. The Mental Health ACCESS Act of 2012 would make a range of improvements to mental health services for our servicemembers and veterans. Among its other provisions, this bill would expand the availability of mental health services for family members of veterans and deployed servicemembers. Please discuss the importance of veterans having good, stable family support when they return home from deployments, and the extent to which VA can help accomplish this goal.

Response. Family members of Veterans with emotional symptoms and problems that arise during their military service or post-deployment face many challenges as they strive to be a significant source of strength and support for their Servicemember or Veteran family member. A recent study found that 86 percent of Veterans with Post Traumatic Stress Disorder (PTSD) view their symptoms as a source of family stress (Batten et al., 2009). In the case of PTSD, symptoms of emotional

numbing, including difficulties experiencing and expressing positive and negative feelings, can hinder the ability of the Veteran with PTSD to feel close or connected to family members (Riggs et al, 1998). Also, symptoms such as irritability, being easily startled, and having trouble concentrating or sleeping can contribute to conflict within the family (Taft et al., 2007). Other issues that can contribute to relationship and family issues include difficulty with trusting others, lowering of self-esteem, and problems with power and control.

Family members are an extremely important source of support for Veterans as they heal. The ability to reconnect and reestablish strong bonds with loved ones is a critical part of the post-deployment adjustment and the recovery process. The ultimate goal of family support is creating and sustaining mutually-satisfying relationships that bolster the Veteran's successful community adjustment. Research shows that more than three-fourths of Veterans with PTSD are interested in more family involvement in treatment (Batten et al., 2009). Furthermore, the success of treatment for PTSD can be increased if family members provide the Veteran with social and emotional support.

VA has the ability to provide a number of services, including several couple- and family-based programs to help families develop the skills and attitudes to support recovery. VA offers a telephone hotline, Coaching into Care, for family members to learn effective strategies to encourage the Veteran to begin or reinstate VA Services. Many VA facilities sponsor "The Support and Family Education (SAFE) Program," which is an 18-session educational workshop for families of Veterans living with PTSD or serious mental illness. Families may attend as many sessions as needed. SAFE topics include Communication Tips for Family Members, Problem-Solving Skills for Families, and Skills for Managing Stress Effectively as a Family Member. VA also offers Veteran-Centered Brief Family Consultation (VCBFC), in which the family meets with a mental health professional as needed to resolve specific issues related to the Veteran's treatment and recovery. This intervention is designed to be brief; it usually consists of between one and five sessions for each consultation. Finally, VA offers more intensive couples counseling to help Veterans and their loved ones have more satisfying relationships.

Recently, VA was authorized through section 304 of Public Law 111-163 to provide services to family members up to 3 years after deployment to receive readjustment counseling and mental health services to assist the family member in readjusting after deployment. These services are available through Vet Centers, as well as at an increasing number of VA medical centers as new peer support specialists are hired. Mental health services for family members can be arranged with community organizations as needed.

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Question 3. A veteran is lost to suicide every 80 minutes, and so far this year, one servicemember commits suicide per day. One of the keys to effective suicide prevention is ensuring there is timely access to care. Often veterans only seek care when they are on the verge of crisis. If VA turns them away because they are too busy, we have lost the opportunity to help that individual. Concerns remain whether there are enough providers in the system.

How can VA use authorities like those provided in the Mental Health ACCESS Act, along with existing hiring and retention authorities, to recruit and retain top mental health providers?

Response. In direct support of the Mental Health Hiring Initiative (MHHI), the Veterans Health Administration (VHA) Workforce Management and Consulting (WMC) Office, in partnership with the VHA Human Resources (HR) and Office of Mental Health (OMH), has developed and implemented a systematic process to recruit, hire, and retain top mental health providers.

WMC created multiple task forces that target the recruitment and staffing efforts to bring these new employees into VA as effectively and efficiently as possible. The

Recruitment and Marketing Task Force provides oversight of the national recruitment and marketing strategies for MHHI.

Recruitment & Marketing Task Force

Key processes include use of a skilled national team of professional health recruiters, targeted advertising and outreach, aggressive recruitment from a pipeline of qualified candidates to leverage against mission critical mental health vacancies, and provision of consultative services to Veterans Integrated Service Networks (VISN) and VA stakeholders.

The National Recruitment Program (NRP) provides VHA with an in-house team of highly skilled professional recruiters employing private sector best practices to fill VA's most mission critical clinical occupations. As of July 16, 2012, the NRP has provided dedicated recruitment support to 251 mental health positions at the specific request of VISN/VAMC leadership (primarily psychiatry and psychology). This team of recruiters has helped hiring managers identify and select over 100 psychiatrists. One example of their efforts was recruitment at the American Psychiatric Association (APA) event held May 5–8, 2012, in Philadelphia, PA, which resulted in identifying 7 psychiatrists who have received offers, and all are projected to be on board by September 30, 2012.

The Marketing and Advertising task group has implemented an aggressive, multi-faceted, sustained national marketing and outreach campaign to include maximum visibility to rural and highly rural markets. Completed milestones include:

- Spotlight advertisement renewed on USAJobs Web site as of June 18, 2012. An earlier run resulted in over 8,000 “click-throughs” to www.VAcareers.va.gov.
- Online banner advertisement currently being run on seven professional mental health association homepages.
- Eleven Web banners currently running through the Joining Forces partnership and its APA-affiliated networks.

VA has taken these efforts over the past several months and in previous years to partner with professional associations, societies, and other health care organizations for the purpose of recruiting additional mental health providers.

Hiring and Tracking Task Force

The Hiring and Tracking Task Force provides oversight for MHHI. This team moves the hiring process forward expeditiously in a focused manner and addresses any issues or concerns immediately while resolving road blocks to fill each position promptly. This task force provides daily oversight on the tracking status of each position and consultative services to VISN Human Resource officers (HRO), OMH, and VHA recruiters, as needed. This task force tracks the daily progress of the 1,900 new hires as well as the 2,815 existing vacancies. The task force conducts daily conference calls with the field H.R. community to ensure engagement and accountability. Hiring Task Force members collaborate with VISN HROs to ensure efficiency and flexibility by implementing specific workflows to enhance timelines:

Recruitment and Retention Incentives

VHA promotes maximized flexibility with, and availability of, recruitment and retention incentives (relocation, home buy-out, signing bonuses, student loan repayment programs, etc.) to better attract the best qualified candidates. VHA collaborates with the Office of Human Resource Management to reassess current salary tables for psychiatrists to make these positions more competitive with private industry and DOD.

Provider retention remains a top strategic priority for VHA in its commitment to maintaining quality services to Veterans. These incentives permit the staffing and retention of difficult-to-fill positions with high quality candidates who possess unique skills and competencies. VA clinical education programs are a crucial resource for VA's employment pipeline. With over 100,000 trainees rotating through VA facilities annually, we have a vigorous developmental cohort from which to recruit new staff in 40 or more disciplines. We know, for example, that roughly 70 percent of current VA optometrists, physicians, and psychologists participated in VA training programs prior to their employment in VA. VA is still reviewing the provisions of the Mental Health ACCESS Act to determine how those provisions might complement these efforts.

Question 4. I understand the Department has reviewed each VISN office and is proposing to reduce the number of staff.

a. How are you posing to change which functions will be performed by the network offices?

Response. VA recognizes the need to improve the consistent and efficient use of staffing resources in each VISN office and to ensure that staffing is aligned with

mission and function. To this end, a workgroup comprised of a small group of VISN directors was chartered in the fall of 2011 to conduct a review of each VISN office to establish definitions of core and non-core staff functions, identify targeted staffing levels, develop an implementation timeline and plan to align VISN staffing levels, and develop a monitoring mechanism to assure achievement of target staffing levels. As part of the VISN staffing alignment process, each VISN was asked to review its organizational chart and staffing reports, and identify which functions are performed by whom, which functions are core to the mission of the VISN office, and describe the basis for consolidating certain functions. The input provided by the VISNs was evaluated by the workgroup. The workgroup identified a core set of staff for all VISNs and that plan has now been approved by the Under Secretary of Health. VHA staff briefed staffs on the House and Senate Committees on Veterans' Affairs on July 17, 2012.

b. What do you believe is an appropriate number of medical centers for a network office to oversee?

Response. VISN boundaries were developed originally based on patient-referral patterns, including aggregations of patients and facilities that would be needed to support a continuum of primary, secondary, and tertiary care, and to a lesser extent, to be consistent with jurisdictional boundaries such as state lines. Every VISN composition is unique, and the complexity levels of the VA medical centers, size of patient populations, geographies and regional aspects vary widely. There is no prescribed number of appropriate medical centers for a Network Office to oversee. However, currently the maximum number of health care systems in any one VISN is 11, and that number does represent the upper limit that would be advisable.

c. When was the last time the Department reviewed the network boundaries to see if they are still the most appropriate way to organize the health care system?

Response. The current VISN boundaries were first drawn in 1995 as part of VHA's "Vision for Change" plan for reorganizing the Veterans Health Administration, which called for the dissolution of the hierarchical central office, regional office and network structure, in favor of 22 VISNs with 5–11 medical centers and various other VA assets. One of the sub-objectives of the VISN boundaries of 1995 was to achieve a basic budgetary and planning unit for delivery of Veterans health care, and a means of pooling resources. The last time VA reviewed the number of VISNs was in 2002, and merged VISNs 13 and 14 to form VISN 23. When the VISNs were originally formed, there were no medical foster homes, no ambulatory surgery centers, and hundreds fewer community-based outpatient clinics, community living centers (nursing homes), and domiciliaries. VA has subsequently gathered more data on long-term care and mental health services, as well as for some inpatient services, because sufficient information was not available at the time regarding demand for these services and other factors.

Question 5. VA currently has discretionary authority to pay beneficiary travel for some individual who are not otherwise covered specifically by law. Given how difficult it can be for veterans who are blind or have the serious injuries outlined in S. 1755, it would seem these veterans could use this assistance. How many of these veterans received beneficiary travel benefits from VA under the existing authority?

Response. VA does not track beneficiary travel payments by patient diagnosis. However, historical data indicates that approximately 33 percent of VHA users collect travel benefits. Assuming the same benefit use rate for the three groups identified in S. 1755, VA estimates the following beneficiary travel usage based upon workload for FY 2011.

Condition	VHA Users	Beneficiary Travel Users
Spinal Cord Injury (SCI)	20,724	6,839
Amputee	7,088	2,339
Blind	39,956	13,185
Total	67,768	22,363

Question 6. The Department recently set a goal to increase access to mental health care services through telehealth consultations, and is working to improve veterans' access to services in rural areas. As you know, bandwidth capacity in rural areas can be severely limited. Some medical centers have to prioritize clinical services when networks are slow in order to protect critical hospital functions. One particularly vulnerable service is these remote mental health care services are inter-

rupted. What is VA's plan to ensure each medical center and clinic involved in the clinic-based telehealth program is properly equipped and will have enough bandwidth to conduct video consultations?

Response. In anticipation of using telehealth to expand Veterans access to mental health services (telemental health) and other specialty care services, VA ensured the necessary support structures are in place as part of its FY 2011–2012 Expansion Initiative. The Telehealth Expansion Initiative began in June 2011, and resulted in the completion of major purchases in all VISNs of clinical videoconferencing equipment and associated telehealth peripherals and equipment; and the hiring of Telehealth Program Managers in each VISN and Telehealth Coordinators at every VAMC. In FY 2012, funding support continued for these positions and VISNs were provided additional funding to recruit 1,144 Telehealth Clinical Technicians (TCTs) to assist clinicians with delivery of telehealth based care, where the patient and the provider are separated geographically.

As of 3rd quarter FY 2012, this VA initiative has:

- Provided more than 3,200 clinical videoconferencing units for telehealth to all VAMCs and their associated sites of care.
- Ensured these sites of care have the necessary telecommunications capability (“bandwidth”), namely being able to provide two concurrent clinical video telehealth (CVT) consultations at 384 kilobits/second, in place by September 2012.
- Recruited and trained a 1,012 telehealth clinical technicians (TCT) to assist clinicians in VA medical centers and community-based outpatient clinics to provide care via telehealth, and to offer the first line of support in the event of technical problems with equipment as of June 2012.
- Established a national telehealth help desk that provides immediate access to technical assistance for clinicians and TCTs at all VA sites of care with expertise to resolve technical problems that TCTs cannot address on-site.

As a result of this preparatory work VA has the technology infrastructure and technical support to meet its goals for increased access to mental health care services through telehealth consultations.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SCOTT BROWN TO MADHULIKA AGARWAL, M.D., M.P.H., DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, U.S. VETERANS HEALTH ADMINISTRATION

Question 1. Please describe the relationship that currently exists between VA and the Fisher House Foundation.

Response. Fisher Houses are housing facilities located at, or in proximity to, a VA medical facility; are available for residential use on a temporary basis by patients of that facility and their family members; and are constructed by and donated to the Secretary by the Zachary and Elizabeth M. Fisher Armed Services Foundation.

VA has 21 operational Fisher Houses with planned expansion to 38 VA Fisher Houses over the next several years. In 2011, over 11,797 families and caregivers utilized VA Fisher Houses in order to be close to a Veteran or Active Duty Servicemember during the course of medical treatment.

VA Fisher Houses improve access to care for Veterans and Active Duty Servicemembers by providing a supportive environment for family members and caregivers to stay during their course of medical treatment. Veterans and Active Duty Servicemembers are more likely to travel long distances to receive care if their families and caregivers can accompany them without bearing the burden of costs associated with hotel lodging. Once donated to VA, it is the expectation of the Fisher House Foundation that VA Fisher Houses are maintained in pristine condition, and funding is available to support the costs of refurbishing, redecorating, and replacing major appliances in VA Fisher Houses. The corresponding VA medical center is also responsible for funding all Fisher House operations.

Question 2. In the opinion of VA leadership, how many VA medical centers or campuses require a Fisher House, and which sites are the most critical?

Response. VA has a formal process to identify and prioritize VA medical centers for Fisher House construction. First, VA initiates a formal call for Fisher House applications.

Applications are evaluated and prioritized based upon the following criteria:

- The availability of services in specialty areas such as Polytrauma, Spinal Cord Injury, Blind Rehabilitation, Transplant, Inpatient Palliative Care and Hospice Programs, and Oncology Programs;
- VA medical centers serving a large post-9/11 Active Duty population;
- VA medical centers serving large rural catchment areas; and

- The availability of land to construct a VA Fisher House on or within close proximity to a VA medical center.

The following are locations with an identified need for a Fisher House:

- Michael E. DeBakey VA Medical Center, (second house)—Houston, Texas
- North Florida /South Georgia Veterans Healthcare System—Gainesville, Florida
- Tennessee Valley Healthcare System Murfreesboro Campus—Murfreesboro, Tennessee
- Clement J. Zablocki Veterans Affairs Medical Center—Milwaukee, Wisconsin
- Louis Stokes VA Medical Center—Cleveland, Ohio
- VA Long Beach Healthcare System—Long Beach, California
- VA Connecticut Healthcare System—West Haven, Connecticut
- VA Eastern Colorado Healthcare System—Denver, Colorado (new medical center)
- Orlando VA Medical Center—Orlando, Florida
- Omaha-VA Nebraska/Western Iowa Healthcare System—Omaha, Nebraska
- VA Maine Healthcare System—Togus, Maine
- VA Caribbean Healthcare System—San Juan, Puerto Rico
- New Mexico VA Healthcare System—Albuquerque, New Mexico
- Portland VA Medical Center—Portland, Oregon
- Southern Arizona VA Healthcare System—Tucson, Arizona

VA continues to assess on a regular basis the need for additional Fisher Houses, and many VA medical centers have expressed interest in future Fisher House construction.

Question 3. For those existing VA medical centers and campuses without a Fisher house, what is the VA currently doing to provide families with comparable lodging?

Response. VA medical centers provide alternative resources to accommodate families requiring temporary lodging assistance. These resources may include providing lodging at a temporary lodging facility located at a VA health care facility (generally referred to as a “Hoptel”), or a temporary, non-VA lodging facility, such as a hotel or motel, funded by a VA health care facility. VA medical centers also have relationships with community Hospital Hospitality organizations, such as Ronald McDonald House, to assist with temporary lodging accommodations for family members as needed.

Question 4. In the absence of legislation, what can VA do within existing authorities to fund the Fisher House construction on the grounds of medical centers and campuses?

Response. The construction of VA Fisher Houses is a joint venture between the Department of Veterans Affairs and the Fisher House Foundation. Existing statutory authority (38 U.S.C. § 1708) defines the term “Fisher House” as a housing facility that is located at, or in proximity to, a Department medical facility; is available for residential use on a temporary basis by patients of that facility and others described in 38 U.S.C. § 1708(b)(2); and is constructed by, and donated to the Secretary by, the Zachary and Elizabeth M. Fisher Armed Services Foundation. Current statutory authority does not authorize VA to fund Fisher House construction.

Question 5. In 2011 GAO released a report entitled, *Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing*. In that report, GAO found that VA and HUD lacked information regarding the characteristic and needs of homeless women veterans at the national, state, and local levels. What is the VA currently doing to get a handle on this problem, especially as it relates to understanding the unique needs of homeless women veterans with children?

Response. Established in 2009 by Department of Veteran Affairs Secretary, the National Center on Homelessness among Veterans (the Center), is a multi-site initiative within VISN 4 and 8, with leadership offices located at the Philadelphia VAMC. As a key component of VA’s National Homeless Programs Office, the Center and its academic affiliates play a critical role in piloting new innovations and developing the empirical knowledge needed to improve the care and quality of life for Veterans who are homeless or at-risk for homelessness. The Center’s goal is to improve services to homeless Veterans by developing, promoting, and enhancing policy, clinical care research, and education. The Center is also designed to be a national resource for both VA and community partners, improving the quality and timeliness of services delivered to homeless Veterans and their families. The Center is developing a comprehensive Homeless Registry, a data warehouse that tracks and monitors homeless program expansion, operation, and treatment outcomes. The Homeless Registry allows “real-time” access to data by VA providers, program administrators, VAMC staff, as well as VISN and VHA Central Office leadership to facilitate performance monitoring and decisionmaking.

The registry enhances VHA's capacity to utilize longitudinal programmatic and Veteran-specific data to better evaluate how programs function and how the system as a whole is progressing to end Veteran homelessness. The registry has the capacity to provide individualized reports on Veteran characteristics by geographic regions. This new capacity facilitates VHA's ability to target resources (program funding and grant funding) to where the need is greatest. Examples include gender specific, age, and service era data that inform decisions related to Supportive Services for Veteran Families (SSVF) and Department of Housing and Urban Development-Department of Veterans Affairs Supportive Housing (HUD-VASH) programs as well as Grant and Per Diem (GPD).

VHA has also realigned its data collection about homeless programs to be more consistent with those in HUD's Homeless Management Information System (HMIS) standards. VA bed capacity is now entered into the HMIS bed inventory section to achieve coordinated and complete data collection of VA resources in HMIS. VA and HUD have collaborated on a single reporting mechanism of Veteran homelessness in the Veterans Annual Homelessness Assessment Report (Vet AHAR). These modifications promote greater consistency in reporting prevalence of Veteran homelessness both inside and outside of VA.

In June 2012, the Homeless Data Cube became available through the VHA Support Service Center (VSSC). The Homeless Data Cube provides data on VA Homeless Services, data analysis, and reporting. The data in the cube goes back to 2006 through the present and utilizes a variety of data sources. The Homeless Data Cube contains descriptive and demographic data on homeless Veterans, including gender, Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) status, etc. The Homeless Data Cube also contains utilization and outcome data on homeless and at-risk Veterans served within VA. Finally, the data can be analyzed by program, location (including national, facility, VISN and state), and fiscal year.

Since 1993, VA has collaborated with local communities across the United States in Project Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) for Veterans. The mission of CHALENG is to bring together Veterans, representatives from VAMCs and Veterans Benefits Administration regional offices, community providers and advocates, local officials, and other concerned citizens to identify the needs of homeless Veterans and then work to meet those needs through planning and cooperative action. In 2011, the CHALENG Veterans survey provided gender specific information, and in 2012, the community partner survey will include gender specific questions to increase awareness of women and their families' unique needs.

VA is working with the US Interagency Council on Homelessness, national Veterans Service Organizations, and Federal, state, local and community partners that serve homeless and formerly homeless women Veterans and children to capture the needs of homeless women Veterans.

Chairman MURRAY. Thank you very much. We really appreciate the VA's testimony today. I just have a couple of questions I am going to ask and then I will submit the rest for the record because we want to make sure we have time to get to the second panel today, and I know there are a number of Committee Members here who want to ask you questions as well.

Let me just begin. The witnesses on the next panel are going to talk about VA's fertility treatment options for seriously injured veterans. Their testimony, when taken collectively, is resoundingly clear. VA's fertility treatment options fall short for our veterans with very severe injuries.

Unlike the Department of Defense, the VA is prohibited by regulation from offering IVF. I wanted to ask you today, is the VA considering lifting the ban?

Dr. Agarwal.

Dr. AGARWAL. Thank you for the question, Madam Chairman.

Consistent with VA's goals to improve health and quality-of-life for veterans, we do offer certain infertility treatments and diagnostic tests including genetic counseling.

However, regulation in 1999 did exclude IVF services from VA's defined medical benefits package. DOD in April this year has defined and clarified implementation guidance on provision of IVF services for certain categories of servicemembers, and the VA is reviewing its regulatory options and your Women's Health Bill, which was introduced on June 19, and we will work with you and your staff to bring about what needs to happen.

Chairman MURRAY. Well, the VA cannot offer much in the way of care for spouses. What does that mean for couples who need extra assistance conceiving a child because of the war injury?

Dr. AGARWAL. Thank you again for this question, Madam. Congress has generally restricted eligibility of health care services in VA to spouses. There are some rare exceptions such as in CHAMPVA.

S. 3313 is aimed at expanding that authority to include infertility management for spouses under some circumstances when the veterans injury has precluded their ability to procreate naturally. We do not have our position on this yet but are reviewing it and again look forward to working with you and the Committee.

Chairman MURRAY. I appreciate it. On our second panel we are going to have some compelling testimony. I hope that the Members of our Committee are able to hear what I have been hearing as well on this.

I also wanted to just mention the Mental Health ACCESS Act of 2012, which I have introduced. I want to stress we need comments back from the VA very urgently on this. This is going to expand the availability of mental health services for family members of veterans and deployed servicemembers.

As we talked about, the VA currently has very limited authority to provide service to family members. So, I would appreciate your comments back on that as soon as you can as well.

With that, let me turn it over to Senator Burr for any questions he has.

Senator BURR. I thank the Chairman.

Mr. Secretary Schoenhard, VA's written testimony states that the VHA has, and I quote, already reviewed each VISN headquarters, is in the process of working with each to streamline operations, create efficiencies internal to each VISN and to realign resources.

Has General Shinseki been briefed on what that realignment is going to look like?

Mr. SCHOENHARD. Ranking Member Burr, yes, he had been briefed, and we are still in the process of discussion and evaluation.

Senator BURR. When does the Secretary plan to approve those recommendations?

Mr. SCHOENHARD. Sir, we should be having this accomplished here in the coming weeks. We look forward to briefing you and your staff.

Senator BURR. Will we be briefed before the Secretary signs off on it or after the Secretary signs off on it?

Mr. SCHOENHARD. Sir, I think we would brief you after the Secretary signs off.

Senator BURR. Does the Committee play any part in this process?

Mr. SCHOENHARD. Sir, we would very much appreciate the opportunity to brief you and the members of your staff and any Members of the Committee regarding our work.

Senator BURR. Before or after the Secretary signs off?

Mr. SCHOENHARD. Sir, I think we would like to further evaluate and review our work and then sit with you, Sir.

Senator BURR. In the 17 years since Dr. Kaiser created the VISNs, there has been a significant growth in the number of VISN headquarters staff. The original plan called for 220 full-time workers, full-time employees. Yet, the current staff is at 1,340.

Do you anticipate the staff level in VISN reorganization to be cut?

Mr. SCHOENHARD. Sir, we do. Let me just, if I can, just back up and say we have done a systemic review of the function of the VISN, and I think that you will be seeing reductions in our staff as a result of this effort.

Senator BURR. Well, I just was taken a little bit aback by the Under Secretary's comments that my legislation was too prescriptive. I am not sure how you can set up an administrative structure without it being prescriptive.

Mr. SCHOENHARD. Yes, sir.

Senator BURR. You have got to design what it is over, what its mission is, and hopefully what the staffing is; and that is, in fact, what I put in my legislation.

Is that what your review is going to do?

Mr. SCHOENHARD. Yes. We have looked at the core function of a VISN, the core staff required to accomplish that mission, and I think that our focus has been with the end in mind what is it that a VISN should do as the main operating vehicle for accountability and leadership to address all of the concerns we have heard this morning regarding care to rural veterans, care and mental health and the rest, to do that in a way that is population health based, is based on the veterans in that location with sufficient span of control to accomplish that mission and to serve veterans.

Senator BURR. I look forward to the opportunity for you and I to get together.

Mr. SCHOENHARD. Yes, sir.

Senator BURR. Sooner rather than later.

Mr. SCHOENHARD. Yes, sir.

Senator BURR. Mr. Murphy, you addressed the Second Amendment issue. If individuals, let me ask you this. How many veterans' names have been turned over to NICS? How many are currently on that list?

Mr. MURPHY. I do not have the details on the number of names that are currently on their list. I can tell you the details around the number of requests for relief or removal from the list.

Senator BURR. How many names have been requested to be relieved?

Mr. MURPHY. 185, Senator.

Senator BURR. How many have been granted?

Mr. MURPHY. A total of 19.

Senator BURR. That is out of 127,000 names that have been turned over on the NICS list?

Mr. MURPHY. Correct. I am assuming your numbers are correct. I do not have those in front of me.

Senator BURR. Trust me, they are.

Mr. MURPHY. OK.

Senator BURR. If individuals seek relief from the NICS reporting requirements, does the VA assist them in coming up with the evidence needed to show whether they are dangerous?

Mr. MURPHY. Yes, Senator, we do.

Senator BURR. What do you do?

Mr. MURPHY. The Duty to Assist Act requires us to fully develop the case. This is not a light matter in the Veterans Administration. This is a fully adjudicated, fully developed claim with a full decision letter, with an explanation of how the decision was arrived at with all supporting evidence and documentation provided to them.

Senator BURR. Are there any veterans that are determined incapable to handle their own personal finances whose name is not put on the NICS list?

Mr. MURPHY. Let me make sure I understand the question. Are there veterans who—

Senator BURR. You have somebody that has determined that a veteran cannot write a check. So, they cannot handle their finances. They have now assigned to a spouse to be in charge of the finances.

Is there anybody that that has happened to that that veteran was not then listed on the NICS list?

Mr. MURPHY. I can say that they are not supposed to be. I am not saying that through administrative process for errors that it had not occurred.

Senator BURR. My understanding, and I will get you to go back and clarify this if I am wrong, every veteran who is relieved of their financial or deemed that they cannot handle their own finances is automatically put on the list.

Mr. MURPHY. They are placed on the list by the Veterans Administration. Yes.

Senator BURR. So, what are the qualifications of the VA employees who make the decisions about whether veterans and their families should be stripped of their Second Amendment? What training do these people go through?

Mr. MURPHY. I do not believe we have an option in this, Senator. We are directed—

Senator BURR. You have VA employees that are making a decision on whether somebody is capable of doing their own personal finances. That determination that they are not capable of doing that strips them of their Second Amendment right. It is very simple.

What training does that VA employee go through to be qualified to make a determination that would strip somebody of their constitutional rights?

Mr. MURPHY. Our employees, our adjudicators are trained in determining whether or not that veteran is capable of making the financial determinations they have with the funds that the Veterans' Administration provides to that individual.

As a result of that decision, they are placed on the NICS list. It is not a determination whether the individual is capable of han-

dling firearms or not. It is, can they manage their personal finances or not.

Senator BURR. I know. But when they go on the NICS list, they are now deprived of firearm ownership.

Mr. MURPHY. That is correct.

Senator BURR. OK. So, a determination that they cannot handle their personal finances strips them of their Second Amendment right and also, the way that it is written, it forbids any firearm to be handled by anybody in the household.

So, you, in essence, strip the spouse of the Second Amendment right. You strip children of the Second Amendment right because you have determined that a veteran cannot handle their own personal finances.

Are we in agreement?

Mr. MURPHY. We are.

Senator BURR. OK. I do not want to make this too simplistic. But if a veteran cannot sign their name to a check and the VA determines that their spouse should be assigned the financial responsibilities because you are transferring money into an account, do we agree that that would trigger their listing on the NICS list and they would lose their Second Amendment right as well as everybody else in the household?

Mr. MURPHY. That is one I need to ask Mr. Hipolit to verify for me because I am unaware of the requirement for other members of the household's restriction to own firearms.

Mr. HIPOLIT. Yes, that is correct as well. I was also personally not aware of the household restriction. I know that if VA determines that the person is incapable of handling their financial affairs, that does get them on the NICS list.

Senator BURR. But you would agree, Mr. Hipolit, that a determination that they cannot handle their finances has a wide definition to it?

Mr. HIPOLIT. I would say that if VA determines that they are unable to handle their finances, that does qualify them to get on the NICS list and their names are referred for the list.

Senator BURR. That is not necessarily a mental determination. It could be a physical determination, correct? If they are not capable of handling their finances.

Mr. HIPOLIT. If they had a physical disability that impaired their ability to handle their financial affairs.

Senator BURR. So, they are automatically classified as dangerous?

Mr. HIPOLIT. Our determination is just whether they can handle their financial affairs and then that automatically triggers the requirements to refer their names.

Senator BURR. So, would you agree that the purpose of the NICS list which is to take guns away from dangerous people and the threshold that VA currently uses to determine who goes on the NICS list are potentially two very different things?

Mr. HIPOLIT. I think that the law enforcement agencies determined who should be put on the NICS list, and they determined that person is found to be—

Senator BURR. But they do not in the case of veterans. In the case of veterans, the only person that determines whether they go

on the NICS list is the VA, and it is determined based upon are they capable of handling their own personal finances.

Mr. HIPOLIT. Well, the law that requires us to make the referral is a regulation from the—

Senator BURR. And you are the only agency in the Federal Government that across-the-board sends every person that is not qualified to handle their personal finances to the NICS list?

Are you aware of that?

Mr. HIPOLIT. That is not my understanding. It is my understanding that other agencies refer people as well.

Senator BURR. Other agencies refer people but they have a different threshold for the ones that they refer. I think they might use the definition of dangerous, and what I have heard you say is dangerous does not come into play. Mental capacity does not come into play. Capability of handling your own personal finances is the only threshold, and when they hit that, they are automatically put on the NICS list.

Mr. HIPOLIT. From the VA standpoint, if they are determined not to be able to handle their financial affairs, we have to refer them for the NICS list.

Senator BURR. I hate to dig in on this. I just want to point out to you that the threshold is very, very different at VA. There are many veterans, spouses, and family members who are deprived of their Second Amendment rights to own firearms based upon an arbitrary decision by somebody at VA that they cannot handle their own personal finances.

These people are all of a sudden labeled as dangerous when, in fact, the decisions may have been a physical disability that did not permit them to handle their own finances. I hope this is something the Committee will look at. I am actually shocked that the Veterans' Affairs Committee is not outraged at the way this is being implemented. 127,000 of our country's veterans are stripped of a constitutional right. Some probably should. Many of those 127,000 should have never had their right taken away.

I thank the Chair.

Chairman MURRAY. Senator Boozman.

Senator BOOZMAN. Just really quickly to follow up. So, the process is that they are deemed where they need help in handling their finances.

How do they become aware that they are on the list? Do you send him a letter, explaining again that all the guns in the house need to go out and all that?

I guess what I am saying is do the people who are actually on the list know that they are on the list—

Mr. MURPHY. It is actually more extensive than that, Senator.

Senator BOOZMAN [continuing]. And the ramifications of what has happened to them.

Mr. MURPHY. There is a decision made and with the appointing of a fiduciary comes a VA employee actually visiting the veteran's home, talking with the veteran, explaining to the veteran, and ensuring that they are in a safe environment for that veteran to be living.

Mr. HIPOLIT. Under the NICS Improvements Act, there was a notification requirement put in. Before VA declares somebody incom-

petent, we have to make them aware that that would affect their ability to possess and buy a firearm. So, there is a notification requirement.

Senator BOOZMAN. Of the 18 that were reversed, how long did it take to go through the process?

Mr. MURPHY. The number of days to complete is 187.

Senator BOOZMAN. 187 days?

Mr. MURPHY. Yes, sir.

In that, there are some requirements to allow veterans time notices with time to respond, multiple 60-day periods. So, in order to provide due process to the veteran to fully develop their rights under this in the appeals process 187 days.

Senator BOOZMAN. Did you say 18 had been reversed?

Mr. MURPHY. It is 19, Senator.

Senator BOOZMAN. 19.

Mr. MURPHY. Yes, sir.

Senator BOOZMAN. So, the average of those was 187 days?

Mr. MURPHY. Correct, to get reversed.

Senator BOOZMAN. What was the longest?

Mr. MURPHY. I do not have the details on the spread. If you would like, I would be more than happy to provide those for you.

Senator BOOZMAN. What would you guess?

Mr. MURPHY. The 187 days average includes some of the veterans for us just starting this process. So, what I would say that that number would be higher than what the average if I just looked over the last few cases that went through.

So, the first few veterans that went through going through a new process took a little bit longer time and pushed it beyond that 187 days. But I believe that the next time I appear before you, if you asked me this question, it is going to be some number below that 187.

Senator BOOZMAN. Thank you, Madam Chair.

Chairman MURRAY. Thank you. Senator Burr, do you have a question?

Senator BARR. Madam Chairman, just one follow-up question to Mr. Murphy because you said that you were under duty to assist.

Mr. MURPHY. That is correct, Senator.

Senator BARR. I have got this memo from the Department of Veterans Affairs, dated November 22, 2010, and it says that the duty to assist as demonstrated in an order and examinations for securing private medical records do not apply in this program.

Mr. MURPHY. Well, Senator, then I was in error.

Senator BARR. OK. I just wanted to make sure we were on the same sheet. Thank you.

Mr. MURPHY. I did bring three documents today. I understand how important this is to you, so what it is is our Fast Letter, the specific instructions to the field for the relief process. In addition to that, I have two redacted decision letters: one that was granting the relief; and one that was denying the relief. If you would like to see those, Senator, I would make those available to you.

Senator BARR. Let me just ask the Chair if she would make them available for the record?

Chairman MURRAY. I will do that.

[The letters referred to follows:]



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington, D.C. 20420**

November 22, 2010

Director (00/21)
All VA Regional Offices and Centers

Fast Letter 10-51

SUBJ: Processing Requests for Relief from the Reporting Requirements of the National Instant Criminal Background Check System (NICS)

This letter provides new information on the National Instant Criminal Background Check System (NICS) relief program and procedures for processing relief requests.

Within 30 days of date of this letter, the Compensation and Pension (C&P) Service will return all pending requests for relief in its possession, with their associated claim folders and principle guardianship folders (PGFs), to regional offices (ROs) and centers for action in accordance with this letter. Please conclude all actions within 90 days of receipt of the claims folder.

Background

The Brady Handgun Violence Prevention Act of 1993, Public Law 103-159 (The Brady Act), prohibits the sale of firearms to certain people. The NICS Improvement Amendments Act (NIAA) of 2007 sets new requirements for federal and state agencies, and contains an amendment to the Brady Act that obligates VA to allow beneficiaries the opportunity to request relief from the reporting requirements imposed by the Brady Act. VA is also obligated to provide beneficiaries both written and oral notification of the firearms prohibitions, penalties for violating them, and information regarding the availability of the relief program.

NICS Relief Program

The NIAA places the responsibility for administering the relief program on the agency that provided the information to NICS. The primary focus regarding relief provisions outlined in this letter is public safety. Further, relief from the reporting requirements is not a benefit under Title 38 and as such, principles common to the VA adjudication process, such as benefit of the doubt and duty to assist (as demonstrated in ordering examinations or securing private medical records) do not apply to this program. The burden of proof for these relief requests resides with the claimant, and failure to meet that burden is sufficient to deny the request. Decisions that deny relief are not subject to

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review by the Board of Veterans' Appeals, but VA denials of requests for relief under the NIAA are subject to review in Federal district court. Accordingly, it is important that all denials contain a detailed explanation of the basis for denial.

Handling Requests for Relief

Requests for relief from the Brady Act reporting requirements must be clear and explicit. Do not infer or interpret a request for relief as a claim for reconsideration of incompetence or a claim of competency as a request for relief.

Development

If the request for relief is received following the final rating of incompetency, establish end product (EP) 290 using the "NICS Relief Request" claim label. If the evidence of record is sufficient to grant relief according to the criteria outlined below, follow the procedures under *Administrative Decision*. If the evidence is insufficient to grant relief, send the attached development letter (Enclosure 1). Allow the beneficiary 30 days to respond to the letter.

The beneficiary may submit a request for relief prior to the final incompetency rating. If the request for relief is received prior to the final rating of incompetency, send the development letter (Enclosure 1), but do not render a decision on the request for relief until the rating of incompetency is final and the 30-day development response time has expired. Then follow the procedures under the *Administrative Decision* section below.

If the beneficiary submits a claim for reconsideration of competency in conjunction with the request for relief, establish EP 020. After any appropriate development, refer the claim to the rating team. If the rating veterans service representative confirms and continues incompetency, do not address the issue of relief in the rating decision. Instead, follow the procedures under *Administrative Decision* outlined below.

Note: We will program all NICS development and decision letters in PCGL as soon as possible. In the interim, copy and paste the text of the enclosures into a free text document.

Deciding Relief

In deciding requests for relief, decision makers must consider the beneficiary's record and reputation, as well as the beneficiary's mental and physical status. To grant relief, the record must show affirmatively, substantially, and specifically that the beneficiary is not likely to act in a manner dangerous to public safety, and that granting relief will not be contrary to the public interest.

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In making determinations, consider not just the beneficiary's desire to own firearms and/or ammunition, but the safety of himself, his family, and the community. As VA's determinations on requests for relief have the potential to affect public safety, grant relief on the basis of clear and convincing evidence.

In determining whether to grant relief, relevant records may include:

- A statement from the primary mental health physician assessing the beneficiary's mental health status over the last five years.
- Medical information addressing the extent of mental health symptoms and whether or not the beneficiary is likely to act in a manner dangerous to himself/herself or to the public.
- Information documenting that a court, board, or commission that originally determined incompetence has restored competency status or otherwise determined that the beneficiary has been rehabilitated through any procedure available under the law.
- Statements or records from law enforcement officials, such as the Federal Bureau of Investigation (FBI), the Bureau of Alcohol, Tobacco, and Firearms (ATF), or the Attorney General, showing that the granting of relief would not be contrary to the public interest.

When determining relief requests, consider if any of the following unfavorable factors are manifest over the past five years:

- The presence of any mental disability that has been evaluated at more than 10-percent disabling. (If there is no rating of record, consider whether evidence indicates that any current mental disability causes no more than mild or transient symptoms observable only during periods of significant stress, or whether symptoms of mental disability are completely alleviated through the use of continuous medication (38 CFR 4.130). Also, consider the presence of any personality disorder when determining relief requests.
- Evidence of recurring substance abuse or any substance abuse within the last year.
- Local, state, or federal convictions for felonies and/or violent offenses (including, but not limited to, menacing, stalking, assault, battery, burglary, robbery, rape, murder, and attempts thereof).
- Demonstration of overtly aggressive or hostile behavior and/or demeanor.
- Presence of suicidal or homicidal ideations.

Administrative Decision

The RO or center will handle all requests for relief by preparing an administrative decision (see 38M21-1MR, Part III, Subpart v, Chapter 1, Section A, Topic 2). The RO

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Director must approve all administrative decisions after concurrence by the Veterans Service or Pension Management Center Manager, or designee.

Inform the beneficiary of the determination by sending the NICS relief grant or denial letter (Enclosure 2 or 3). If relief is granted, notify the NICS Manager within three days at VAVBAWAS/CO/NICS under the subject "NICS relief grant." The notification must include the beneficiary's name, claim number, Social Security number (if different than claim number), date of birth, contact information (including address and telephone number), and the date of the grant of relief. Upon granting relief, the C&P Service will notify the FBI, which manages the NICS database for the Department of Justice, to remove the beneficiary from the NICS database. The FBI will remove the beneficiary's name from the database within approximately two months after notification by the NICS Manager.

If a beneficiary who was formerly found incompetent is found competent, the request for relief becomes moot. In the final competency rating, include the following statement under *Reasons for Decision* for the competency issue:

"We received your request for relief from the Department of Justice (DoJ) reporting requirements contained in the Brady Handgun Violence Prevention Act. We have determined you are competent for VA purposes, so it is not necessary to render a decision on that request. VA will inform DoJ of your changed status."

File all documents exclusive to this relief decision on the right side of the claims folder.

Questions

Questions concerning information contained in this letter should be e-mailed to VAVBAWAS/CO/NICS.

Recission: At the earliest opportunity, we will incorporate into the M21-1MR the provisions of oral and written notice from pages 4 and 5 of Fast Letter (FL) 09-08, *National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007*, which is otherwise rescinded.

/S/

Thomas J. Murphy
Director
Compensation and Pension Service

Enclosures

Enclosure 1 – NICS Relief Development Letter

XXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX

In reply, refer to:
File Number: XXXXXXXX

IMPORTANT — reply needed

Dear Mr./Ms.:

We received your request for relief from the Department of Justice reporting requirements contained in 18 U.S.C. § 922(d)(4) and (g)(4). VA must report to the National Instant Criminal Background Check System (NICS) individuals whom VA determines to be unable to contract or manage their own affairs.

Pursuant to 18 U.S.C. § 925(c) and § 101(c) (2) (A) of the *NICS Improvements Amendment Act of 2007*, Public Law 110-180, VA is obligated to decide whether you are eligible to receive relief from the reporting requirements of the Brady Handgun Violence Prevention Act. This letter contains information about what we will do with your request and what you can do to help us decide it.

We may grant relief if clear and convincing evidence shows the circumstances regarding your disability, and your record and reputation are such, that you are not likely to act in a manner dangerous to yourself or others, and the granting of relief is not contrary to public safety and/or the public interest.

What Can You Do?

To support your claim for relief, you may submit such evidence as:

- A statement from your primary mental health physician assessing your mental health status over the last five years.
- Medical information addressing the extent of your mental health symptoms and whether or not you are likely to act in a manner dangerous to yourself or to public.
- Information documenting that a court, board or commission that originally determined incompetence has restored your competency status or otherwise determined that you have been rehabilitated through any procedure available under the law.

- Statements or records from law enforcement officials, such as the Federal Bureau of Investigation (FBI), the Bureau of Alcohol, Tobacco, and Firearms (ATF), or the Attorney General, which show that the granting of relief would not be contrary to the public interest.

Please put your VA file number on the first page of every document you send us.

Where Should You Send Your Evidence?

Please send all documents to this address: (include RO address)

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you within 30 days, we will make a decision on your request based on the evidence of record.

How Can You Contact Us?

Please give us your VA file number, **XXXXXXXXXX**, when you do contact us.

- Send written correspondence to the address above.
- Send us an inquiry using the Internet at <https://iris.va.gov>.
- Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.

We look forward to resolving your request in a timely and fair manner.

Sincerely yours,

Veterans Service Center Manager

Enclosure 2 – NICS Relief Grant Letter

XXXX
XXXXXXXXX
XXXXXX, XX XXXXX

In reply, refer to:
File Number: xxx xx xxxx

Dear Mr./Ms. :

We received your request for relief under the *National Instant Criminal Background Check System (NICS) Improvement Amendments Act (NIAA) of 2007* (Public Law 110-180).

What We Decided

We decided that you are eligible for relief from the Department of Justice reporting requirements imposed by the Brady Handgun Violence Protection Act.

We reviewed the following evidence in considering your claim:

- (enter evidence)

Our review of this evidence reveals that your disability, record, and reputation are such that you are not likely to act in a manner dangerous to yourself or others. Further, the granting of relief is not contrary to public safety or the public interest. Please allow the Department of Justice up to eight weeks to update its records in accordance with our decision.

If You Have Questions or Need Assistance

You may find more information about the Relief from Disabilities program in 18 U.S.C. § 925(c). If you have any questions regarding this decision, you may contact us by letter, Internet, or telephone. In all cases, be sure to refer to your VA file number, XXXXXXXX.

To Contact VA by	Here is what to do.
Mail	Send inquiries to the address at the top of this letter
Internet	Send an inquiry via VA's website at https://iris.va.gov .
Telephone	Call 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.

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We sent a copy of this letter to your representative, XXXXXX, whom you can also contact if you have questions or need assistance.

Sincerely yours,

Veterans Service Center Manager

cc:

Enclosure 3 – NICS Relief Denial Letter

XXXX
XXXXXXXXXX
XXXXX, XX XXXXX

In reply, refer to:
File Number: xxx xx xxxx

Dear Mr./Ms. :

We received your request for relief under the *National Instant Criminal Background Check System (NICS) Improvement Amendments Act (NIAA) of 2007* (Public Law 110-180).

What We Decided

We determined you are *not* eligible for relief from the Department of Justice reporting requirements imposed by the Brady Handgun Violence Protection Act.

We considered the following evidence:

- (enter evidence)

Based on this review, we are unable to conclude through clear and convincing evidence regarding your disability, record, and reputation that

- you will not likely act in a manner dangerous to yourself or others, and
- the granting of relief would not be contrary to the public interest.

Your Right for Review

NIAA relief requests are not matters which fall within the scope of title 38 of the United States Code and denial of such requests are not subject to review by the Board of Veterans' Appeals. However, denials of requests for relief under the NIAA are subject to review in Federal district court. See 18 U.S.C. § 925(c) for more information concerning appellate rights.

If You Have Questions or Need Assistance

You may find more information about the Relief from Disabilities program in 18 U.S.C. § 925(c). If you have any questions regarding this decision, you may contact us by letter, Internet, or telephone. In all cases, be sure to refer to your VA file number, XXXXXXXX.

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To Contact VA by	Here is what to do.
Mail	Send inquiries to the address at the top of this letter
Internet	Send an inquiry via VA's website at https://iris.va.gov .
Telephone	Call 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833.

We sent a copy of this letter to your representative, XXXXXX, whom you can also contact if you have questions or need assistance.

Sincerely yours,

Veterans Service Center Manager

cc:

Senator BOOZMAN. Madam Chair, can I just ask one other thing quickly?

Chairman MURRAY. Yes, Senator Boozman.

Senator BOOZMAN. In regard to Senator Ayotte, you know, with her bill and the cemetery issue in the Philippines, can you all comment about that?

I guess, you know, one of the things that we are so proud of when you go overseas and you see the—we are the only Nation in the world that really does that, you know, that takes such good care of our veterans. That really distinguishes us instead of the mass graves and this and that. We have done such a tremendous job. Tell me about, you know, rectifying that or if you feel like we need to rectify it, specifically what the problem is, how we got into this situation.

Mr. MURPHY. That is a bill, well, the picture is shown there and VA's understanding of exactly the condition of that specific cemetery, that is a bill that falls clearly under the American Battle Monuments Commission, and we have to defer to their input on that bill.

Mr. HIPOLIT. I would add that the National Cemetery Administration maintains cemeteries within the United States and the Commonwealth of Puerto Rico. We do not have overseas cemeteries. The American Battle Monuments Commission traditionally maintain the overseas cemeteries.

Senator BOOZMAN. So, is this particular cemetery in a Catch-22 situation where it does not have anybody who has claimed it because I suspect if it fell under their—if they felt like it fell under their jurisdiction, they would be taking care of it.

Mr. HIPOLIT. I cannot speak for them, but I think as of this time no Federal agency has responsibility for that cemetery.

Senator BOOZMAN. Can we say that you all are committed to helping to work that out where there is a claiming of the cemetery so we can do the appropriate thing?

Mr. HIPOLIT. Our position is that we need to defer to the American Battle Monuments Commission because that would be more within their jurisdiction than within VA's. I can see that those pictures were quite moving of the current condition of the cemetery, and I can fully understand the concern over it.

Senator BOOZMAN. Good. Thank you very much.

Chairman MURRAY. Thank you very much.

With that, I would like to thank this panel. I do have additional questions I will submit for the record because I want to leave time for our second panel today. So, thank you again very much.

Dr. AGARWAL. Thank you.

Chairman MURRAY. With that, I like to call up our second panel; and as we are changing out positions here, I am going to introduce them.

We are going to be joined today by Tracy Keil. She is the wife of a paralyzed veteran, as well as Dr. Mark Thomas Edney, who is an Operation Iraqi Freedom veteran and a urologist who is representing the American Urological Association.

Speaking on behalf of VetsFirst today is Vice President of Veterans Policy, Heather Ansley. Rounding out this panel is Joy Ilem. She is the Deputy National Legislative Director of the Disabled American Veterans.

Before I turn to the testimony from this panel, I also want to take a moment to thank retired Staff Sergeant Andrew Robinson for joining us today. He is in the audience.

Andrew was injured in 2006 when a roadside bomb threw him from the truck that he was in. Like Tracy, who we will be hearing from in just a moment and her husband Matt, Andrew and his wife Sarah also went through some very challenging times and had to use in-vitro fertilization to conceive their now 6-month-old twins I understand.

Andrew, I want to thank you for your service to the country, and thank you for driving down to be here with us today for this important legislative hearing.

All of your statements will be entered into the record, and I really do appreciate all of your testimony today.

Ms. Keil, I am going to start with you and thank you so much for your courage in coming speaking to our Committee today. So we will begin with you.

**STATEMENT OF TRACY KEIL, CAREGIVER AND
SPOUSE OF AN OIF VETERAN**

Ms. KEIL. Good afternoon, Chairman Murray, Ranking Member Burr, Members of the Committee. Thank you for inviting me to share my family's experiences with you today.

My husband, Staff Sergeant Matthew Keil, was shot in the neck while on patrol in Ramadi, Iraq, February 24, 2007, just 6 weeks after we were married.

The bullet went through the right side of his neck, hit his vertebral artery, went to his spinal cord, and exited his left shoulder blade. Matt instantly became a quadriplegic.

When I first saw him 3 days after he was injured, I was in shock. They explained to me that he had a Christopher Reeves-type injury. He was on a ventilator for the rest of his life, and he would never move his arms or legs.

Matt and I looked at each other in the hospital room at Walter Reed, and he asked me if I still loved him. I told him, baby, you are stuck with me. At that moment, we knew that we would be OK if we stayed in it together.

I knew that we just needed to work really hard to get Matt off his ventilator and increase his life expectancy so that we could live out our dreams.

Ultimately, we moved to Craig Hospital in Denver to be closer to our families. Four weeks to the day of arriving at Craig Hospital, Matt was officially off his ventilator, and we could truly concentrate on him doing physical rehabilitation.

Matt was able to regain 10 percent function of his left arm but not his hand. He was feeling good and getting used to his new normal of being a wheelchair and asking for help for everything. It was while we were at Craig Hospital that we started talking about having a family.

The Craig doctors talked to us about in-vitro fertilization, letting us know that that would be most likely the only way we could conceive. We started to get really excited that even though so much had been taken away from Matt physically that we could still have the future that we always dreamed up.

We had our whole lives ahead of us. Matt was just 24 when he was injured, and I was 28. We were very fortunate that he survived his injuries that day, and we made a promise to each other on our wedding day, for better or for worse, in sickness and in health; and we meant every word and we still do today.

It is a challenge for my husband and I every day, but we knew we still wanted a family. I remember back when he was in rehab at Craig and all we could talk about was when we were going to be adjusted to our new normal and when we will be ready to have children. We always knew since the day we met that we wanted to have kids.

In 2008, we moved into a fully accessible home built for us by Homes For Our Troops, and we started filling like things were falling back into place in our lives. We felt like we were getting back on track to where we were before he was injured.

However, his injury ultimately, unfortunately, prevents him from having children naturally. In mid-2008, I started asking the VA what services they could offer my husband and I to assist us with fertility. I remember hitting roadblocks at every turn, and I decided to take things into my own hands.

At one point, I was leading 12 women whose husbands were injured, writing letters, and making phone calls, and trying to get anyone to listen to us that we really needed help.

Fertility treatments are very expensive; and since I had left my full-time job, we were still trying to adjust living on one income. I felt helpless and hopeless that our dreams of having a family may never come true.

The VA did finally say that they would cover the sperm withdrawal from my husband and that costs around \$1,000 and that

they would store it for us at no charge. However, they could not offer me anything.

It is very difficult to put into words the emotions that I felt when I found out there was no help available for us from the VA or TRICARE. I felt very defeated, sad, disappointed and, in some ways, I felt helpless.

I researched everything I could about how to get TRICARE to cover some of the costs, but they could not because it was a direct result of my husband's injuries and that fell under the VA. The VA said they had no programs in place for this sort of thing. I even started asking nonprofits to assist with the cost and they could not help due to the other immediate needs of injured servicemembers.

In January 2010, my husband and I decided that we needed to move forward with our plans to start a family and we began our journey of fertility treatments. We selected a doctor in the private sector that has been a leader in IVF. We were fortunate that the best fertility doctor in the world is right in our town.

Having a doctor located near our home was helpful because I had to go every other day and then daily near the time of the transfer. This made it very easy for my husband to be there with me every step of the way.

I was on several medications that I took every day along with injections into my stomach three times a day. I would go to the doctor every other day for blood draws to check my hormone levels and make sure everything was progressing normally.

Each time I would be at the fertility clinic I was charged anywhere from \$250 to \$650. TRICARE did not cover any of these costs of anything related to the fertility treatments because I did not have any fertility issues myself. Everything was a direct result of my husband's injuries.

We are fortunate that Matt and I got pregnant on our first try with IVF. We welcomed our twins Matthew and Faith November 9, 2010. As you can see from the attached photographs, they are happy, healthy, and they love riding around with their dad.

As a couple who had already sacrificed so much for our country, I do not believe we should also have to give up on our dream of having a family. Fertility treatments are not a guarantee of having children, but it does give us hope.

It gives us hope that we can have a normal life just like everyone else. Part of living the American dream for us was having a home to raise our children and, of course, having the children to fill our home.

Now we have both, and while it is incredibly difficult to raise children while your husband is in a wheelchair, it is possible. We are living proof that anything is possible.

This is exactly the way our family is supposed to be. I strongly believe that my husband is supposed to be in a wheelchair. I cannot tell you why but this is the life that we are supposed to be living, and it is what it is supposed to look like. We are happy. We are healthy, and we are living out our dreams.

Now that my husband is retired, we are able to raise our children together as stay-at-home parents. We are a team and my only wish is that other families could find this happiness. One of the things I love the most about having children now is that their dad

is just their dad. They do not see the wheelchair. They make him feel like the man he was before he was injured, and they complete our life together and the kids have helped fulfill our dreams that we had when we got married and started our life together.

I would like to emphasize this statement. Wartime changes a family. It should not take away the ability to have one.

I hope that hearing our story today has helped you understand the importance of offering fertility treatments to injured veterans who have lost the ability to reproduce naturally.

I have always wanted more than anything for my husband to feel whole again. There is no magical cure for spinal cord injury. There is nothing out there that will help him walk again or move his arms.

However, Congress, the VA, and the American people have said countless times that they want to do everything they can to support him and other wounded warriors. This is your chance to honor his sacrifice and others like him. Having a family is exactly what he needed to feel whole again.

Please help us make these changes so that other families can share in this experience, and I also ask that you turn to the last page of my written statement and look at the photos I have provided. This is the face of a truly recovered injured veteran.

Thank you for your time and I look forward to your questions.
[The prepared statement of Ms. Keil follows:]

PREPARED STATEMENT OF TRACY KEIL, CAREGIVER AND SPOUSE OF OIF VETERAN

Good Afternoon. Chairman Murray, Ranking Member Burr, Members of the Committee, thank you for inviting me to share my family's experience with you today.

My husband, Matt, was shot in the neck while on patrol in Ramadi, Iraq, on February 24, 2007, just 6 weeks after we were married. The bullet went through the right side of his neck, hit his vertebral artery, went through his spinal cord and exited through his left shoulder blade. Matt instantly became a quadriplegic. When I first saw him 3 days after he was injured I was in shock, they explained to me that he had a "Christopher Reeve type injury." He would be on a ventilator for the rest of his life, and would never move his arms or legs.

Matt and I looked at each other in his hospital room at Walter Reed and he asked me if I still loved him? I said "baby you're stuck with me!" at that moment we knew that we would be OK if we stayed in this together. I knew that we just needed to work really hard to get Matt off his ventilator to increase his life expectancy. Ultimately we moved to Craig Hospital in Denver to be closer to family support.

Four weeks to the day of arriving at Craig Hospital in Denver, Matt was officially off of his ventilator and we could truly concentrate on him doing physical rehabilitation. Matt had regained about 10% function of his left arm but not his hand. He was feeling good and getting used to his new normal of being in a wheelchair and asking for help for everything.

It was while we were at Craig hospital that we started talking about having a family. Craig doctors talked to us about invitro fertilization and recommended some doctors for us to speak to when we were ready to start a family. We started to get really excited that even though so much had been taken away from Matt physically that we could still have the future we always dreamed of.

My husband is the most amazing man I have ever met. He is strong, honest and loyal, and he wanted us to both have everything we always wanted before his injury and we agreed that this injury wasn't the end, it was the beginning of a new life, and we were in this together.

We had our whole lives ahead of us. Matt was just 24 when he was injured and I was 28. We are very fortunate that he survived his injuries that day and we made a promise to each other on our wedding day "For better or worse, in sickness and in health." I meant every word and still do today. It is a challenge for my husband and me every day, but we knew we still wanted to start a family. I remember back when he was in rehabilitation at Craig Hospital it's all we could talk about was

when we were going to be adjusted to our new normal and when would we be ready to have children. We always knew we had wanted children.

In 2008 we moved into a fully handicap accessible home built for us by Homes For Our Troops. We were starting to feel like things were falling into place in our lives. We felt like we were starting to get back on track to where we were before Matt was injured.

His injury unfortunately prevents him from having children naturally. In mid 2008 I started asking the VA what services they could offer my husband and I to assist us with fertility. I can remember hitting road blocks at every turn. I decided to take things into my own hands and write letters and make phone calls to try and get anyone to listen to us that we needed help. Fertility treatments are very expensive and since I had left my full time job we were still adjusting to living on one income.

I felt helpless and hopeless and thought that our dreams of having a family may never come true. The VA finally said that they would cover the sperm withdrawal from my husband * * * that costs \$1,000 and that they would store the sperm for us at no charge.

It was very difficult when I found out there was no help available for us from the VA or TRICARE. I felt very defeated, sad, disappointed and in some ways I felt helpless. I researched everything I could about how to get TRICARE to cover some of the costs but they couldn't because it was a direct result of my husbands' injury and that fell under the VA. The VA said that they had no programs in place for this sort of thing. I even started asking non profits to assist with the cost and they couldn't help due to the other immediate needs of injured servicemembers.

I am very pleased that this issue is being addressed because it is necessary for the success of the families. We shouldn't have to struggle with how we are going to pay for costly fertility treatments when they are a direct result of a combat injury. We already have so many adjustments to make to all of our hopes and dreams and plans. We should never have to contemplate whether or not to even have children because of how expensive fertility treatments can be. I have always wanted more than anything for my husband to feel whole again. There is no magical cure for a spinal cord injury, there is nothing out there that will help him walk again or move his arms. What we do have though is a strong voice. We can help other families just like ours so they don't have to go through what we went through.

In January 2010 my husband and I decided that we needed to move forward with our plans to start a family and we began our journey of fertility treatments. We selected a doctor in the private sector that has been a leader in IVF. Having a doctor located near our home was very important for us because I had to go to the doctor every other day and then daily near the time of the transfer. This made it very easy for my husband to be there with me every step of the way. I was on several medications that I took 3 times a day along with giving myself hormone injections into my stomach three times a day for several weeks. I would go back to the doctor every other day for blood draws to check my hormone levels to make sure everything was progressing normally. TRICARE did not cover any of the costs of anything related to the fertility treatments because I did not have any fertility issues, everything was a direct result of my husbands' injury.

Matt and I were very fortunate that we got pregnant on our first try with IVF. We welcomed our twins Matthew and Faith on November 9, 2010.

Fertility treatments are not a guarantee of having children, but it gives us hope. It gives us hope that we can have a normal life just like everyone else. Part of living the American Dream for us was having a home to raise our children * * * and of course having the children to fill our home. Now we have both and while it is incredibly difficult to raise children while your husband is in a wheelchair it is possible. We are living proof of anything is possible.

To be honest, not walking is the easy part. The hard part is that it affected every single aspect of our lives. Matt requires assistance with almost everything. As his caregiver, I feed him, bathe him, dress him, get him in and out of bed, I am the sole driver in our household, I even assist him with changing the channel on the TV. He has lost almost all independence. The day we had our children something changed in both of us. This is exactly what we had always wanted, our dreams had arrived. While it may be challenging to care for my husband and my children, this is exactly what our family is supposed to be. I strongly believe that my husband is supposed to be in a wheelchair, I can't tell you why, but this is what our life is supposed to look like. We are happy, we are healthy and we are living out our dreams. Now that my husband is medically retired we have the ability to raise our children together as stay home parents. We are a team and my only wish is that other families could find this happiness.

Since having our children I see my husband light up again, I see him happy, fulfilled. He is truly living the American Dream. I cannot imagine where we would be if we didn't save money knowing we would need to do IVF in the future.

One of the things I love the most about having children now is that their dad is just their dad. They don't see the wheelchair. They will be kind to people with disabilities and more understanding. All of the injured veterans who have children are helping share with others that people with disabilities are just like everyone else, they just do things a little differently. My husband is a shining example of a wonderful father who loves his children and we would have done anything possible to have them.

They make him feel like the man he was before he was injured, they complete our life together and the kids have helped fulfill our American dream. The VA, Congress and the American People have said countless times that they want to do everything they can to support my husband or make him feel whole again and this is your chance. Having a family is exactly what we needed to feel whole again. Please help us make these changes so that other families can share in this experience.

If the VA does decide to begin offering fertility treatments I think it's important to note that this is a very personal issue. Selecting a doctor to perform these treatments was very personal for my family and we didn't want to use "just anybody." We wanted to go to the best. I think it would be wonderful to let the private sector help these men and women start their families and do their part to help injured servicemembers. This way if the families choose, they can go to a private sector doctor to have these services performed. I know that it is a challenge for my family to drive to the VA on a daily basis for treatments. Sometimes families can find something closer to their homes to make things easier. We have to remember that we are talking about the most severely injured veterans that encounter fertility issues due to their injuries, so doing whatever is easiest for the family is extremely important.

Fertility is an area where we need experts in the field with extensive experience. Those doctors are already set up in private practices across the country. I think it would be very beneficial to the families to fee base the fertility specialist of their choice. There is also the option of capping the benefit at a certain amount of money or a certain amount of rounds of fertility treatments. As family of a severely injured veteran, I do not expect taxpayers to pay for every single thing we could ever wish for, so putting a limit on the fertility amounts is certainly understandable and expected.

There are about 600 men and women who have returned home with damage to their reproductive ability. Today I ask you to please support these brave servicemembers in their dream to have families. I am here today to say that this injury took away so much of my husband physically that he cannot get back, but we could not let this injury take away our dream of a family. Having children meant that we were back to where we were before he was injured. It brought a sense of accomplishment and fulfilled our dreams of a family. In some ways it made my husband feel whole again.

I hope that hearing our story today has helped you understand the importance of offering fertility treatments to injured veterans who have lost the ability to reproduce naturally. What happened to them is by no fault of their own. Wartime changes a family, it shouldn't take away the ability to have one.

Thank you for your time.

Chairman MURRAY. Ms. Keil, thank you so very much for your courage in speaking out for so many others. I have been looking at the pictures. They are actually in front of me. I am sorry the audience cannot see them. They are absolutely adorable.

And you are right. That is truly compelling. So, thank you very much for being here today.

Dr. Edney, we will turn to you.

**STATEMENT OF MARK THOMAS EDNEY, M.D., OIF VETERAN,
MEMBER, LEGISLATIVE AFFAIRS COMMITTEE OF THE AMERICAN UROLOGICAL ASSOCIATION**

Dr. EDNEY. Chairman Murray, Ranking Member Burr, Members of the Committee, honored guests, fellow servicemembers, I thank the Committee on Veterans' Affairs for inviting me to testify.

My name is Mark Edney. I am a Urologist, a physician who treats genitourinary disease and injury. I am also an Army Reservist.

It is an honor and privilege to be able to testify before the Senate Committee on Veterans' Affairs in support of Senate 3313. My testimony has the support of many organizations dedicated to this issue, including the American Urological Association, The Men's Reproductive Health Alliance, the American Fertility Association, and the Men's Health Network, and others, many of whom are represented in the room today.

I am a husband and the father of three children, ages 10, 7, and 5 years. In my 10 years of reserve service, I have been called back to duty three times: first to Walter Reed Army Medical Center in 2004, next a combat tour with the 399th Combat Support Hospital in Mosul, Iraq in 2006, and finally a tour at Tripler Army Medical Center in Hawaii in 2009.

I have seen and treated genitourinary injury in the theater of operations, and I have also participated in its chronic management in our largest military medical centers.

It is important to understand the breadth of the types of injuries that can occur that threaten fertility. The most common mechanism of injury to the genitourinary organs in theater right now is blast effect from improvised explosive devices and also from gunshot wounds.

The most common types of male genitourinary injuries are testicular rupture, penile shaft, urethral and bladder injury. Blast injuries to the phallus often result in erectile dysfunction or render it otherwise incapable of intercourse.

Urethral injuries often result in scar tissue, preventing the release of semen. Shrapnel often penetrates the perineum, the area that includes the sexual organs and the rectum.

Even with proper current protective gear, the perineum is exposed. In these instances, the external sexual organs may be preserved, but injury can occur to the pelvic portion of the tissue cylinders responsible for normal function.

Damage can also occur to the nerve and vascular supply responsible for normal function. Damage anywhere in the sperm delivery system may result in the absence of sperm in the semen.

There are a range of female injuries that can result from fertility problems. Blast injury can occur to the perineum and the vaginal vault which precludes intercourse. Shrapnel or bullet penetration of the pelvis can injure the ovaries, inhibiting egg development and delivery. Damage to the fallopian tubes easily results in a lack of ability to transmit the egg to the uterus.

Overall genitourinary injuries comprise five to 10 percent of wounds suffered in battle, but they can be some of the most psychologically debilitating.

Spinal cord and Traumatic Brain Injury are two major classes of non-neurologic injury that can also impede utility through sexual dysfunction in men.

There are also non-ballistic threats to women's reproductive health in theater. A recent survey of female soldiers revealed that there can be a lack of confidence of the unit level health care providers with respect to competence in women's health issues and

concerns around confidentiality leading to avoidance of care seeking.

There are underappreciated psycho-social issues with female family separation that can have both psychological and physiological effects that lead to sexual dysfunction and fertility issues.

The issue of military sexual trauma which can have a profound impact on sexual function and fertility continues to be addressed military-wide through the sexual harassment, assault response and prevention program.

To support these issues, S. 3313 has critical provisions that improve female—the female veterans call center and expand the counseling of women upon separation from the military.

Given the many ways that injured soldiers can return to their home units, their civilian life, and their families with fertility-threatened injuries, the question becomes how are we willing to help them.

Though genitourinary is not publicly visible, it is no less physically or psychologically debilitating than loss of limb or other overtly disfiguring injury. Professionals who specialize in fertility will attest to the intense psychological pain and suffering endured by infertile couples who will go to great financial and emotional extremes in order to conceive a child.

S. 3313 contains powerful provisions that provide access to advanced reproductive technologies for fertility impaired soldiers, their spouses, and surrogates.

Intrauterine insemination or IUI and in-vitro fertilization or IVF are the advanced reproductive techniques that S. 3313 makes available.

IUI is the deposition to process sperm into the uterine canal to then finish the normal cycle of fertilization. It is used when female anatomy is intact at and above the cervix but when any number of the injuries I have mentioned preclude delivery of sperm to the uterine cavity.

IVF is employed when the injury or combination of injuries precludes the normal meeting of sperm and egg. Fertilization is achieved in the laboratory. Then the fertilized eggs is then re-planted back into the uterus for normal gestation.

If the uterus has been rendered incapable of sustaining a pregnancy, a surrogate can be engaged for the pregnancy of the natural parents fertilized egg.

It is noteworthy that the substantial cost of an IVF cycle in the private sector where battle injury infertile VA couples now must turn is on the order of \$20-30,000 per cycle with success rates of 20 to 40 percent per cycle. Multiple cycles are often necessary.

The expertise and technology exists within the VA and the DOD for a fraction of the cost. We just need S. 3313 to unlock it for these most deserving Americans.

There is a desperate need to establish a research database of soldiers with genitourinary injury to better study the continuum of care from prevention to initial management to reconstruction and to fertility treatment and outcomes.

Senator Murray's bill takes a critical step in calling for the Department of Defense and the NIH to conduct collaborative research

to address the long-term reproductive health care needs of veterans with service-connected reproductive injuries.

Also to this end, I want to bring to the Committee's attention H.R. 1612, which has been reintroduced this session with the sponsorship of Congressman Brett Guthrie and 25 cosponsors in the House.

The bill, promulgated by the American Urological Association, sets up a national commission on uro-trauma. The 16-member commission, which is a collaboration of the Departments of Defense, Veterans Affairs, and Health and Human Services, will be a sunset commission with defined objectives.

They are in summary, one, to study the current state of knowledge from prevention to initial management to chronic therapy. Two, to identify public and private resources that can be brought to bear for fertility-impaired soldiers. Three, to identify care enhancing programs of potential benefit to the genitourinary injured soldier.

The bill is described in more detail in my written testimony, and I would be happy to discuss it further with any Members of the Committee who might be interested in supporting it.

We as a Nation have done better recently at addressing the physical disability that results from war injury. Appropriately, hundreds of millions of dollars have been dedicated to the research and development of prosthetics to return soldiers with loss of limb to a higher degree of physical ability. We are getting better at detecting and addressing the psychological wounds of war from PTSD and dramatic brain injury.

There is an important group who have been left behind. Those suffering the publicly invisible but intensely emotionally painful loss of fertility as the result of genitourinary injury.

Let us together show these finest Americans that we are willing to go beyond our current efforts of physical and emotional support. Let us use the expertise and tools that we have in place today to restore their fertility so that they may 1 day look into the eyes of their own children and see the family history, the pride, and hope for the future that so many of the rest of us have been blessed to know.

We owe these brave Americans no less for the sacrifices they have made for our great Nation.

I thank the Committee again for the privilege and honor of being asked to testify.

[The prepared statement of Dr. Edney follows:]

PREPARED STATEMENT OF MARK T. EDNEY, M.D., F.A.C.S., ARMY RESERVIST, OPERATION IRAQI FREEDOM VETERAN AND MEMBER, LEGISLATIVE AFFAIRS COMMITTEE, AMERICAN UROLOGICAL ASSOCIATION

Chairman Murray, Ranking Member Burr, Members of the Committee, honored guests, fellow servicemembers, I thank the Committee on Veterans' Affairs for inviting me to testify.

It's an honor and privilege to testify before the Senate Committee on Veterans Affairs in support of Senate Bill 3313. This Bill provides critically needed support for soldiers within the Department of Veterans Affairs who have suffered fertility-impairing trauma in battle. My comments have the support of many organizations that have tangibly dedicated themselves to the care, rehabilitation, and restoration of fertility to soldiers who have suffered urogenital and other forms of trauma that threaten fertility. These organizations include the American Urological Association, The Men's Reproductive Health Alliance, the American Fertility Association, and

the Men's Health Network. This is by no means an exhaustive list of the professional organizations and patient advocacy groups with a vested interest in this subject, many of whom are represented in the room today.

I am a Urologist, a specialist who treats genitourinary disease and injury, in private practice in Salisbury, MD. I am a husband and the father of three children 10, 7, and 5 years old. I am also an Army Reservist of 10 years. I have been called to active duty 3 times: first to Walter Reed Army Medical Center in 2004, one tour with the 399th Combat Support Hospital in Mosul, Iraq in the winter of 2006, and finally a tour at Tripler Army Medical Center in 2009. I have seen and treated genitourinary trauma in the theater of operations and have participated in its chronic management at our largest military medical centers stateside.

To begin, a brief review of the mechanics of natural human fertilization may be helpful. The testicle produces two elements essential to fertility: sperm and testosterone. After going through the stages of maturation, sperm leave the testicle through a series of tubes (the epididymis and vas deferens) and wait temporarily in the section of vas deferens that enters the prostate gland (ejaculatory duct). When ejaculation occurs, the supporting fluid (semen), is released from the seminal vesicles, sperm is released from the ejaculatory ducts (emission), and the mixture is propelled forward to be deposited in the vagina. Sperm then begin their journey across the cervix, into the body of the uterus. Eventually a very small percentage of the original populations make it to the fallopian tube to meet the egg which upon penetration of a single spermatozoon, is then fertilized. The fertilized egg (zygote) then implants in the wall of the uterus for the remainder of gestation.

Normal female physiology is as follows: Eggs mature in the ovaries and once per cycle, an egg (oocyte) is released into the fallopian tube and begins its migration toward the body of the uterus. If it encounters a sperm on the way and becomes fertilized, the resulting zygote (fertilized egg) implants into the wall of the uterus and gestation ensues. If not, the oocyte is expelled and the process repeats on a monthly basis.

It's important to understand the breadth of types of injuries that result in threats to fertility. The most common mechanism of injury to the genitourinary organs in Operation Iraqi Freedom and Operation Enduring Freedom is blast effect from improvised explosive devices (IEDs), followed by gunshot wounds. The most common types of male genitourinary injuries, sometimes seen in isolation, but commonly in combination are: testicular rupture (unilateral or bilateral), penile shaft/pendulous urethral injury, posterior urethral injury, and bladder injury. Spinal cord injury and Traumatic Brain Injury are two major classes of non-urological injury that can impede fertility through ejaculatory dysfunction. If testicular rupture injuries present within a few hours as most do with current evacuation systems, salvage is possible with rates of up to 74% reported recently. Bilateral testicular loss is a devastating injury that obviously precludes future fertility.

Blast injuries to the phallus often result in either erectile dysfunction or otherwise render it mechanically incapable of intercourse to achieve a natural pregnancy. Urethral injuries of either the pendulous or posterior aspect often result in stricture (scar tissue) formation that renders ejaculation either impaired or impossible. Shrapnel often penetrates the perineum, the area that includes the sexual organs and rectum. The perineum, even with proper use of the current protective gear, is unprotected. In these instances, the external sexual organs may be preserved but injury can occur to the portion of the erectile bodies (the tissue cylinders in the penis responsible for erection) that attach to the pubic bones or to the nerve and vascular supply responsible for erectile function. Even if the testicles are uninvolved or salvaged after a shrapnel injury, damage to the ductal system anywhere from epididymis to ejaculatory duct may result in lack of sperm delivery to the ejaculate.

There is a groin-protective garment that is issued to soldiers as they are deployed. It is a triangular shaped shield that attaches to the front of the Improved Outer Tactical Vest (IOTV). Its design and location, however, are felt by many soldiers to be cumbersome and to inhibit mobility and so it is not worn by many. There is a critical need to invest in the research and development of protective gear for the genital organs that is effective and practical for the tactical environment.

Blast or gunshot wounds to the female pelvis can also result in a variety of fertility-impairing injuries. Trauma to the perineum and vagina can easily result in an altered vaginal vault that renders intercourse impossible. Additionally, penetrating shrapnel injury to the female pelvis can disrupt the ovaries, fallopian tubes, body of the uterus or the vaginal vault. Fallopian tube injuries can preclude the normal passage of the egg and therefore prevent fertilization. Uterine injury can result in a uterus incapable of sustaining a pregnancy which then opens the issue of surrogacy.

Women also experience non-ballistic risks to maintenance of reproductive health while in theater. A recent white paper developed by the Army's Women's Health Assessment Team identified several barriers to optimal genitourinary health for female soldiers in theater. These included lack of secure facilities for women to attend to personal hygiene. There is in some instances a lack of confidence in unit-level health care provides with respect to competence in women's health issues and concerns around confidentiality leading to avoidance of care-seeking. There are under-appreciated psycho-social issues with female family separation that can have both psychological and physiological effects that lead to sexual dysfunction and fertility issues. The issues of military sexual trauma, which can have profound impact on sexual function and fertility, continue to be addressed military-wide through the Sexual Harassment/Assault Response and Prevention (SHARP) program. S. 3313 seeks to meet these needs in two critical ways. First, by increasing the number of retreat-style counseling opportunities for returning female soldiers, and second, by improving the functionality of the female veterans' call center.

Given the many ways that injured soldiers can return to their home units or civilian life and their families with fertility-threatening injuries, the question becomes how are we willing to help them? Though genitourinary trauma is not publicly visible it is no less physically or psychologically debilitating than loss of limb or other overtly disfiguring injury. Procreation is one of the most fundamental of human instincts.

The range of male and female injuries described above can all result in the inability for couples to achieve a pregnancy in standard fashion. That's where advanced reproductive technology is brought to bear and where S. 3313 will have an immediate and profound impact for fertility-impaired soldiers, and their spouses. The advanced techniques are specifically intrauterine insemination (IUI) and in-vitro fertilization (IVF). IUI involves processing sperm that have been obtained either from the ejaculate or harvested from the testicle or epididymis, and implanting them directly into the uterus to complete the remainder of the natural fertilization process. In-vitro fertilization (IVF) is the process by which sperm and egg are united in a controlled laboratory environment and post-fertilization the zygote is placed in the uterus for implantation. IUI is employed when female anatomy is intact and functional from the cervix up, but either a male or female injury precludes depositing a requisite number of sperm into the vagina. As IUI is less technology and labor intensive, it is also less expensive per cycle. IVF is employed when a male and or female injury precludes the natural union of sperm and egg in the fallopian tube for any number of the reasons mentioned above. In cases where the uterus has been rendered incapable of sustaining a pregnancy, a surrogate can be engaged to carry the fertilized egg for the natural parents. More labor intensive than IUI, IVF also costs more but it is important to note that the cost per cycle of IVF in government facilities is tens of thousands of dollars less than in the private world, where VA couples are now forced to seek care at \$20-30,000 dollars per cycle. The per-cycle success rate depends on a variety of factors including age. Pregnancy rates range between 20 and 45% per cycle and live birth rates range between 10% and 30% per cycle.

An important provision of S. 3313 provides treatment to the spouse of the injured soldier. It's important to understand the concept of sub-fertility. It is possible that a soldier with a fertility impairing injury, given a normally functioning partner, could still conceive naturally. Should the partner, however, have a condition resulting in sub-fertility (low sperm count, low sperm volume for men or hormonal cycle variables or minor anatomic variation for women), the partner under S. 3313 would be eligible for treatment.

Currently the Department of Defense as of April 2012 (DOD instruction 1300.24) provides for advanced fertility treatment for soldiers who have suffered genitourinary injury. This DOD policy is a start but as currently written only covers those soldiers with the most severe general injury status who may be infertile. There are soldiers in the DOD who may have suffered isolated genitourinary injury and despite their infertility may remain functional in their MOS and this class of soldiers is not covered for infertility care under current policy. It's important that the Department of Veterans Affairs create policy based on "infertility injury" and not a more general injury scale so as to capture every soldier who has been rendered infertile from battle injury. Every soldier with battle injury infertility deserves access to advanced reproductive technology.

There is a desperate need, not only within the Department of Veterans Affairs but including the Departments of Defense and Health and Human Services to fund a longitudinal, prospective database of soldiers with genitourinary injury to better study the continuum of care from prevention, to initial management in theater, to reconstruction at higher levels of care to fertility treatment and outcomes. S. 3313

takes a critical step in calling for the Dept of Defense and NIH to conduct collaborative research to address long-term reproductive health care needs of veterans with service-connected GU/reproductive injuries. Also to this end, I want to bring to the Committee's attention H.R. 1612 which has been re-introduced this session with the sponsorship of Congressman Brett Guthrie along with 25 co-sponsors in the House. The Bill, promulgated by the American Urological Association, seeks to establish a National Commission on Urotrauma. The 16 member Commission, a collaboration of the Departments of Defense, Veterans Affairs, and Health and Human Services, will be a sunset Commission with defined objectives as follows: 1) To conduct a comprehensive study of the present state of knowledge of the incidence, duration, and morbidity of, and mortality rates resulting from urotrauma and of the social and economic impact of such conditions; 2) To evaluate the public and private facilities and resources (including trained personnel and research activities) for the prevention, diagnosis, and treatment of, and research in such conditions; and 3) To identify programs (including biological, behavioral, environmental, and social programs) in which, and the means by which, improvement in the management of urotrauma can be accomplished. The Bill has been scored at a nominal cost and the offset has been identified. I would be happy to discuss the Bill further with any Members of the Committee who would like to learn more and perhaps support it.

There is a wealth of expertise and the infrastructure is in place within the Department of Veterans Affairs and Department of Defense to provide soldiers with fertility-impairing injuries comprehensive management so that they may have their own children. S. 3313 unlocks that capability for soldier in the VA system to protect them from the \$20–30,000 per cycle fees in the private sector where they now by necessity seek treatment. This is a wrong that S. 3313 rights. We as a nation have done better recently at addressing the physical disability that results from war injury. Appropriately, hundreds of millions of dollars have been dedicated to the research and development of prosthetics to return soldiers with loss of limb to a higher degree of physical ability. We are getting better at detecting and addressing the psychological wounds of war from PTSD and Traumatic Brain Injury. There's an important group who have been left behind: those suffering the publicly-invisible but intensely emotionally painful loss of fertility as a result of genitourinary injury. Let's together show these finest of Americans that we are willing to go beyond our current efforts of physical and emotional support. Let us use the expertise and tools that we have in place today to restore their fertility so that they may one day look into the eyes of their own children and see the family history, pride, and hope for the future that so many of the rest of us have been blessed to know. We owe these brave Americans no less for the sacrifices they have made for our great Nation.

Chairman MURRAY. Thank you very much, Dr. Edney.

With that, let us now turn to Ms. Ansley please.

STATEMENT OF HEATHER ANSLEY, M.S.W., VICE PRESIDENT OF VETERANS POLICY, VETSFIRST

Ms. ANSLEY. Thank you. Chairman Murray, Ranking Member Burr, and distinguished Members of the Committee, thank you for inviting VetsFirst to share our views and recommendations regarding the legislation that is the subject of this morning's hearing.

My oral testimony will focus on our support for the Mental Health ACCESS Act of 2012. First, however, I would like to take a moment to highlight our support for some of the other bills included in today's hearing that are of particular interest to our members.

Specifically, we support S. 3313, which has been discussed already today. S. 1838, regarding service dog training, and S. 1755 concerning coverage for rehabilitation services for certain veterans.

Each of these bills is critically important to allowing disabled veterans to live in their communities full, healthy lives. Our comments on these and other bills before the Committee are included in our written testimony.

The chair of the VetsFirst Committee who was on the Hill with me yesterday spent 16 months at the Bronx VA in the late 1960s

after acquiring a spinal cord injury and he recently told me that during those 16 months he had one visit with a psychologist.

The visit ended rather abruptly when he told the psychologist that he was thinking about returning to grad school. The psychologist shut the folder and wished him well. Thirty-six years later, after becoming a quadriplegic, he finally sought the mental health counseling that he needed to deal with the emotional and mental consequences that any type of serious injury brings.

Although the services of the Bronx VA have greatly improved since that time, we want to make sure that another generation of veterans do not have problems accessing VA mental health care.

Through VetsFirst work with the Consortium for Citizens with Disabilities, CCD, which is a coalition of over 100 national consumer, service-provider, and professional organizations that advocate on behalf of people with disabilities, we are working to expand our efforts and working with members of the disability community, the veterans community, and mental health communities to engage in efforts to address these concerns.

To expand our efforts, we are working with the Mental Health Liaison Group, MHLG, which is a coalition comprised of national behavioral health organization's that represents consumers, family members, advocates, professionals, and providers and advocates on behalf of people with until health or substance use issues.

We highlighted our concerns about wait times for appointments and asserted our belief that clinicians might need to be given the time and resources to provide patients with evidence-based therapy in a letter that we sent to VA earlier this year.

We have also expressed that VA should leverage the full range of certified mental health professionals that are available. We are pleased that VA has reached out toward us regarding our concerns, and we welcome the opportunity to continue working with VA and appreciate the outreach to both CCD and MHLG including the Vietnam Veterans of America, the American Foundation for Suicide Prevention, Mental Health America, and VetsFirst, who are the members of the coalitions that are leading this outreach effort with VA.

The remainder of my comments on the Mental Health ACCESS Act of 2012 reflect the views of VetsFirst and my comments addressed only Title II which directly concerns VA.

Access to quality mental health care is critical in ensuring that veterans are able to successfully reintegrate into their communities. We appreciate the requirement in this legislation for a VA to develop a measure of access to health care that will evaluate the timeliness, satisfaction, capacity, and availability of furnishing evidence-based therapies.

We also support the requirement that VA develop a comprehensive staffing model that will include productivity standards. Requiring the VA to work with the National Academy of Sciences to create a study committee to advise in the development of these guidelines and measures will provide a heightened level of expertise. The mandates for transparency that require posting this information online will increase accountability.

To increase access, we also support expanding eligibility for Vet Centers services which is a positive step for servicemembers, families, and veterans.

As we all know, Vet Centers are vital links to care for many who might not otherwise seek services. The role that Vet Centers plays an important role in the delivery of this care. We support this legislation expansion of eligibility as long as Vet Centers are properly resourced to meet the needs that they are designed to address.

Although VA must have sufficient resources to meet the mental health needs of our Nation's veterans, we also believe that the scope of the need requires VA to link with community resources.

We support the requirement for VA to carry out a national program of outreach to connect with community mental health resources which represents a good opportunity to mobilize qualified providers in a concerted effort to organize clinicians who meets VA requirements and that will help to expand service capacity.

In addition to community resources, peer support counselors are also an important component of the mental health delivery system. The counselors serve as a useful vector for helping individuals to seek more formal types of care and that establishing one of these programs at each VA medical center will ensure the availability of these services to as many veterans as possible.

Again, thank you for the opportunity to share VetsFirst's views on this legislation. This concludes my testimony and I will be pleased to answer any questions that you may have.

[The prepared statement of Ms. Ansley follows:]

PREPARED STATEMENT OF HEATHER L. ANSLEY, ESQ., M.S.W., VICE PRESIDENT OF VETERANS POLICY, VETSFIRST, A PROGRAM OF UNITED SPINAL ASSOCIATION

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

VetsFirst represents the culmination of 60 years of service to veterans and their families. United Spinal Association, through its veterans service program, VetsFirst, provides representation for veterans, their dependents and survivors in their pursuit of Department of Veterans Affairs (VA) benefits and health care before VA and in the Federal courts. Today, United Spinal Association is not only a VA-recognized national veterans service organization, but is also a leader in advocacy for all people with disabilities.

WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2012 (S. 3313)

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

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

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

to veterans' spouses or surrogates. We are disappointed, however, that these services are not required for veterans who are not service-connected.

We appreciate the requirement for the promulgation of regulations to implement these new statutory requirements. To provide a level of certainty to veterans and their spouses, it will be important for VA to develop a non-inclusive list of the types of technologies that will be provided (at a minimum) by VA. It must also be clear to veterans and their spouses or surrogates whether VA will provide services related to subsequent costs of pregnancy and post-partum care.

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

VetsFirst also supports efforts in the legislation to improve access to VA services for women veterans. Women make up an increasing percentage of the veteran population. Consequently, VA must improve efforts to address the unique needs and concerns of women veterans. Otherwise, women may be hesitant to take advantage of their benefits.

MENTAL HEALTH ACCESS TO CONTINUED CARE AND ENHANCEMENT OF SUPPORT
SERVICES (ACCESS) ACT OF 2012

The need to access high quality VA mental health services when needed is critically important for our Nation's veterans and their families. After a decade of war, the number of veterans who need mental health services due to Post Traumatic Stress Disorder and other wounds related to their service has greatly increased. Veterans from previous wars also continue to need mental health care services which allow them to be vital contributors to their communities and families.

The difficulty of some veterans in accessing VA mental health care services in a timely manner has been detailed in numerous hearings before this Committee over the last year. The report from VA's Office of Inspector General regarding access to mental health care that was released on April 23, 2012, highlighted concerns about appointment times and the lack of accurate performance data. Aside from the statistics, we are acutely aware of the sheer human toll of war as reflected by the number of servicemembers and veterans who are committing suicide on a daily basis.

As an organization that is both a veterans service organization and a disability organization, we are very concerned about the ability of veterans to have timely access to evidence-based therapies. Through our work with the Consortium for Citizens with Disabilities (CCD), VetsFirst is working with members of the disability, veterans, and mental health communities to engage in efforts to address these concerns. Specifically, representatives of the CCD Veterans and Military Families Task Force and the Mental Health Liaison Group (MHLG) have been meeting regularly to better determine how we might work with VA to improve access to mental health services for our Nation's veterans.

CCD is a coalition of over 100 national consumer, service provider, and professional organizations which advocates on behalf of people with disabilities and chronic conditions and their families.

The MHLG is a coalition comprised of national behavioral health organizations representing consumers, family members, advocates, professionals, and providers which advocates on behalf of individuals with, or at risk of, a mental health or substance use condition, including servicemembers, veterans, and their families.

On April 5, the CCD Veterans and Military Families Task Force and MHLG sent a letter signed by 41 member organizations to VA expressing our concerns about the delay in veterans receiving VA mental health services. In this letter, which is included with our testimony, member organizations highlighted our concerns about wait times for appointments. We also asserted our belief that clinicians must be given the time and resources to provide veterans with evidence-based therapies that represent the best practices for addressing veterans' specific needs. Last, we asserted that VA should leverage the full range of certified mental health professionals, including psychiatric social workers and licensed professional counselors, to increase access to these best practice therapies.

We are pleased to report that VA reached out to us regarding our concerns, and we look forward to growing our partnership to ensure that our Nation's veterans have access to needed mental health services. We welcome the opportunity to continue working with VA and appreciate the outreach to CCD and MHLG, including Vietnam Veterans of America, the American Foundation for Suicide Prevention,

Mental Health America, and VetsFirst who are the member organizations leading the outreach effort.

The remainder of VetsFirst's comments on the Mental Health ACCESS Act of 2012 reflect our individual views. For purposes of our testimony, we are limiting our comments to Title II—Department of Veterans Affairs Matters.

Access to quality mental health care is critical in ensuring that veterans are able to successfully reintegrate into their communities. To ensure that access standards are being met, VA must develop comprehensive measures that accurately determine whether proper access to services is being provided. We appreciate the requirement in this legislation for VA to develop a measure of access to health care that will evaluate timeliness, satisfaction, capacity, and availability and furnishing of evidence-based therapies by VA. We also support the requirement that VA develop a comprehensive staffing model that will include productivity standards.

The development of access measures and staffing guidelines for mental health care is crucial to meeting the mental health care needs of veterans. Requiring VA to contract with the National Academy of Sciences to create a study committee to advise in the development of these guidelines and measures will provide a heightened level of expertise. We also support the requirement for the study committee to assess the mental health needs of our newest veterans. The mandates for transparency through reporting and posting the measures and guidelines online will help to facilitate accountability.

Expanding access to Vet Centers is a positive step in efforts to address the mental health care for veterans, servicemembers, and their families. Vet Centers are a critical link to care for many veterans who might not otherwise seek services. The role that Vet Centers play in the delivery of this care is crucial. Thus, the services and supports provided by Vet Centers must be available when needed by these individuals. We support this legislation's expansion of eligibility for services as long as Vet Centers are properly resourced because of the great need for readjustment services by servicemembers and their families.

We also support the proposed organization of VA's Readjustment Counseling Service. We appreciate the inclusion of language stating that, "The Readjustment Counseling Service is a distinct organizational element within Veterans Health Administration." We are also pleased that the Chief Officer of the Service will have direct authority over staff and assets and that its budget request will be listed separately. The autonomy of the Service contributes to its successful outcomes and outreach to veterans.

Although VA must have sufficient resources to meet the mental health needs of our Nation's veterans, the scope of the need requires VA to fully utilize any available resources that will properly meet these needs. Requiring VA to carry out a national program of outreach to connect with community mental health resources represents a good opportunity to mobilize qualified providers. A concerted effort to organize clinicians who meet VA requirements will expand the capacity of VA services. We are also pleased that the legislation requires training in military culture to ensure that these providers are able to better meet the needs of veterans.

In addition to community resources, peer support counselors are also an important component of the mental health delivery system. These counselors serve as useful vectors for helping individuals to seek more formal types of mental health care. Requiring that peer support counseling programs be established at each medical center will ensure the availability of these services to as many veterans as possible.

We believe that the steps taken in Title II of this legislation will strengthen VA's ability to serve veterans, servicemembers, and their families.

To require VA to consider the resources of individuals applying for pension that were recently disposed of by the individuals for less than fair market value when determining the eligibility of such individuals for such pension (S. 3270)

VA's pension program provides benefits for veterans who are low-income and are either permanently and totally disabled, or age 65 and older, if they served during a period of war. These benefits are critical for veterans who have few other resources available to them.

Because these benefits are very important to low-income disabled veterans, we believe that these benefits must be protected to ensure that they are fully available when needed. As a result, we do not condone fraudulent efforts to benefit from the VA's pension program. We also believe, however, that people should not have to impoverish themselves just to receive the services that they need whether in VA's program or any other government benefits program.

The look-back proposed in this legislation seeks to preempt efforts to transfer assets to make veterans eligible for pension benefits. Without commenting further on the specific merits of this proposal, we are concerned that the legislation does not

exempt transfer of assets to special needs trusts. Special needs trusts are designed to supplement the services and supports received by people with disabilities through Social Security and Medicaid. The funds in a special needs trust may be used for expenses such as modifying a home for accessibility, paying for recreational activities, or purchasing tickets to visit family. If the funds were made directly available to the individual, then he or she may lose eligibility for Supplemental Security Income (SSI) benefits and Medicaid services and supports, which are income dependent. By placing the funds in a special needs trust, parents can ensure, for instance, that their disabled children retain eligibility for these crucial benefits and services.

A good example illustrating the importance of special needs trusts is found in the current quandary with the DOD survivor benefit plan (SBP). An SBP annuity allows for retiring servicemembers to make a portion of their retired pay available to their survivors. However, Federal law requires that these benefits must be paid to a "natural person." Thus, if a child with a disability is in receipt of income dependent services and supports, then the child may lose these benefits and services because SBP funds cannot be paid to a special needs trust. Unfortunately, the amount received from the annuity may not be sufficient to pay for the services lost. Thus, the child not only loses eligibility for the services but then is unable to pay for them privately.

In the November 2011 edition of *Exceptional Parent Magazine*, Kelly A. Thompson, an attorney, relayed how this dilemma played out for one adult child with a disability.

"A recent example concerns a 52 year-old man with an intellectual disability who had lived in a group home for 18 years and attended a day program for individuals with disabilities. His only income was SSI of \$674 per month. His SSI benefits and Medicaid paid for his programs and services. However, when his father, a retired Navy officer, died, his adult son began to receive military SBP in the amount of \$2,030 per month. This SBP payment made him ineligible for Medicaid waiver services. The private pay cost of the programs and services he was receiving prior to his father's death is \$8,600 per month, more than four times his SBP payment. He lost his group home placement, as well as his day program, and was transferred to a state "training center"—a large institutional setting isolated from the community."¹

People with disabilities greatly benefit from access to special needs trusts. In the Omnibus Budget Reconciliation Act of 1993, Congress exempted the transfer of assets for the benefit of a person with a disability under the age of 65 from the look-back provisions of the Medicaid program. Thus, not only is a person with a disability able to benefit greatly from a special needs trust but the transfer of assets to the trust for the benefit of another does not count against the transferor in the event that he or she subsequently needs Medicaid assistance. In light of the importance of special needs trust, it is clear that these benefits should be available for the disabled children of veterans, without disadvantaging the veteran in receiving VA pension benefits if needed.

It should also be noted that a person with a disability who is under the age of 65 may have his or her own assets transferred into a special needs trust that directly benefits him or her. These types of trusts may only be established by a parent, grandparent, legal guardian, or a court and allow the individual to remain eligible for Medicaid services and supports. Any remaining funds available at death must be used to pay-back the Medicaid program for services provided.

Any efforts to penalize transfer of assets under the VA's pension program must provide for appropriate exemptions for transfers to special needs trusts similar to those available through other Federal programs also based on financial need.

To require VA to carry out a pilot program on service dog training therapy (S. 1838)

Service animals provide multi-faceted assistance to people with disabilities. Specifically, service animals promote community integration. In addition to performing specific tasks such as pulling a wheelchair or opening a door, these same service animals can also help to break down barriers between people with disabilities and society. In addition to increased social interaction, many people with disabilities also report experiencing a greater sense of independence.

We support efforts to ensure that properly trained service animals are available to veterans who can benefit from their assistance. This legislation provides a unique opportunity to benefit not only veterans seeking the assistance of a service dog but

¹ Kelly A. Thompson, "The Dilemma for Military Parents of Children with Disabilities." *EP Magazine*. November 2011.

also provides veterans with post-deployment mental health concerns or Post Traumatic Stress Disorder the opportunity to benefit from training these dogs. The dual nature of this approach has the potential to assist a wide range of veterans.

To provide coverage under the VA's beneficiary travel program for the travel of certain disabled veterans for certain special disabilities rehabilitation (S. 1755)

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

We strongly support providing travel benefits for catastrophically disabled non-service-connected veterans who need to travel to receive in-patient care at special disabilities rehabilitation programs. Every effort must be made to reduce barriers that limit access to these services. The long-term savings of ensuring that these veterans are able to maintain their health and function significantly outweighs the short-term costs associated with this legislation.

Veteran Voting Support Act of 2011 (S. 1264)

Exercising the right to vote is a fundamental aspect of American citizenship. For servicemembers and veterans who have served as the defenders of our Nation's freedoms, the opportunity to register to vote and exercise that right is particularly meaningful.

The Veteran Voting Support Act seeks to increase access to voter registration opportunities by requiring VA to provide voter registration applications and assistance to veterans during specified interactions with VA. Although we support the efforts of this legislation to ensure that veterans have increased opportunities to register to vote, we are concerned by the lack of a meaningful enforcement mechanism and protections for registrants that are available through the National Voter Registration Act (NVRA).

The NVRA provides mechanisms, including state designation of Federal agencies as voter registration agencies, to ensure that citizens, including veterans, have more opportunities to register to vote or update a previous registration. Since 2008, at least seven states have requested that VA agree to designation as a voter registration agency.

If VA were to be designated as a voter registration agency under the NVRA, in the event of a violation, either the Department of Justice (DOJ) or a third party may bring an action requesting enforcement. Under the Veteran Voting Support Act, however, the only initial remedy is for the veteran to provide written notice to the facility director or the Secretary of Veterans Affairs. If the violation is not remedied within 90 days, the individual may file a written notice of complaint with DOJ and the Election Assistance Commission. But, there is no opportunity for third party litigation, which has proven critical in ensuring that the NVRA is enforced by individual states.

Although the Veteran Voting Support Act parallels the NVRA, other important aspects of the NVRA would not be available under this legislation. For example, if a veteran registers to vote through VA under the mechanism of the Veteran Voting Support Act, then the veteran's registration will not be official until submitted by VA. Under the NVRA, the registration would be considered officially submitted once provided to VA.

Last, we are concerned that the Veteran Voting Support Act does not require VA to report the number of voter registration applications submitted to VA. Thus, it will be difficult to determine whether VA is fully implementing the legislation as required. Ultimately, we believe that the NVRA provides a better system of voting rights that is more enforceable than those envisioned under the Veteran Voting Support Act.

Unfortunately, VA has expressed concern that agreeing to state designation as a voter registration agency would be too costly and would expand VA's mission at a time when resources are critically needed to assist veterans of the wars in Iraq and Afghanistan, as well as meet the needs of veterans of all eras. We believe, however, that serving as a voter registration agency enhances VA's fulfillment of its mission to help veterans reintegrate into their communities.

Thus, we would support legislation that is at least modeled on the requirements of the NVRA.

Thank you for the opportunity to testify concerning VetsFirst's views on these important pieces of legislation. We remain committed to working in partnership to en-

sure that all veterans are able to reintegrate in to their communities and remain valued, contributing members of society.

Chairman MURRAY. Thank you very much.

Ms. Ilem.

STATEMENT OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Chairman Murray and the Members of the Committee, thank you for inviting DAV to present our views on the bills under consideration today. I will limit my remarks to five bills that are of particular interest to DAV and our members.

In accordance with the long-standing resolutions, DAV is pleased to support S. 1391, a bill that would change the standard of proof required to establish service connection for veterans with Post Traumatic Stress Disorder resulting from military service and mental health conditions related including PTSD due to military sexual trauma.

We believe the enactment of this bill would provide a common-sense standard of proof or veterans who have experienced serious mental and physical trauma but that is often difficult to verify because of a lack of documentation.

S. 2259 would provide cost-of-living adjustment or COLA in the rates of compensation for veterans with service-connected disabilities and the rates of DIC. DAV supports this legislation. However, consistent with DAV resolution 172, we oppose rounding down adjusted rates to the lower whole dollar.

We thank the Chairman for her continued efforts on improving VA services for women veterans and are pleased to support S. 3313. This bill is focused on improving the Department's ability to meet the long-term reproductive health care needs of veterans who have a service-connected condition that affects the veteran's ability to reproduce.

While DAV has no specific resolution from our membership related to reproductive and infertility research and infertility counseling and treatment because it focuses on service-connected injuries and would be beneficial to many DAV members and veterans, we have no objection to the passage of these provisions.

Regarding the remaining sections of the bill, DAV has heard positive feedback related to counseling services in retreat settings and the childcare pilot programs established in Public Law 111-163. We supported the original provisions for these pilots in accordance to DVA resolution 185 and are pleased to support the proposal to expand them in this measure to include veterans seeking readjustment counseling services at Vet Centers.

The Mental Health ACCESS Act of 2012 focuses on improving and enhancing the programs and activities of DOD and VA related to suicide prevention, resilience, and behavioral health disorders of members of the Armed Forces, veterans, and their families.

We appreciate the bill's provisions related to implementing a comprehensive set of measures to assess timeliness, satisfaction, and barriers to mental health care, improving access to services, productivity standards for the providers, and establishing an IOM study committee with the inclusion of members that have VA clinical mental health experience.

Of particular interest to DAV is section 204 of the measure. As intended by Congress in establishing its original mandate in 1979, the RCS was to be an independent, non-medical, non-psychiatric model of care for veterans who were in need of combat related readjustment services but did not necessarily want to go to traditional mental health clinics in VA.

Today's new combat veterans have made it clear to DAV and others that date too desire a similar non-stigmatizing readjustment program to aid them and to have found Vet Centers to be a welcoming, non-judgmental places to receive that help.

DAV is pleased to support this comprehensive measure in accordance with DAV resolution 189 and 200 and we appreciate the Chairman's continued efforts on improving mental health programs for veterans, members of the Armed Forces, and their families.

The final bill we would like to comment on is S. 3084, the VISN Reorganization Act of 2012. This measure would require the Secretary of the VA to restructure and realign VHAs 21 current Veterans Integrated Service Networks or VISNs and to set personnel limits for the VISNs.

DVA has no specific resolution concerning the organizational alignment of the VISNs and no formal position on this bill. However, we have urged Congress to examine VISN staffing and functions by conducting an independent study of the VISN structure.

In this regard, we appreciate Senator Burr's intention to address this critical issue in his measure. It appears from VA's testimony in the previous panel that it is working toward a VISN reorganization plan; and like this Committee, we look forward to hearing more about that plan and are hopeful that the best VISN model to serve our veteran population will be established.

Madam Chair, that concludes my statement and I am happy to answer any questions you or Committee Members may have. Thank you.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY J. ILEM, DEPUTY,
NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Murray, Ranking Member Burr and Members of the Committee: On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to present our views on the 23 legislative bills and two draft measures under consideration today.

S. 1264, VETERAN VOTING SUPPORT ACT OF 2011

The Veteran Voting Support Act of 2011 would require the Secretary of Veterans Affairs to permit facilities of the Department to be designated as voter registration agencies and expand assistance to veterans in registering to vote and voting. Section 3 of the bill directs the Department of Veterans Affairs (VA) to provide mail voter registration application forms to each veteran who seeks to enroll in the VA health care system; and is already enrolled in such system when there is a change in the veteran's enrollment status or when there is a change in the veteran's address.

It also requires the Secretary to accept completed voter application forms and transmit them to appropriate state election officials and requires forms accepted at VA medical centers, community living centers, community-based outpatient centers, and domiciliaries be transmitted within ten days of acceptance, unless a completed form is accepted within five days before the last day for registration to vote in an election, in which case it must be transmitted within five days of acceptance.

Section 4 requires each director of a VA community living center, domiciliary, or medical center to provide assistance in voting by absentee ballot to resident veterans, and requires such assistance to include: 1) providing information relating to

the opportunity to request an absentee ballot; 2) making available absentee ballot applications upon request, as well as assisting in completing such applications and ballots; and 3) working with local election administration officials to ensure the proper transmission of the applications and ballots.

Section 5 requires the Secretary to permit nonpartisan organizations to provide voter registration information and assistance at facilities of the VA health care system.

Section 6 prohibits the Secretary from banning any election administration official, whether state or local, party-affiliated or non-party affiliated, or elected or appointed, from providing voting information to veterans at any VA facility. It also directs the Secretary to provide reasonable access to facilities of the VA health care system to state and local election officials for the purpose of providing nonpartisan voter registration services to individuals.

Although DAV has a long-standing resolution encouraging disabled veterans to register to vote and to vote—and initially provided our support for S. 1556, the Veteran Voting Support Act of 2009—at this time we have reconsidered our position on the bill due to concerns about the overall negative impact this bill would have on the Veterans Health Administration (VHA) and the fact that VA is currently providing voter registration to veterans when requested. Currently, VHA Directive 2008–053 defines VA’s policy for assisting patients who seek information on voter registration and voting. Based on the policy, VA does not solicit voter registration but provides assistance to veterans who are inpatients under VA’s care; residents of VA community living centers and domiciliaries who want to get registered to vote or vote in an election. Additionally, state and local election officials, as well as nonpartisan groups are invited into VA health care facilities and those visits are coordinated to ensure there are no disruptions in patient care services. Finally, flyers and information on the voting assistance program are posted throughout facilities and volunteers have been specifically recruited in the past to help with these efforts. Based on this policy, it appears that much of the bill would be duplicative of VA’s current efforts and therefore unnecessary. Likewise, we are confident that the policy and existing Federal Regulations under title 38, subsection 17.33, ensure veteran patients the opportunity to exercise their voting privilege.

S. 1391

S. 1391 would change the standard of proof required to establish service connection for veterans with Post Traumatic Stress Disorder (PTSD) resulting from military service, and for veterans suffering from certain mental health conditions, including PTSD, resulting from military sexual trauma that occurred in service.

Essentially, S. 1391 would eliminate the requirement of an in-service, verifiable stressor in conjunction with claims for PTSD. Under this change, VA would now be able to award entitlement to service connection for PTSD even when there is no official record of such incurrence or aggravation in service, provided there is a confirmed diagnosis of PTSD coupled with the veteran’s written testimony that the PTSD is the result of an incident that occurred during military service, and a medical opinion supporting a nexus between the two.

In November 2010, VA modified its prior standard of proof for PTSD related to combat veterans by relaxing the evidentiary standards for establishing in-service stressors if it was related to a veteran’s “fear of hostile military or terroristic activity.” S. 1391 would build upon that same concept and expands it to cover all environments in which a veteran experiences a stressor that can reasonably result in PTSD, regardless of whether it occurred in a combat zone, as long as it occurred when the veteran had been on active duty or active duty for training. The legislation would also remove the current requirement that the diagnosis and nexus opinion come only from VA or VA-contracted mental health professionals, but would instead allow any qualified mental health professional.

S. 1391 would also allow VA to award entitlement to service connection for certain mental health conditions, including PTSD, anxiety and depression, which a veteran claims was incurred or aggravated by military sexual trauma experienced in service, even in the absence of any official record of the claimed trauma. Similar to the evidentiary standard above for PTSD, the veteran must have a diagnosis of the covered mental health condition together with a written testimony by the veteran that the claimed trauma was incurred during military service. Further, the veteran must have a medical opinion from a mental health professional indicating that the claimed mental health condition is reasonably related to military sexual trauma, which would include a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment while the veteran was serving on active duty or active duty for training.

DAV supports S. 1391, which is consistent with DAV Resolutions 59 and 171. DAV Resolution 171 states that, “establishing a causal relationship between injury and later disability can be daunting due to lack of records or certain human factors that obscure or prevent documentation of even basic investigation of such incidents after they occur * * *” and that, “* * * an absence of documentation of military sexual trauma in the personnel or military unit records of injured individuals prevents or obstructs adjudication of claims for disabilities for this deserving group of veterans injured during their service, and may prevent their care by VA once they become veterans * * *.” Further, DAV Resolution 59 states that, “* * * proof of a causal relationship may often be difficult or impossible * * *” and that, “* * * current law equitably alleviates the onerous burden of establishing performance of duty or other causal connection as a prerequisite for service connection * * *.” Enactment of S. 1391 would provide a commonsense standard of proof for veterans who have experienced serious mental and physical traumas in environments that make it difficult to establish exact causal connections.

S. 1631

S. 1631 would authorize the Secretary of Veterans Affairs to establish a center for technical assistance for non-Department health care providers who furnish care to veterans in rural areas. This bill makes the head of such center the Director of the Rural Veterans Health Care Technical Assistance Center. It also requires the Secretary, in selecting the center’s location, to give preference to a location that, among other things, has a high number of veterans in rural and highly rural areas, and is near one or more entities carrying out programs and activities relating to health care for rural populations.

The purpose of the center would be to develop and disseminate information, educational materials, training programs, technical assistance and materials and other tools to improve access to health care for veterans living in rural areas. It would also help to establish and maintain Internet-based information such as best practice models, research results and other appropriate information.

VHA’s Office of Rural Health’s (ORH) mission is to improve access and quality of care for enrolled rural and highly rural veterans by developing evidence-based policies and innovative practices to support their unique needs. ORH includes information on its Web site about the three Veterans Rural Health Resource Centers (VRHRC) that have been established. The Western Region center in Salt Lake City focuses on outreach, access issues and the special needs of Native Americans (American Indian, Alaska Native, Native Hawaiian, Pacific Islander) and aging veterans. The Central Region center in Iowa City, Iowa focuses on evaluating rural health programs and piloting new strategies to help veterans overcome barriers to access and quality. The Eastern Region center located in Gainesville, Florida focuses on developing models to deliver specialty care services to rural areas, training VA and non-VA service providers caring for rural veterans and bringing specialty care to community-based clinics via tele-health technology.

DAV Resolution No. 203 supports the mission of the VA’s Office of Rural Health and improvements to VA coordinated health care services for veterans living in rural areas. DAV originally supported S. 1631 when it was introduced in September 2011. It is unclear from the information we have available to us if any of the VRHRCs are in fact devoting resources toward the intent of this bill, which is to aid non-VA providers who furnish care to veterans in rural areas with technical assistance. We urge the Committee to ask VA to provide specific details in this regard. In the event that VA is not working toward this goal, we continue to support this bill and taking other actions to help medical providers better deliver much-needed health care to veterans in rural areas.

S. 1705

Introduced by Chairman Murray, this bill would designate the VA Medical Center in Spokane, Washington, as the “Mann-Grandstaff Department of Veterans Affairs Medical Center.” DAV has no resolution on this issue and has no national position on this bill.

S. 1707, VETERANS SECOND AMENDMENT PROTECTION ACT

Introduced by Senator Burr, this bill would amend title 38, United States Code, to clarify the conditions under which certain persons may be treated as adjudicated mentally incompetent for certain purposes. DAV has no resolution on this issue and has no position on this bill.

S. 1755

S. 1755 would provide for coverage under VA's beneficiary travel program disabled veterans with vision impairment, a spinal cord injury, or multiple amputations for travel related to in-patient care in a special disabilities rehabilitation program. Currently, VA is authorized to pay the actual necessary expense of travel (including lodging and subsistence), or in lieu thereof 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 a service-connected rating of 30 percent or more; receiving treatment for a service-connected condition; in receipt of VA pension; whose income does not exceed the maximum annual VA pension rate, or; traveling for a scheduled compensation or pension examination.

Notably, the VA Secretary has the discretionary authority under section 111(b)(2), to make payments for beneficiary travel to or for any person not currently eligible for travel by such person for examination, treatment, or care.

DAV has no resolution on this issue and has no position on this bill. However, we would note that while the intended recipients of this expanded eligibility criteria would certainly benefit, we would urge the Committee to consider a more equitable approach rather than one based on the specific impairments of a disabled veteran. Further, we ask that if the Committee does favorably consider this measure, it also take appropriate actions to ensure that sufficient additional funding be provided to VA to cover the cost of the expanded program.

S. 1799, ACCESS TO APPROPRIATE IMMUNIZATIONS FOR VETERANS ACT OF 2011

This measure would require the Secretary of Veterans Affairs to make available periodic immunizations against certain infectious diseases as adjudged necessary by the Secretary of Health and Human Services through the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices. The bill would include such immunizations within the authorized preventative health services available for VA-enrolled veterans. The bill would establish publicly reported performance and quality measures consistent with the required program of immunizations authorized by the bill. The bill would require annual reports to Congress by the Secretary confirming the existence, compliance and performance of the immunization program authorized by the bill.

Although DAV has no adopted resolution from our membership dealing specifically with this matter of immunizations for infectious diseases, DAV Resolution No. 193 calls on VA to maintain a comprehensive, high quality, and fully funded health care system for the Nation's sick and disabled veterans, specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations with compromised immune systems. If carried out sufficiently, the intent of this bill could also contribute to significant cost avoidance in health care by reducing the spread of infectious diseases and obviating the need for health interventions in acute illnesses of those without such immunizations. For these reasons, DAV supports this bill and urges its enactment.

S. 1806

S. 1806 would amend the Internal Revenue Code of 1986 to allow taxpayers to designate overpayments of tax as contributions to the homeless veterans assistance fund. DAV has no resolution on this issue and has no position on this bill.

S. 1838

S. 1838 would require the Secretary of Veterans Affairs to carry out a pilot program on service dog training therapy. If enacted, this measure would require the Department to conduct a pilot program to assess the feasibility and advisability of using service dog training activities as part of an integrated post-deployment mental health program. The purpose of the pilot program is for VA to produce specially trained service dogs for veterans; to determine how effectively the program would assist veterans with Post Traumatic Stress Disorder (PTSD) and the feasibility of extending or expanding the pilot program.

DAV has no resolution on this issue and has no position on this bill. However, we are looking forward to the receipt of findings from VA's ongoing research project to determine the efficacy of service dog usage by veterans challenged by mental illness and post-deployment mental health conditions related to combat, including PTSD. We recognize that trained service animals can play an important role in maintaining functionality and promoting maximum independence and improved

quality of life for persons with disabilities—and that pilot programs such as the one proposed could be of benefit to certain veterans. However, we do have a concern about VA's experience with advanced training methods for the many varieties of highly specialized service dogs.

S. 1849, RURAL VETERANS HEALTH CARE IMPROVEMENT ACT

S. 1849, the Rural Veterans Health Care Improvement Act, would require VA to develop a five-year strategic plan for ORH for improving access to, and the quality of, health care services for veterans in rural areas.

DAV supports the intention of S. 1849 in accordance with DAV Resolution No. 203. However, we note that the VA's ORH has made available its "Strategic Plan Refresh" for Fiscal Years 2012–2014 with six specific goals and a number of initiatives to achieve those goals. The VA's Strategic Plan on rural health care is comprehensive and seems to cover many of the provisions listed in S. 1849; however, we would like to see additional information on the use of mobile clinics and coordination of care for women veterans living in rural areas. We ask VA to provide an update on the use of mobile clinics in rural areas and the provisions in the bill that would require a survey of each VA facility that serves rural and highly rural areas concerning the provision for and coordination of care for women veterans—including options for fee-basis care and specialty care. DAV is interested in hearing VA's testimony on these topics, and in the event that their current two-year plan does not address those specific provisions outlined in S. 1849, we would support passage of an amended version of this bill related to those specific provisions or any others that are missing from VA's plan.

S. 2045

S. 2045 would require judges of the United States Court of Appeals for Veterans Claims to reside within 50 miles of the District of Columbia. DAV has no resolution on this issue and has no position on this bill.

S. 2244, VETERANS MISSING IN AMERICA ACT OF 2012

This bill would direct the Secretary of Veterans Affairs to cooperate with veterans service organizations and other groups in assisting the identification of unclaimed and abandoned human remains. The VA would also be required to determine if any such remains are eligible for burial in a national cemetery. The VA would cover the burial cost if the remains are determined to be that of an eligible veteran who does not have a next of kin or other person claiming the remains, and there are no available resources to cover burial and funeral expenses. In addition, the bill calls on the VA to establish a public database of the veterans identified in this project. DAV has no resolution on this issue and has no position on this bill.

S. 2259, VETERANS' COMPENSATION COST-OF-LIVING ADJUSTMENT ACT OF 2012

S. 2259 would provide for a cost-of-living adjustment (COLA), effective December 1, 2012, in the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for the survivors of certain disabled veterans based on the Social Security COLA. DAV generally supports this legislation; however, consistent with DAV Resolution 172, we oppose rounding down the adjusted rates to the next lower whole dollar.

S. 2320, REMEMBERING AMERICA'S FORGOTTEN VETERANS CEMETERY ACT OF 2012

S. 2320 would direct the American Battle Monuments Commission to provide for the ongoing maintenance of Clark Veterans Cemetery in the Republic of the Philippines, and for other purposes. DAV has no resolution on this issue and has no position on this bill.

S. 3049

S. 3049 would expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs. DAV has no resolution on this issue and has no position on this bill.

S. 3052

S. 3052 would require the Secretary of Veterans Affairs to notify veterans who electronically file claims for benefits that they may be able to receive assistance from veterans service organizations (VSOs), and to provide contact information for such VSOs. DAV Resolution 001 states that, " * * * our first duty as an organiza-

tion is to assist the service-connected disabled, their surviving spouses and dependents * * *,” and the inclusion of information explaining the availability of VSO assistance and VSO contact information on electronic claims applications would likely increase our ability to do exactly that. In fact, DAV has made this exact request to the Veterans Benefits Administration as they have been developing a new electronic paperless claims system, and it is our understanding that just as VSO contact information is provided to veterans who file paper claims, it will similarly be provided to those who file electronic claims. As such, while enactment of statutory language may not be necessary, we are not opposed to the favorable consideration of this bill.

S. 3084, VISN REORGANIZATION ACT OF 2012

S. 3084, the VISN Reorganization Act of 2012, would require the Secretary of Veterans Affairs to restructure and realign VHA’s 21 current Veterans Integrated Service Networks (VISNs) as well as set personnel limits for VISNs.

Section 2 of the bill would place a limitation on the number of VISN management units at 12, down from the current 21, and would lay out the missions, policies, budgets, procedures and other responsibilities of these integrated regional VISNs, including alliances with other agencies, health care organizations and governments in conducting their work. It would also specify that each network’s VISN headquarters be restricted to not exceed employment of more than 65 full-time employee equivalents, including contractors, and would require VA to submit reports to Congress annually on VISN employment; budget and other benchmarks. This section would also prescribe a consolidation of the existing 21 VISNs in a specified pattern and direct the Secretary to choose one of the existing VISN offices consolidated as sites of the new combined VISN headquarters, including dealing with leased space in commercial buildings, relocation of employees and reemployment assistance for those displaced.

Section 3 of the bill would establish four VISN regional support centers whose main purpose would be to evaluate the effectiveness and efficiency of the new VISNs, across a number of parameters, with a preference that these support centers be established in existing VA medical center locations.

Section 4 of the bill would clarify that this reorganization of VISNs would not require any change to existing direct care at VA sites, including medical centers, CBOCs, or Vet Centers.

DAV has no resolution concerning the organizational alignment of the VHA, or of the VISNs; thus, DAV has no position on this bill. However, last year, DAV, along with other national VSOs, put forward a set of nine recommendations to eliminate waste, duplication and inefficiency within VA, one of which dealt with the size of VISN bureaucracy versus its original mandate as outlined in VA’s “Vision for Change” report that led to the creation of the current VISN structure.

We would also note that the VA Office of Inspector General recently completed two reports on VHA’s VISNs, with a particular concern about the size of their staffing. Results of these reviews were inconclusive, but strongly suggested that VISNs have expanded their permanent staffing allocations significantly compared to the levels in 1995, rather than relying on using “temporary” task forces and working groups pulled from medical centers and other facilities as envisioned in the original plan. In addition, a number of coordinator positions covering a variety of subjects (OEF/OIF; suicide; quality; credentialing of professionals; and FRC, etc.) have been imposed by Congress or VA Central Office over the years, further adding to their staffing totals. Also, pressures on acquisition, human resources and financial management have dictated establishment of consolidated functions for the activities at the VISN level leading to additional personnel.

In our recommendations, DAV and the other VSOs urged Congress to examine VISN staffing and functions by contracting with the National Academy of Sciences, Institution of Medicine (IOM), to conduct an independent study of the VISNs, including their staffing levels, and to submit recommendations to Congress about whether and how these functions should be reorganized. We believe such a study is necessary before setting specific limitation on either the number of VISNs (12) or FTEE per VISN (65). Therefore, we recommend that the Committee ask IOM to conduct such a study, with appropriate protections for the many benefits the structure has brought to VA health care, before taking any legislative action to restructure or reorganize VHA’s VISN system.

S. 3202, DIGNIFIED BURIAL OF VETERANS ACT OF 2012

S. 3202, the Dignified Burial of Veterans Act of 2012, would authorize VA to furnish a casket or urn to a deceased veteran when VA is unable to identify the vet-

eran's next-of-kin and determines that sufficient resources are not otherwise available to furnish a casket or urn for burial in a national cemetery. The bill would further require that VA report back to Congress on the industry standard for urns and caskets and whether burials at VA's national cemeteries are meeting that standard. Under current law, VA is not authorized to purchase a casket or urn for veterans who do not have a next-of-kin to provide one, or the resources to be buried in an appropriate manner. DAV has no resolution on this issue and has no position on this bill. However, if it is to be favorably considered by the Committee, we urge additional resources be provided to VA to ensure that implementation of this discretionary authority does not result in a reduction of funding for other authorized programs.

S. 3206

S. 3206 would extend from 2013 to 2018 the authorization of appropriations under title 38, United States Code, section 322, allowing VA pay a monthly assistance allowance to disabled veterans training or competing for the Paralympic Team. It would similarly extend the authorization of appropriation under section 521A for VA to provide assistance to United States Paralympics, Inc.

The DAV has testified previously on sections 521A and 322 before and after enactment of Public Law 110-389.^{1,2} Specifically, while the intent of Public Law 110-389 is laudable, our concern was and remains the impact it may have on the National Disabled Veterans Winter Sports Clinic, which is a rehabilitation event and not a training ground for future Olympians.³

In addition, the same paragraph allows for individuals with disabilities who are not veterans or members of the Armed Forces to participate in sports programs that receive funds originating from VA grants. As an organization devoted to improving the lives of our Nation's wartime disabled veterans, we are concerned about any shift of VA's mission, personnel, and resources away from disabled veterans, their families and survivors.

Unfortunately, our concern was appropriate based on issues surrounding the implementation, oversight and accountability for the first year of the grant program authorized under section 521A. As you may be aware, VA and U.S. Paralympics, a division of the United States Olympic Committee (USOC), signed its Memorandum of Understanding at the beginning of fiscal year 2010, announced the Olympic Opportunity Fund and subsequently sought proposals. It was in this first year that it became apparent to DAV there was a lack of VA oversight and accountability on the implementation of the grant program and grant recipients, as well as a lack of accountability to ensure adherence by certain grant recipients to the intent of the law.

We note, however, that a number of improvements have been and continue to be made since the consolidation of VA's Office of National Programs and Special Events, which managed VA's National Rehabilitation Special Events, with the Office of National Veterans Sports Programs and Special Events, and additional staff and resources were provided to this office. Furthermore, we look forward to the actions VA will take to address the findings and recommendations of the Government Accountability Office's investigation of this grant program.

In an effort to ensure limited VA resources are wisely spent directly, rather than incidentally, on disabled veterans and disabled members of the Armed Forces to participate in recreation and sport activities, we urge this Committee, if this measure is favorably considered, to include a future mandatory review of this grant program by the Government Accountability Office (GAO). We also urge this Committee to conduct oversight of this grant program subsequent to the release of GAO's upcoming and future reports.

S. 3238

S. 3238 would designate the VA community-based outpatient clinic in Mansfield, Ohio, as the David F. Winder Department of Veterans Affairs Community Based

¹ *Meeting the Needs of Injured Veterans in the Military Paralympic Program*: Hearing before the House Committee on Veterans' Affairs, 111th Congress. 17 (2009) (testimony of Adrian Atizado)

² *Legislative Hearing on H.R. 4255, H.R. 6221, H.R. 6224, H.R. 6225, and H.R. 6272*: Hearing before the Subcommittee on Economic Opportunity of the Committee on Veterans' Affairs, 111th Congress. 19 (2008) (testimony of Kerry Baker)

³ Section 521A, paragraph (d) of the bill states, amongst other things, that a program under that section includes a program that "promotes * * * competition." The activities described in that same section are, among others, instruction, participation, and "competition in paralympic sports."

Outpatient Clinic. DAV has no resolution on this issue and has no national position on this bill.

S. 3270

S. 3270 would require the Secretary of Veterans Affairs to consider the resources of individuals applying for pension that were recently disposed of by the individuals for less than fair market value when determining the eligibility of such individuals for such pension. DAV has no resolution on this issue and has no position on this bill.

S. 3309, HOMELESS VETERANS ASSISTANCE IMPROVEMENT ACT OF 2012

S. 3309, the Homeless Veterans Assistance Improvement Act of 2012, is a comprehensive bill that focuses on improving services for homeless veterans.

Sections 2, 3 and 4 of the bill require that recipients of VA grants for comprehensive service programs for homeless veterans meet physical privacy, safety, and security needs of such veterans; modify the authority of the Department to provide capital improvement grants for comprehensive service programs that assist homeless veterans by not only establishing but maintaining such programs; and provide funding for furnishing legal services to very low-income veteran families in permanent housing.

Section 5 modifies the requirements relating to per diem payments for services furnished to homeless veterans allowing such payments to include furnishing care for a dependent of a homeless veteran who is under the care of that veteran while he or she receives services from the grant recipient (or entity).

Section 6 authorizes grants by VA to centers that provide services to homeless veterans to be used for operational expenses. The aggregate amount of all grants awarded in any fiscal year may not exceed \$500,000.

Section 7 expands the authority of VA to provide dental care to eligible homeless veterans who are enrolled for care for a period of 60 consecutive days, and who are receiving assistance under section 8(o) of the United States Housing Act of 1937 (42 U.S.C. 17 1437f(o)); or receiving care (directly or by contract) in any of the following settings; 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 8 of this measure extends the dates, authorities and resources affecting homeless veterans for the following programs in title 38, United States Code:

- Comprehensive programs
- Homeless veterans reintegration programs
- Outreach, care, treatment, rehabilitation and therapeutic transitional housing for veterans suffering from serious mental illness
- Program to expand and improve provision of benefits and services by VA 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; and
 - The Advisory Committee on Homeless Veterans

DAV is pleased to support S. 3309, the Homeless Veterans Assistance Improvement Act of 2012, as it is in line with DAV Resolution No. 205, which calls for us to support sustained and sufficient funding to improve services for homeless veterans. This resolution approved by our membership also urges Congress to strengthen the capacity of VA's programs to end homelessness among veterans and to provide health care and other specialized services for mental health, including dental care.

S. 3313, WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2012

S. 3313, the Women Veterans and Other Health Care Improvements Act of 2012, contains a number of important enhancements to women veterans health care programs.

Section 2 of 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 reproduce.

The Secretary of Veterans Affairs would ensure that any information produced by the research deemed useful for other activities of the VHA be disseminated throughout the VHA. Within three years after the date of enactment, the Secretary will report to Congress on the research activities conducted.

Section 3 of the measure clarifies that fertility counseling and treatments, including treatment using assisted reproductive technology, are medical services the Secretary may furnish to veterans.

Section 4 of this bill requires the Secretary to furnish reproductive treatment and care for spouses and surrogates of veterans by allowing the Secretary to furnish fertility counseling and treatment, including the use of assisted reproductive technology, to a spouse or surrogate of a severely wounded veteran who has an infertility condition incurred or aggravated while on active duty and who is enrolled in the health care system established under section 1705(a) 25 of title 38, United States Code, if the spouse and the veteran apply jointly for such counseling and treatment through a process prescribed by the Secretary.

In the case of a spouse or surrogate of a veteran not described who is seeking fertility counseling and treatment, the Secretary may refer such spouse or surrogate to a qualified clinician and would be required to prescribe regulations to carry this out no later than one year after 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 condition that affects the veteran's ability to reproduce. For these reasons DAV has no objection to the passage of these sections of the bill, with the exception of subsection (b) of section 4 of the measure: DAV has no position on that particular subsection.

Section 5 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.

Sections 6 and 7 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; and to modify the duration of the established child care pilot programs for certain veterans receiving VA health care under Public Law 111-163 to note that the pilot program may operate until the date that is two years after the date on which the pilot program is established in the third VISN.

Section 7 of the measure would also require a child care pilot program in at least three Readjustment Counseling Service Regions for certain veterans receiving readjustment counseling and related mental health services. It requests the Secretary of Veterans Affairs to carry out a pilot program to assess the feasibility and advisability of providing assistance to qualified veterans to obtain child care so that such veterans can receive readjustment counseling and related mental health services.

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.

No later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate. There is authorized to be appropriated to the Secretary of Veterans Affairs to carry out the pilot program \$1,000,000 for each of fiscal years 2014 and 2015.

We thank the Chairman for her continued efforts on improving VA's women veterans health programs and services and are pleased to support this draft measure. DAV has heard positive feedback related to the pilot program of counseling women veterans newly separated from active duty in retreat settings and the childcare pilots established in Public Law 111-163. We supported the original provisions for these program pilots and are pleased to support the proposal to expand them. Likewise, we are supportive of the provisions in section 5 of the bill that require VA to enhance the capabilities of the Department's women veterans call center related to assistance with accessing health care and benefits and referrals to community resources to obtain assistance with services not furnished by VA.

DRAFT BILL TO ESTABLISH AND NAME OUTPATIENT CLINIC IN HAWAII

Introduced by Senator Inouye, this bill would authorize the Secretary of Veterans Affairs to carry out a major medical facility project lease for a VA outpatient clinic at Ewa Plain, Oahu, Hawaii and designate such clinic as the Daniel Kahikina Akaka Department of Veterans Affairs Clinic. DAV has no resolution on this issue and has no national position on this bill.

DRAFT BILL ON MENTAL HEALTH ACCESS ACT OF 2012

This draft measure, the Mental Health Access to Continued Care and Enhancement of Support Services Act of 2012, or the Mental Health ACCESS Act of 2012, is a comprehensive bill focused on improving and enhancing the programs and activities of the Department of Defense (DOD) and VA related to suicide prevention and resilience and behavioral health disorders of members of the Armed Forces and veterans.

All of the sections in Title I of this bill are related to DOD matters with the exception of sections 105, 106 and 109. These provisions require collaboration between the two agencies with respect to improving sharing of patient records and information under the medical tracking system/electronic health record shared between DOD and VA; participation of members of the Armed Forces in peer support counseling programs of VA; and compliance of DOD with requirements for use of VA's Schedule for Rating Disabilities in determinations of disability of members of the Armed Forces. DAV recognizes the need for the both Departments to collaborate on certain mental health matters and we are supportive of these specific sections in accordance with DAV Resolution No. 200, approved by our membership. This resolution supports program improvements and enhanced resources to support readjustment services for the post-deployment mental health needs of war veterans. Further, DAV Resolution No. 177 calls for improved collaboration between VA and DOD in making disability determinations. As for the remaining sections in Title I of the measure, however, DAV takes no formal position on the issues that fall exclusively under the jurisdiction of DOD.

Sections in Title II of the measure deal with VA mental health matters. Section 201 would instruct the Secretary of Veterans Affairs to develop and implement a comprehensive set of measures to assess mental health care services VA is providing. The provisions would require VA to specifically assess the timeliness of the furnishing of mental health care; the satisfaction of patients who receive it; VA's current capacity to furnish mental health care; and the availability and furnishing of evidence-based therapies.

The section also would require that the Secretary develop and implement guidelines and productivity standards for providers of mental health care for the staffing of general and specialty mental health care services, including those resident in community-based outpatient clinics. The bill would require the Secretary to enter into a contract with the National Academy of Sciences Institute of Medicine (IOM) to create a study committee to assess and provide an analysis and recommendations on the state of VA's mental health services. The study committee would also be responsible for assessing barriers to accessing mental health care by Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn (OEF/OIF/OND) veterans as well as the quality of mental health care they are receiving.

We are especially pleased that the bill would require VA to provide detailed recommendations for overcoming observed barriers, and to improve access to timely, effective mental health care at VA health care facilities and that the Secretary and IOM would be required to include at least one former VHA official and at least two former VA employees who were providers of mental health care as members of the study committee. Likewise, we are pleased the bill includes provisions to ensure transparency in the process—specifically that the measures and guidelines developed and implemented as well as an assessment of the performance of VA using such measures and guidelines are to be made available to the public on a VA Web site and must be updated quarterly at a minimum.

Given the previous hearings held by this Committee on mental health matters and the findings from various informal surveys and official reports on timeliness of VA mental health care and ongoing staffing shortages, DAV fully supports the aforementioned provisions. These requirements are in line with a mandate from our membership contained in DAV Resolution No. 200.

Section 202 would expand the Vet Center mandate established in Public Law 111–163 to include Readjustment Counseling Service (RCS) furnishing counseling to certain members of the Armed Forces and their family members. This language would authorize limited eligibility for family members to receive counseling separately from a given servicemember when those family members are dealing

with combat-related deployment problems. Under this section, counseling furnished could include a comprehensive assessment of the veteran's or family member's psychological, social, and other characteristics to ascertain whether they are experiencing difficulties associated with coping with the deployment of a member, or readjustment of the family to civilian life of a veteran or servicemember following a deployment.

The RCS provides an optimal model of psychological counseling for a veteran's family to assist with recovery and post-deployment mental health challenges. Therefore, we believe this provision is fully consistent with the RCS's mission and goals to help combat veterans recover from that unique experience. Public Law 111-163 provided VA a new authority for active duty personnel to receive Vet Center services outside their military chains of command, as well as a number of other, novel authorities enabling family caregivers of severely injured veterans to receive direct VA services. Historically, Vet Centers have been counseling family members in certain circumstances when such counseling is helpful to keep families intact, to deal with survivors' grieving of a lost servicemember or veteran, to deal with separation anxieties and depression, and to aid family members in coping with a number of deployment-related stresses. Therefore, we see these new provisions as consistent with the RCS mission to continue as a non-medical source of healing and recovery for this young population. We believe this is an important, but incremental improvement in the RCS mandate. Therefore, DAV fully endorses this provision in accordance with DAV Resolution No. 189 that supports a comprehensive Vet Center Program for combat veterans of all eras.

Section 203 establishes authority for the Secretary of Veterans Affairs to furnish mental health care through facilities other than Vet Centers to immediate family members of Armed Forces personnel deployed in connection with a contingency operation; this authority would be subject to the availability of appropriations for this purpose. We support this provision, also on the strength of Resolution No. 189.

Section 204 stipulates the organization of the RCS in the VA and notes that it is a distinct organizational element within the VHA that provides counseling and other important health and psychological services. This measure would require the Chief Officer of the Readjustment Counseling Service to report directly to the Under Secretary for Health with no intervening supervisory layers between them. The provision would also specify qualifications of an individual for holding this sensitive post.

For the past 35 years, the RCS has served as a quasi-independent source of psychological counseling for combat veterans and family members. In fact, the Committee may recall that the original charter for the RCS was modeled on a novel readjustment counseling service initiated independently by DAV following the Vietnam War when it became apparent to our predecessors that VA was not addressing the urgent counseling and readjustment needs of a number of Vietnam veterans. As intended by Congress in establishing its original mandate in 1979, the RCS was to be an independent, non-medical, non-psychiatric source of care for certain veterans who did not want to be labeled "mentally ill" by VA, but who were in need of services to aid them in readjusting from the sacrifices they endured in military combat environments. The RCS succeeded all expectations in playing that role. Today's combat veterans have made it clear to DAV and others that they desire a similar, non-stigmatizing service to aid them, and have found the Vet Centers to be welcoming, non-judgmental places to receive that help.

Without notice to this community and without any consultation beforehand, the VHA journalized the RCS under its medical professional arm. The RCS office now reports through, and is thus restrained by, a gauntlet of bureaucracies led by VA physicians and those working for VA physicians in VA Central Office. Reporting to physicians is wholly inconsistent with the non-medical, psychological and pastoral mission of RCS, and detracts from its historic role as planner, budgeter, staffer and operator of all RCS programs in 300 Vet Centers in every State and most major cities. No other VA medical professional service in the current VHA configuration possesses this level of combined responsibility or accountability as does the RCS. We cannot see any advantage having been accrued to VHA as a consequence of this realignment (except perhaps to promote medical and psychiatric traditionalism), but many disadvantages have become apparent.

With these views in mind, we strongly endorse this section that would return RCS to its traditional state of independence from medical and psychiatric supervision in a VA bureaucracy.

The section also would require funding for the activities of the Readjustment Counseling Service, including the operations of Vet Centers, to be derived from amounts appropriated for the VHA for medical services and not through the Veterans Equitable Resource Allocation system that funds most other VA clinical care.

The section would also require the budget request for the RCS to be segregated from other funding needs for VHA. We fully support these provisions on the same basis that we support RCS being maintained as a separate entity in VHA's organization, reporting only to the Under Secretary for Health. If funding for RCS is routed through VERA, it is subject to the overall needs of each VISN. This would give each VISN office the opportunity to parse RCS funding to other needs deemed more urgent or higher priority. We do not support this concept. RCS funding should be maintained and justified by RCS only, exclusive of interference by outside interests.

The section also requires that, not later than March 15 of each year, the Secretary shall submit a report to the Committee on Veterans' Affairs of the Senate and the House of Representatives on the activities of the RCS during the preceding calendar year. Each report would include for each period covered: 1) a summary of the activities of the RCS, including its Vet Centers; 2) a description of the workload and additional treatment capacity of the Vet Centers, including, for each Vet Center, the ratio of the number of full-time equivalent employees and the number of individuals who received services or assistance; 3) a detailed analysis of demand for and unmet need for readjustment counseling services; and 4) the Secretary's plan for meeting any such unmet needs. We support this provision.

Section 205 would instruct the Secretary of Veterans Affairs to carry out a national program of outreach to societies, community organizations, and government entities in order to recruit mental health providers, who meet the quality standards and requirements of the VA to provide mental health services for the Department on a part-time, without-compensation basis. In carrying out this program the Secretary could partner with a community entity or assist in the development of a community entity, including by entering into an agreement that would provide strategic coordination of the societies, community organizations, and government entities in order to maximize the availability and efficient delivery of mental health services to veterans. The Secretary would be required to provide training to mental health providers to ensure that clinicians who provided mental health services under this authority gain sufficient understanding of military and service specific culture, combat experience, and other factors that are unique to the experience of OEF/OIF/OND veterans.

DAV is pleased to support this comprehensive draft measure and we appreciate the Chairman's continued efforts on improving mental health programs and services for our Nation's servicemembers, veterans and their families. We are especially appreciative of your recognition of the importance of the RCS's role in restoring new veterans to society and family life following their strenuous deployments to Afghanistan and Iraq, over this decade-long war. We particularly appreciate those provisions in this bill.

DAV would again like to thank the Committee for the opportunity to submit our views on the numerous legislative measures under consideration at this hearing. Much of the proposed legislation would significantly improve VA benefits and services for our Nation's servicemembers, veterans and their families.

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

Chairman MURRAY. Thank you.

Thank you very much to all of our folks who have come today to testify. We really appreciate it. I just am going to do a couple of questions and then submit some for the record as our time is running out rapidly.

But I did want to go back to Ms. Keil. The Department of Defense, as I mentioned earlier, provides access to advanced reproductive treatments and recently issued some guidance on offering these services at no cost to severely injured servicemembers and their spouses.

The VA, on the other hand, cannot provide these services, and it is pretty clear they do not meet the reproductive health needs of veterans who have experienced severe trauma as you outlined to us in your testimony a few moments ago.

When you and your husband, Matt, were trying to conceive, you faced some very substantial roadblocks from both the Department of Defense and VA; and since that time, DOD has changed their

policy. They now do offer fertility services for severely injured veterans.

I believe that veterans like Matt have earned DOD and VA coverage and there should be no difference. I assume you agree with that.

Ms. KEIL. I absolutely agree. My understanding is that you would need to travel to a military treatment facility in order to receive those services that the DOD is offering, whether that be Fort Bragg or Walter Reed. That is not an option for families of the most severely injured such as my husband.

There is no way that I could travel to one of those treatment facilities and to care for my husband, and I want him there every step of the way.

So, that for us would not be an option. I feel that he, with his service and sacrifice, I feel that he now falls under the VA guidelines of care. He is a medically retired servicemember, and he ultimately is the VA's responsibility.

So, I feel that we fall under their responsibility.

Chairman MURRAY. Thank you very much. I really appreciate that.

Ms. Ilem, I just wanted to ask you. One of the issues I hear a lot about especially for women veterans is the lack of childcare. It is a substantial barrier to families accessing health care, and Congress has begun to address that issue.

The last Congress, as you know, we created a pilot program to provide childcare at several of our VA medical centers. This year the legislation I have introduced expands upon that success to include childcare at several Vet Centers.

This is important because Vet Centers, as you know, provide mental health care and readjustment counseling services in a comfortable, non-clinical setting that some veterans prefer.

So, I wanted to ask you. I was really pleased to hear your testimony today about the positive experiences that a number of your members have had.

How do you think expanding access to child care services would improve the accessibility to care for our veterans?

Ms. ILEM. And we definitely appreciate your leadership on that issue. It was a long time coming. It certainly has been identified as a barrier over the years in numerous studies and I think we heard from the recent event that you hosted with a number of women veterans who need psychological counseling that are using the Vet Center and even VA's that child care, having access to child care was a big issue because for the children it is just not an appropriate place for them to bring their children, discussing some very private matters during those sessions.

So, I think it absolutely opens the door one more step for those that Vet Centers should be included and we welcome those provisions.

Chairman MURRAY. OK. Thank you very much and again we are out of time but I do want to thank all of our witnesses today, and I will just let everyone know that I am going to be working with all the Members of this Committee as we develop legislation based on today's hearing on all of these bills as well as our last legislative hearing for our markup which is going to be held in July.

I am optimistic that by the time of the next markup, the President is going to be signing into law the Honoring America Veterans and Caring for Camp Lejeune Families Act of 2012, which includes legislation from our last markup.

Veterans legislation continues to be bipartisan and that is as it should be. So, I want to thank all the members of our Committee. The Senators who are working on legislation I look forward to working with all of you in the coming weeks on this critical legislation affecting our Nation's heroes.

Thank you very much.

With that, this Committee hearing is adjourned.

[Whereupon, at 11:59a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF MAX CLELAND, SECRETARY, AMERICAN BATTLE MONUMENTS COMMISSION

Mr. Chairman and Members of the Committee: Thank you for this opportunity to offer testimony on several bills before the Committee. As only one, S. 2320, the Remembering America's Forgotten Veterans Cemetery Act of 2012, pertains to responsibilities of the American Battle Monuments Commission, I will limit my testimony to it.

S. 2320 would direct the American Battle Monuments Commission to provide for the ongoing maintenance of the former Clark Air Base Cemetery in the Republic of the Philippines.

We agree that Clark cemetery is a problem that warrants resolution. When the Air Force vacated Clark Air Base and the base rights agreement with the Philippines expired, the cemetery became the responsibility of the Philippine Government. Over time, this had the effect of leaving its care in the hands of a few dedicated VFW volunteers. They have done a wonderful job with limited resources, particularly considering that burials of U.S. veterans have continued since the Air Force departure, but the volunteers cannot be expected to continue that effort indefinitely.

We do not know how many of the 8,000 dead at Clark cemetery are U.S. veterans—the Clark Veterans Cemetery Restoration Association Web site cites several thousand as confirmed veterans and others as presumed veterans.

We are on record as stating that Clark cemetery does not fall within our Commission's core commemorative mission. That remains true. However, given the Air Force's history with the cemetery and the fact that veterans' burials have continued, we initiated a meeting in ABMC's Virginia Headquarters last December with representatives of the Air Force and the Department of Veterans Affairs National Cemetery Administration to explore possible solutions to this issue. A consensus could not be reached on what should or could be done.

ABMC has serious concerns with S. 2320 as drafted. While this bill's intention is laudable, we do not believe the bill addresses adequately issues that must be resolved before any corrective action is taken.

If the Congress should decide to move legislation forward, the Administration believes such legislation should address three critical elements: access, authority, and funding.

1. Access—To our knowledge, the United States has no legal standing to undertake any work at Clark cemetery. The Department of State would have to enter negotiations with the Philippine Government to provide long-term U.S. access to the cemetery. This would have to be accomplished before any agency of the Federal Government could maintain the cemetery.

2. Authority—ABMC has no authority to spend its appropriations to maintain a cemetery controlled by a foreign government and the Administration does not support any change in this position.

3. Funding—The requirement that the Commission restore, operate and maintain Clark cemetery "subject to the availability of appropriations for the restoration, operation, and maintenance of cemeteries by the American Battle Monuments Commission" is not supportable. We cannot successfully complete a project of this scale with existing appropriations without significant negative consequences on the rest of ABMC's program. There is presently no government estimate of the cost to restore and maintain Clark cemetery. The Clark Veterans Cemetery Restoration Association estimated the restoration cost at \$2.0 million and annual maintenance costs at \$250,000. There are more than 8,000 graves to maintain at Clark cemetery—more than we maintain at 19 of our 24 overseas cemeteries. Most of the headstones at Clark are partially buried in volcanic ash. We believe the association's estimates do

not come close to the amount required given the magnitude of the restoration work required.

ABMC's Fiscal Year 2013 budget request for Salaries and Expenses is \$2.7 million, or five percent, below our Fiscal Year 2012 appropriation. Most of that reduction will be taken in maintenance and infrastructure programs. We cannot sustain such reductions indefinitely while maintaining the standards our war dead deserve and that our Nation demands.

We recognize that the Budget Control Act limits all agencies, including ABMC, to a budgeted level in the out years, and that any increase to our budget would have to be offset from another agency's out year allowances. Nonetheless, if the Congress directs our agency to take on a large-scale new program requirement such as the restoration and maintenance of Clark cemetery, even the association's under-estimated cost would reduce our Fiscal Year 2013 funding request by an additional four percent—for a total reduction of \$5.0 million. Taken further, this would result in a 14 percent cut in program funding for engineering and maintenance, horticulture, logistics and interpretation.

This is not sustainable for an agency of our size and budget. An unfunded new mission of the scope of Clark cemetery cannot help but have a significant impact on our ability to execute our core mission.

Before closing, I must comment on Finding 8 of the bill, which references the Commission's fund raising authority. We caution the Committee from going down this road. Requiring private funding of new memorial projects authorized by the Congress has become common practice, but fund-raising results have not been universally successful. It is not common practice to require private funding of our Nation's overseas cemeteries. S. 2320 implies that the care of ABMC cemeteries could become dependent on the uncertainties of public fund raising. This carries with it the implication that the Congress is prepared to back away from the commitment to provide perpetual care to the war dead buried within them.

S. 2320 has serious issues that prevent us from supporting this legislation.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

The American Society for Reproductive Medicine appreciates the opportunity to provide comment on S 3313, the "Women Veterans and Other Health Care Improvements Act of 2012," and is pleased that the Senate Veterans' Affairs Committee has considered this bill for a public hearing.

ASRM is a multidisciplinary organization of nearly 8,000 medical professionals dedicated to the advancement of the art, science, and practice of reproductive medicine. ASRM members include obstetrician/gynecologists, urologists, reproductive endocrinologists, nurses, embryologists, mental health professionals and others. As the medical specialists who present treatment options for patients and perform procedures during what is often an emotional time for them, we recognize how important a means to addressing their medical condition can be for those hoping to build their families.

The "Women Veterans and Other Health Care Improvements Act of 2012" would direct the Secretary of Veterans Affairs to collaborate with the Secretary of the Department of Defense and the Director of the National Institutes of Health to facilitate research to improve the long term reproductive health care needs of veterans who have a service-connected genitourinary disability or a condition that was incurred or aggravated in the line of duty that affects the veteran's ability to reproduce. ASRM is very pleased that this bill recognizes the need for greater attention, dedication and investment of Federal resources to the disease of infertility. The National Institutes of Health and the Centers of Disease Control are two public agencies that devote resources to this disease, but due to the myriad of causes of infertility, and the numerous implications of the disease, it is vitally important that other Federal agencies work to make combating infertility a priority. The attention to infertility by the agencies governing our military service personnel and our separated from military service personnel is long overdue and welcomed.

The bill allows that the Department of Veterans Affairs may furnish fertility counseling and treatment, included assisted reproductive technologies, to veterans and requires the Department of Veterans Affairs to furnish fertility counseling and treatment, including assisted reproductive technologies, to a spouse or surrogate of a severely wounded veteran who has an infertility condition incurred or aggravated in the line of duty as long as the spouse and veteran apply jointly for such counseling and treatment.

ASRM solidly supports the provision of fertility services to severely wounded veterans. It is nothing but unjust to send our military personnel into harm's way and

to not provide health care services to address health care needs that arise due to their service and dedication to our country.

Of course, because infertility is a disease and one that affects 1 in 8 couples, we advocate for the provision of health benefits to address the disease for all those affected, no matter the cause. Insurance coverage of infertility is rare. And while we can debate as to what is essential and what is not essential when it comes to coverage of health care, there is a huge gap when it comes to the ability of individuals diagnosed with infertility to treat their disease. In fact, the Federal Employee Health Benefits Program, the largest employer-sponsored private health plan in the Nation, and a model for the health reform law in several key areas, does not provide coverage for most infertility services, and specifically for assisted reproductive technology. ASRM would recommend that the Federal Government can demonstrate its commitment to the importance of addressing infertility by requiring its own health program to provide coverage for infertility services for its own workforce.

We would like to raise a couple of additional shortcomings in the bill.

First, the bill is written in such a way to give the Department of Veterans Affairs the option (i.e. "may" furnish) to provide fertility counseling and treatment for veterans generally, but "shall" provide fertility counseling and treatment for spouses or surrogates when a severe injury occurs to the veteran during the line of duty. As written, the bill seems to leave out the required treatment of the veteran himself or herself when injured during the line of duty. Obviously this is not the intent of your bill, but the language should be clarified to require coverage of the injured veteran himself or herself. The source of the infertility can be male factor, female factor or both.

The bill could go further to specifically include furnishing of services to those affected by infertility caused by exposure to toxins during their deployment as these exposures can also compromise one's ability to reproduce. So too, fertility preservation is a common concern for military personnel with orders to deploy, and coverage by TRICARE for those who opt to attempt to preserve their fertility via sperm banking should be allowed.

The bill limits required fertility counseling and treatments to a spouse or surrogate of the injured veteran. Until such time that every state legally recognizes the marriage of same sex partners, the effect of this bill will be that only those veterans whose marriage is deemed legal will be furnished those services outlined in the bill. This effectively denies coverage to injured veterans who are single or who are in same sex partnerships. It is no longer a stigma to reproduce outside of the context of marriage, or a male/female marriage, and ASRM would recommend that holding veterans to a standard that is not the norm any longer in today's society is discriminatory.

ASRM would also recommend that you clarify the term "surrogate" in the bill as this word can have different meanings. It would be appropriate to precede the word "surrogate" with the word "gestational" in the bill language. ASRM would further recommend that the use of donor gametes be a covered treatment option.

Thank you for the opportunity to comment on this bill and for your attention to this important public health issue.

LETTER FROM NATHANIEL BEELER OF AVON, INDIANA

Chairman Murray, Members of the Senate Veterans' Affairs Committee, My name is Nathaniel Beeler and I am 10 years old, almost 11. I live in Avon, Indiana. I am working to alert Senators about an important veteran's issue that is addressed in Senate Bill S. 2320. Clark Veteran's Cemetery in the Philippines urgently needs your support. Many of our soldiers who sacrificed their lives for our country lie in disgraceful conditions at the Clark Veteran's Cemetery in the Philippines. I care deeply for the veterans who sacrificed their lives for my very freedom and I think they should have respectful conditions for the price they paid.

I first read about the cemetery last summer and I wanted to do something to support our fallen heroes. I made a power point presentation and presented this issue to my class in April and we wrote letters to Senator Coats, Senator Lugar, and Congressman Todd Rokita. Since then, I have expanded my efforts to include six petition drives. I have collected a total of 764 signatures, ranging from kindergartners to a WWII Pearl Harbor survivor. After I got out of school in May, I decided to increase my efforts ten-fold.

I know it must grieve you also to know that our veterans are lying in disgrace, buried in ash and weeds. Some have 8-12 inches of ash covering their headstones so that you cannot read their information. This is not how the United States treats their veterans. These brave men and women, who sacrificed for my freedom, kept

our freedom for many generations to come. Now they lay in disgrace and dishonor and that violates their sacrifice and ruins the vision of how the United States treats their fallen comrades.

I know that I am only 10 years old, but I want to do something for the veterans because of how much they have done for me. I live in freedom and luxury in the greatest nation in the world, thanks to them. I get to go to school without being blown up on the way, good food is in our kitchen and available abundantly at the store even though we are at war, and I sleep in a warm, comfortable bed without fear of being attacked and killed in the night, all because of the sacrifice and efforts of our veterans.

Here is the issue: When the Air Force left the Philippines due to volcanic eruption, they left in a hurry, and failed to place the cemetery under the proper agency to manage our cemeteries on foreign soil. S. 2320 would place Clark under the ABMC. All of it is explained in my PowerPoint presentation, which I will attach. [A paper version is held in Committee files.] We have veterans buried there who died in the Spanish American war all the way to an Iraqi veteran. I just read a great book called *The Great Raid of Cabanatuan* and I learned about how many Filipino people sacrificed and suffered and died alongside our troops. They were brave young men and women who helped turn the tide in WWII. Many suffered through or died on the Bataan Death March and were POWs. A lot of them were freed and then went into the jungles and mountains to lead or participate in the underground gorilla effort against the Japanese. We could never have rescued our POWs without their help. This has made me even more dedicated and motivated to doubling up on my efforts to restore Clark Veteran's Cemetery.

Since you are all Members of the Senate Committee on Veterans Affairs, you are very important and Clark needs your support! All of my hope and trust is in you because only the U.S. Government can restore this forgotten cemetery which contains our brave war dead. If the US doesn't do something now, it will be like they have been abandoned twice. I read a good book called *Behind the Enemy Lines*. It is about brave men and women that fought for our country from the Revolutionary War all the way to Iraq. The stories are so amazing, especially the soldiers bravery! The stories reminded me of the men and women who are buried at Clark. I am very devoted and motivated to bring them the honor and dignity they have earned and deserve. By supporting this bill, you could influence other Senators to support S. 2320, and have the domino effect.

When I grow up, I hope to be a pilot in the Marines. I have read that the Marines main statement is: "Leave no man behind." But at Clark, many Marines have been left behind, buried in ash and dishonor. I will never stop fighting for them and their honor, because they never stopped fighting for me and for you and for our Nation.

I am only 10 years old but I have been taught that the United States is the most powerful and just nation in the world and we have this title because of the many veterans who fought under our flag because they believed that freedom was worth dying for. Even if they were fighting for other people's freedom, they believed the ideas the United States stands for are worth dying for. So now they lay in disgrace when they are really heroes. We can't allow this to go on! We have to act now.

I can only go out and get signatures of support and every one I talked to agreed that we should be able to read the headstones of our war dead. But you can make a law and fix this predicament.

A gold star mother signed my petition on Saturday, June 16th. I have thought many times about all the mothers of those who are buried at Clark, and how sad and exasperating it must be to have your child buried in disgrace and dishonor when they sacrificed and gave of themselves in order that we are a free country.

I hope you will support S. 2320! I have another petition drive scheduled for July 4, 2012. It will be my biggest event yet—15,000 people attended in the past. I think I will gain many signatures and much progress for the effort to restore Clark Veteran's Cemetery!

I am attaching my power point and my petitions to be admitted into public testimony, along with my statement. I hope this is read and admitted because I really want to help Clark Veteran's Cemetery to be restored!

Sincerely,

NATHANIEL BEELER.

PREPARED STATEMENT OF THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT
RELATIONS, BLINDED VETERANS ASSOCIATION

INTRODUCTION

The Blinded Veterans Association (BVA) is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. The organization has served blinded veterans for 67 years. On behalf of BVA, thank you for this opportunity to present statement for the record on the issue of the current Department of Veterans Affairs (VA) Beneficiary Travel Program. Chairwoman Patty Murray, Ranking Member Burr, and members of the Senate VA Committee, thank you for the changes you already have made to Beneficiary Travel in recent years, and today we appreciate the introduction of S. 1755 to improve the access for disabled blind and spinal cord injured veterans who require services at the VA specialized Blind Rehabilitation Centers (BRCs) and Spinal Cord Injury Centers (SCIs).

BENEFICIARY TRAVEL FOR BLINDED VETERANS: S. 1755

BVA thanks Senator Tester for introducing S. 1755. We also express appreciation to Congressman Michaud for H.R. 3687, the companion House bill legislation for disabled SCI and blinded veterans who are currently ineligible for travel benefits. This bill would assist low-income and disabled veterans by removing the travel financial burdens to access vital care that improve independence and quality of life. Veterans who must currently shoulder this hardship, which often involves airfare, can be discouraged by these costs to travel to a BRC or SCI site. The average age of veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation programs with 13 Blind Centers and with high quality inpatient specialized services, only to tell low income, disabled blinded veterans that they must pay their own travel expenses to access the training they need. To put this dilemma in perspective, a large number of our constituents are living at or below the poverty line while the VA Means threshold for travel assistance sets \$14,340 as the income mark for eligibility to receive the benefit. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as either a rural resident or a highly rural resident. The data also indicate that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without financial assistance, the data found that for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans. The analysis also confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group.¹ In FY 2007, rural veterans had a median household income of \$19,632, 4 percent lower than the household income of urban veterans (\$20,400).² The median income of highly rural veterans showed a larger gap at \$18,528, adding significant barriers to paying for air travel or other public transportation to enter a BRC or SCI rehabilitation program. More than 70 percent of highly rural veterans must drive more than four hours to receive tertiary care from VA. Additionally, states and private agencies do not operate blind services in rural regions. In fact, almost all private blind outpatient agency services are located in large urban cities. With the current economic problems with state budgets clearly in view, we expect further cuts to these social services that will bring even more challenges to the disabled in rural regions.

Consider the following facts:

- In a study of new applications for recent vision loss rehabilitation services, 7 percent had current major depression and 26.9 percent met the criteria for sub-threshold depression.³

¹Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans* Issue Brief (Summer 2009).

²VSO IB 2013 Beneficiary Travel pg 119–120, 124–125.

³Horowitz et al., 2005, Major and Subthreshold Depression Among Older Adults Seeking Vision Rehabilitation Services The Silver Book 2012, Volume II pg 9 www.silverbook@agingresearch.org.

- Vision loss is a leading cause of falls in the elderly. One study found that visual field loss was associated with a sixfold risk of falls.⁴
- While only 4.3 percent of the 65 and older population lives in nursing homes, that number rises to 6 percent of those who are visually impaired, and 40 percent of those who are blind.⁵
- Individuals who are visually impaired are less likely to be employed—44 percent are employed compared to 85 percent of adults with normal vision in working population age 19–64.⁶

If blinded veterans are not able to obtain the blind center training to learn to function at home independently because of travel cost barriers, the alternative—institutional care in nursing homes—may be far more expensive. The average private room charge for nursing home care was \$212 daily (\$77,380 annually), and for a semi-private room it was \$191 (\$69,715 annually), according to a MetLife 2008 Survey. Even assisted living center charges of \$3,031 per month (\$36,372) rose another 2 percent in 2008. BVA would point to these more costly alternatives in describing the advantages of VA Beneficiary Care so that veterans can remain in their homes, functioning safely and independently, and with the rehabilitation training needed to re-enter the workforce.

We caution that private agencies for the blind are almost always outpatient centers and located in large urban cities. Many rural states have no vision rehabilitation centers and they do not have the full specialized nursing, physical therapy, audiology, pharmacy, radiology or laboratory support services that are necessary for the clinical care that BRCs and SCIs provide. The lack of electronic health care records in private centers is also a problem when veterans return to VA for their other medical follow-up care. BVA requests that all private agencies be required to demonstrate peer reviewed quality outcome measurements that are a standard part of VHA Blind Rehabilitative Service. They must also be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

CONCLUSION

Chairwoman Murray and Ranking member Burr, BVA again expresses its thanks for the changes that the VA committee has made to these Beneficiary Travel programs in the past couple of years. BVA requests support for S. 1755, which will ensure that VHA cover travel costs by changing Title 38, Section 111 of the U.S. Code Eligibility. Veterans who would not otherwise be able to attend special rehabilitation programs to improve their quality of life will now have that opportunity. The end result will also be a previously unavailable means for blind or spinal cord injured veterans to live independently in their own homes. BVA appreciates the opportunity to provide this statement for the record today.

PREPARED STATEMENT OF HON. BRUCE E. KASOLD, CHIEF JUDGE, U.S. COURT OF APPEALS FOR VETERANS CLAIMS

Chairman Murray, Ranking Member Burr, and Distinguished Members of the Committee: Thank you for the opportunity to present written testimony on a number of legislative proposals, in particular S. 2045, which would establish in statute a duty station for the judges of the United States Court of Appeals for Veterans Claims, consistent with other Federal courts, as well as a requirement for active service judges to reside within fifty miles of the District of Columbia. This past March, I provided testimony to the House of Representatives Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs, on a mirror proposal in the House—H.R. 4213—and my testimony today essentially is unchanged.

In the haste of creating the Court of Appeals for Veterans Claims—the youngest Federal appellate court—the application of several policy issues written in statute and applicable to Federal judges in general appears to have been overlooked with regard to the judges of the Court of Appeals for Veterans Claims. A defined duty

⁴Ramratten, et al., 2001 Arch Ophthalmology 119(12) 1788–94. Prevalence and Causes of Visual Field Loss in the Elderly, www.Silverbook.org/visionloss Silver Book, Volume II 2012 pg 9.

⁵Rein, David B. et al., 2006 The Economic Burden of Major Adult Visual Disorders in the U.S. www.Silverbook.org/visionloss Silver Book, Volume II 2012 pg 9.

⁶Rein, et al. The Economic Burden of Major Adult Vision Disorders in the U.S. 2006 www.Silverbook.org/visionloss Volume II pg 10.

station is one example. The duty station for Federal judges generally is prescribed by statute, see 28 U.S.C. § 456, but until your proposal and that of H.R. 4213, no similar legislation has applied to the Court of Appeals for Veterans Claims. In the absence of legislation, the Court's Board of Judges has determined that the duty station for all Court personnel, including active judges other than recall-eligible retired judges, is the Court's principal office. This mirrors your proposed bill.

With regard to a residence requirement, we note that congressional mandate is mixed with regard to establishing such a requirement for an appellate court with national jurisdiction. Although the judges of the Court of Appeals for the Federal Circuit are required to reside within 50 miles of the District of Columbia, see 28 U.S.C. § 456, the judges of the Court of Appeals for the Armed Forces have no residency requirement.

To the extent the perceived need for a residency requirement arises from concerns over the efficient operation of the Court, we note that working from a remote area is becoming more practical. Our cases are now electronically filed and stored and are accessible anywhere a judge can locate a computer. Decisions are circulated for review electronically, and this is the preferred method to distribute cases for review even for those present and working at the Court (as opposed to working remotely). Conversations can and do take place by e-mail, phone, and video (although video is not widely available at the Court yet, but likely not far off). Indeed, recently, one of our judges was on travel and worked a case electronically with his iPad while his wife was driving the car. Moreover, the advent of e-filing and enhanced electronic communication capability, as well as recent changes in the administrative processing of appeals after they have been briefed—as discussed in my testimony before this Committee last month—have resulted in the Court's most productive years.

Should Congress proceed with a residency requirement for the Court, we suggest that it be tied to the Washington, DC, greater metropolitan area, and not just the confines of the District of Columbia, to be consistent with the statutorily required location of the Court's principal office, which can be anywhere in the Washington, DC, greater metropolitan area. See 38 U.S.C. § 7255.

With regard to the other legislative proposals before the Committee, I note that they concern operations unrelated to the Court or matters within the specific purview of the Department of Veterans Affairs. Accordingly, I have no special insight to offer the Committee.

Thank you again for the opportunity to provide a written statement on the proposed legislation.

LETTER FROM DENNIS L. WRIGHT, CAPTAIN, U.S. NAVY (RETIRED),
CHAIRMAN, CLARK VETERANS CEMETERY RESTORATION ASSOCIATION



**Written Statement for the Record
Of the Clark Veterans Cemetery Restoration Association (CVCRA)**

**Submitted to the U.S. Senate, Committee on Veterans Affairs,
Wednesday, June 27, 2012**

**Submitted by
Captain Dennis L. Wright, U.S. Navy (Retired)
Chairman, Clark Veterans Cemetery Restoration Association (CVCRA)**

Chairman Murray, members of the Committee, I am Chairman of the Clark Veterans Cemetery Restoration Association (CVCRA) speaking on behalf of S2320 which was introduced by Senators Kelly Ayotte and Mark Begich with ten additional bipartisan co-sponsors, a bill aptly named "Remembering America's Forgotten Veterans Cemetery Act of 2012".

This Act is a simple piece of legislation. It will correct a tragic oversight by our government when it abandoned and then forgot over 8,300 veterans and their dependents who were interred in the Philippines during the period from 1900 to 1991. The facts are irrefutable:

- The Clark Veterans Cemetery (CVC) is, was, and always has been a military post cemetery
- For 91 years it was exclusively managed by a Branch of our U.S. Armed Forces
- There are Veterans buried in the cemetery that served in every war since the Civil War
- There are 1,054 Unknown Dead "Soldiers, Sailors and Marines" who died during the Spanish and Philippine American Wars (SAW/PAW) with a Monument dedicated in 1908 to commemorate their service
- The CVC was created in 1948 to consolidate multiple older non-WWII military cemeteries scattered throughout the Philippines, and more importantly, to make room for the new WWII Memorial and Cemetery in Manila - - which would not exist today if over 5,000 veterans and dependents who died 1900-1945 and already buried there were not disinterred and reinterred in the new military cemetery for non-WWII dead at Clark
- When the USAF closed Clark AFB in 1991, no provision was made for its perpetual care
- In 1994, after being embarrassed by the decay and deterioration of the cemetery, volunteers from local VFW Post 2485 did their best to restore a minimum level of dignity
- VFW Post 2485 continues to administer the cemetery today solely through donations with several American companies lending their support to build a new perimeter fence and gates, provide security, erect a new memorial plaza, conducted research and creation of an on-line data base with photos of each headstone and history as the research is completed.

- Since the VFW assumed responsibility in 1994, they have buried 400 additional veterans, including one killed in action in Fallujah, Iraq in 2004.
- The annual out-of-pocket cost VFW Post 2485 expends is \$25,000 per year for the six day laborers who maintain the landscaping and assist with burials of veterans.

The solution is equally simple. Congress must do the right thing and direct the American Battle Monuments Commission to assume responsibility for the perpetual care and administration. There is no real budget impact unless one imagines \$25,000 per year, today raised solely through donations, to be a budgetary impact.

We know ABMC will object to this bill. Please do not be misled. ABMC does maintain another active cemetery in Panama, which is virtually identical to the situation at Clark, except Clark is much more historic with SAW/PAW war dead. It also manages another non WWI/WWII site in Mexico. Further, ABMC presently manages two other existing sites in the Philippines, the Cabanatuan POW Memorial 90 minutes to the north, and the Manila WWII Memorial and Cemetery 90 minutes to the south. This "is" ABMC's mission and ABMC "is" authorized today in 36 USC 21 if they chose to do it or more importantly interpret it that way. Don't let ABMC throw up a smoke screen. Also, please do not get distracted by red herrings. There is no cost impact for ABMC to accept the cemetery today in its "AS IS" condition. Then over time, with their expertise and professional management team, ABMC can properly develop a plan to restore the CVC to its rightful place in history with dignity and respect for those who "Served With Honor", the motto of the cemetery.

In summary, thanks to the VFW volunteers and the generosity of several small American companies, the cemetery has been restored to a modest level of decorum and dignity. It is not a difficult task then for the Senate to task AMBC to assume what volunteers have done for the past two decades - - immediately assume responsibility and then plan for an orderly restoration in the out-years.

A bi-lateral agreement will be required between the U.S. and Philippine Government, and the Philippine Government has already asserted, that while it will not cede control or ownership, it will honor a request by the U.S. Government to "care and administer" the cemetery and to take over from the VFW volunteers. Again, please to not be misled by smoke screens from ABMC or others. Senate Resolution 481 has set the framework for bi-lateral cooperation. **The solution is quite simple.** It ranges from a simple Usufruct Agreement to a Diplomatic Note or other form of a Memorandum of Agreement. Also please keep in mind that the majority of ABMC sites, including both of those in the Philippines, are covered by similar Memorandums of Agreement or Diplomatic Notes.

I urge the Committee to take note of the broad base and overwhelming level of support for the CVC from across the nation. Of note are written letters, resolutions and deeds to include:

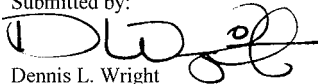
★ ★ ★ ★ ★

"I'm not a hero, I'm just a man"

- Senate Resolution 481 with specific language in support of CVC
- American Legion National Resolution 60
- TMC letter of support - - signed by 32 of their affiliated organizations
- NMVA letter of support
- AFSA letter of support
- MOAA letter of support
- Okaloosa Country Republican Executive Committee Resolution
- 21 organizational Allies declaring their support on our web site at www.cvcra.org with direct links and use of their logos
- VFW Department of the Pacific Resolution which will be presented at the VFW National Convention next month and is expected to pass
- CALVETS Flags for the Fallen Project with local northern California schools donating and sending 1,500 flags for CVC graves
- A young 5th Grader from Avon, Indiana who has gathered over 800 signatures on a CVC Petition of support

Madam Chairman, I thank you and your Committee for your on-going stewardship of important issues in support of, and on behalf of, our Veterans. Please keep in mind that this issue is very, very important to our Military, our Veterans, their families and their friends as attested in the overwhelming support, resolutions and endorsements I have just shared with you. We are asking you and your colleagues to do the right thing - - to see and recognize this as **a simple issue, with a simple solution**. Please approve S2320, Remembering America's Forgotten Veterans Cemetery Act of 2012, as written.

Submitted by:



Dennis L. Wright
Captain, U.S. Navy (Retired)
Chairman, Clark Veterans Cemetery Restoration Association
US: 703-362-3212 or Philippines: +63-999-888-1111 and email: dwright@peregrinedc.com

Attachments:

1. Senate Resolution 481
2. American Legion National Resolution 60
3. TMC letter of support - - signed by 32 of their affiliated organizations
4. NMVA letter of support
5. AFSA letter of support
6. MOAA letter of support
7. Okaloosa Country Republican Executive Committee Resolution
8. Excerpt page from CVCRA web site with other organizations of support
9. VFW Department of the Pacific Resolution
10. CALVETS Flags for the Fallen Project
11. Frequently Asked Question (FAQ) about CVC

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"LET US NOT BE FORGOTTEN"

[Attachments listed were not submitted to the Committee.]

LETTER FROM THE NATIONAL COALITION FOR HOMELESS VETERANS

Chairman Patty Murray, Ranking Member Richard Burr, and Distinguished Members of the Senate Committee on Veterans' Affairs: The National Coalition for Homeless Veterans (NCHV) is honored to submit this written testimony for the

hearing on health and benefits legislation on June 27, 2012. NCHV represents more than 2,100 community- and faith-based organizations nationwide that serve veterans and their families in crisis. These organizations help our Nation's most vulnerable heroes by providing health services, emergency and supportive housing, job training and placement assistance, legal aid, case management and other critical supports.

A few of the bills addressed at today's hearing would significantly impact the ability of service providers to deliver the needed care to help homeless and at-risk veterans achieve or maintain independent living:

- S. 1806, Sen. Barbara Boxer's bill to amend the Internal Revenue Code of 1986 to allow taxpayers to designate overpayments of tax contributions to the homeless veterans assistance fund
- S. 3049, Sen. Mark Begich's bill to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs
- S. 3309, Sen. Patty Murray's "Homeless Veterans Assistance Improvement Act of 2012"

NCHV supports each of these measures. We offer a few targeted recommendations to improve upon S. 3309, however.

S. 1806, A BILL TO AMEND THE INTERNAL REVENUE CODE OF 1986 TO ALLOW TAXPAYERS TO DESIGNATE OVERPAYMENTS OF TAX CONTRIBUTIONS TO THE HOMELESS VETERANS ASSISTANCE FUND

Limited Federal funds for homeless veteran assistance are often concentrated in heavily populated areas. A significant number of community- and faith-based service providers lie outside of major metropolitan areas, which makes it more difficult to compete for Federal grants. However, the homeless and at-risk veterans served by these organizations require the same help to reintegrate into society as those in larger urban areas.

This bill would establish the Homeless Veterans Assistance Fund, which would supplement proven Federal programs and could be authorized to target nontraditional, or "nonconforming entities," and support high-demand activities such as:

- Child care assistance for single veterans in employment assistance programs
- Transportation assistance to medical and employment services
- Security deposits and utility hook-up fees for housing placements
- Clothing, uniforms and tools for employment

The U.S. General Accounting Office has reported that American taxpayers may have overpaid as much as \$945 million, based on data from tax year 1998. This amounts to an average overpayment of \$438 per taxpayer ("Tax Deductions," March 2002). Tax overpayments may be inevitable, but they do not need to be meaningless. The simple act of checking a box, as authorized by this bill, would enable taxpayers to contribute all or part of their overpayments to help prevent and end homelessness for those who have served this country in a way increasingly few Americans ever will.

S. 3049, A BILL TO AMEND TITLE 39, UNITED STATES CODE, TO EXPAND THE DEFINITION OF HOMELESS VETERAN FOR PURPOSES OF BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) currently defines "homeless veteran" based on an incomplete citation of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302 (a)). The full definition of "homeless" under this act includes the following:

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

Sen. Begich's bill serves a single purpose: to include this provision in VA's definition of "homeless veteran." Although some of these veterans may already qualify for VA homeless assistance due to the nature of their circumstances, we must make certain that we do not deny these vulnerable families the help that they need.

S. 3309, "HOMELESS VETERANS ASSISTANCE IMPROVEMENT ACT OF 2012"

Sec. 2. Requirement that recipients of grants from Department of Veterans Affairs for comprehensive service programs for homeless veterans meet physical privacy, safety, and security needs of such veterans.

Earlier this year, the VA Office of Inspector General reported "serious female veteran safety, security, and privacy issues" at certain Grant and Per Diem (GPD) Program sites ("Audit of the Homeless Providers Grant and Per Diem Program," March 2012). Sec. 2 of this bill would help to remove any ambiguity over the need for grantees to fully address these issues in the grant application process.

Sec. 3. Modification of authority of Department of Veteran Affairs to provide capital improvement grants for comprehensive service programs that assist homeless veterans.

Successful GPD providers who have previously received Capital Grants to establish their programs should have the opportunity to compete for funding to maintain those program facilities, including making the necessary renovations to serve homeless women veterans. Sec. 3 of this bill would give the VA Secretary the discretion to make these grants.

Sec. 4. Funding for furnishing legal services to very low-income veteran families in permanent housing.

Outstanding warrants can present a barrier to independent housing for veterans and their families. Dozens of communities around the country have responded to this issue by adopting veteran-specific court programs. One such example is the Homeless Court Program (HCP)—a collaboration between veteran service providers and local court systems in which a veteran's participation in a rehabilitative program can be considered "payment" for various misdemeanor offenses.

Sec. 4 of this bill would set aside at least 1.0 percent of SSVF Program funding for providers that will provide "legal services to assist the veteran family with issues that interfere with the family's ability to obtain or retain housing or supportive services." NCHV recommends that this funding be targeted to communities that have demonstrated both a commitment and an ability to resolve veterans' legal issues. This could be accomplished by restricting these funds to communities with established Veterans Court programs.

Sec. 5. Modifications to requirements relating to per diem payments for services furnished to homeless veterans.

The Grant and Per Diem Program currently lacks authority to directly serve veterans' dependent children. Under the current authorization, veteran families are either forced to split up or be denied entry into the program.

With the introduction and rapid expansion of the SSVF Program, VA has recognized that homelessness cannot be effectively ended and prevented without caring for the veteran family as a whole. This same philosophy should apply to the GPD Program.

Sec. 5 of this bill would allow veterans' dependents to directly receive services through the program. Additionally, under this section the VA Secretary would be required to make per diem payments to "nonconforming entities," such as those discussed earlier in this testimony (regarding S. 1806). The Secretary is already authorized to make these payments. A mandate would potentially benefit underserved communities, but it should not be applied if it will compromise the integrity of the highly competitive GPD Program.

Sec. 6. Authorization of grants by Department of Veterans Affairs to centers that provide services to homeless veterans for operational expenses.

Drop-in service centers are an important element of the GPD Program. They provide essential services and referrals to homeless and at-risk veterans who may not yet be ready or willing to enter into a residential therapy program, or are unable to because of capacity limitations. Yet with a reimbursement rate of no more than \$4.86 per hour per veteran accessing the service center, few grantees can afford to maintain full-time staff for this purpose.

The operational grants allowed by Sec. 6 of this bill would help support established service centers. NCHV recommends this provision clearly identify staffing expense as an allowable operational cost.

Sec. 7. Expansion of Department of Veterans Affairs authority to provide dental care to homeless veterans.

VA dental care for homeless veterans is a limited resource and does not reach enough of the homeless veteran community. For many of these men and women vet-

erans, their job prospects and self-esteem suffer until they are able to address such issues as severe oral pain and missing teeth. The department's dental program helps them alleviate these barriers.

Veterans who live in housing units supported by HUD-VASH vouchers, meanwhile, have an enormous advantage over the homeless veteran population at large: stable housing with regular case management and counseling supports. Given these considerations, NCHV does not endorse Sec. 7 of this bill, which would expand eligibility for VA's homeless veteran dental care to a non-homeless population: HUD-VASH voucher holders.

Sec. 8. Extensions of authorities and programs affecting homeless veterans.

This section would impact nearly every major homeless veteran program in the Federal Government. Among the critical FY 2013 reauthorizations included in this section are:

- \$250 million for the Grant and Per Diem Program
- \$300 million for the Supportive Services for Veteran Families Program
- \$50 million for the Homeless Veterans Reintegration Program (HVRP), the Nation's only employment program wholly dedicated to serving homeless veterans

The GPD Program represents one of six pillars in the VA Secretary's Five-Year Plan to End Veteran Homelessness: community partnerships. Its role in ending veteran homelessness should not be diminished. Therefore, NCHV is concerned that Sec. 8 of this bill would scale back the program's authorization to \$150 million well before the maturity of the Five-Year Plan in 2015. We recommend that the program's authorization be sustained at the \$250 million level.

Additionally, while this section would reauthorize the Special Needs Grant Program through 2015, NCHV maintains that the current authorization level of \$5 million is insufficient to meet the needs of the program's target populations—particularly veterans with dependent children. We recommend that the program's authorization should be at least 15 percent of the total authorization for section 2011, title 38, U.S. Code. This would help to ensure that the necessary capital funding is available to provide safe, private and secure facilities for homeless women veterans and single homeless veterans with dependent children.

IN SUMMATION

NCHV has been at the center of the campaign to end veteran homelessness since 1990, and knows better than most the role that the Senate Committee on Veterans' Affairs has played in bringing our Nation to within reach of the goal of ending veteran homelessness. With passage of this legislation, this Committee will build upon its rich bipartisan legacy of leadership in providing assistance that is responsive to the needs of an evolving veteran population.

We greatly appreciate the opportunity to submit this written testimony on behalf of our Nation's homeless veteran service providers, and look forward to working with this Committee to help advance S. 1806, S. 3049, and S. 3309—with the above recommendations—to the full Senate.

Respectfully,

JOHN DRISCOLL,
President and CEO.

MATT GORNICK,
Policy Assistant Director.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Murray, Ranking Member Burr, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of legislation impacting the Department of Veterans Affairs (VA) pending before the Committee. These important bills will help ensure that veterans receive the best health care and benefits services available to them.

S. 3313, THE "WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2012"

PVA strongly supports the "Women Veterans and Other Health Care Improvements Act of 2012." If enacted, this bill would improve health care services for women veterans within the VA.

PVA is particularly pleased to see the provisions related to reproductive services for catastrophically disabled service-connected veterans. One of the most devastating results of spinal cord injury or dysfunction for many individuals is the loss of the ability to have children and raise a family. PVA has long sought inclusion

of reproductive services in the spectrum of health care benefits provided by the VA. Sections 2, 3 and 4, of the proposed legislation are significant steps in securing these much needed and long overdue treatment modalities that are critical components of catastrophically disabled veterans' maximization of independence and quality of life.

Advancements in medical treatments have for some time made it possible to overcome infertility and reproductive disabilities. For some paralyzed veterans procreative services have been secured in the private sector at great cost to the veteran and family. In April 2010, a Memorandum promulgated by the Office of the Assistant Secretary of Defense (Health Affairs) extended reproductive services, including in-vitro fertilization, to servicemembers and retired servicemembers who had a loss of reproductive ability due to serious injury while on Active Duty. The Memorandum notes "Although many medical and other benefits are available to these members and their families, members with spinal and other injuries that make it impossible to conceive a child naturally are not provided TRICARE coverage, which can assist them in becoming a parent."

An implementing guidance memorandum described available reproductive services as sperm retrieval, oocyte retrieval, in-vitro fertilization, artificial insemination, and blastocyst implantation. Similar to the Department of Defense's recognition that reproductive services are crucial elements in affording catastrophically disabled individuals and their spouses with life-affirming ability to have children and raise a family, so too will passage of the provisions of this bill that authorize the VA to offer similar services to veterans disabled in service to the Nation.

This bill also proposes to improve access to VA care by making both health care and benefits information available through the VA Women Veterans Call Center, as well as referrals for community resources to obtain assistance with services not furnished by the VA. While we support improvements to the call center, PVA believes that VA must continue working toward developing a comprehensive model of care that provides woman veterans with a broader variety of quality services that they need. The FY 2013 Independent Budget reported that 51 percent of women veterans who utilize VA health care services also use non-VA providers. Given this high percentage of woman seeking health care services in the VA and with other providers, the VA must not only work to improve the variety of services available to meet women's health care needs, but it must also work to ensure that there is adequate care coordination with the non-VA providers serving women veterans. Care coordination is the only way to monitor the quality of care provided to women veterans outside the VA health care system.

PVA also supports the proposed extensions of the pilot program for counseling in retreat settings for women veterans newly separated from service, and the pilot programs on assistance for child care for certain veterans. Providing veterans with child care assistance eliminates a barrier to care that prevents many veterans from receiving appropriate health services. Women veterans are one of the fastest growing populations within the VA health care system and we must make certain that they have access to, and receive, quality health care services through the VA.

S. 3238

PVA's National office has no position on naming the VA community-based outpatient clinic in Mansfield, Ohio, as the David F. Winder VA Community-Based Outpatient Clinic. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. With that in mind, we would defer to the views of PVA's Buckeye Chapter.

S. 3206

PVA supports S. 3206, a bill that would extend the authorization for the VA to pay a monthly assistance allowance to disabled veterans training or competing for the Paralympic team. PVA continues to support the partnership between the Paralympics and the VA to expand sports and recreation opportunities to disabled veterans and injured servicemembers. We believe that this has certainly been a worthwhile program as the need for expansion of these activities is necessary. We appreciate the role that the Paralympics have played in this expansion.

S. 3202, THE "DIGNIFIED BURIAL OF VETERANS ACT OF 2012"

PVA fully supports the provisions of S. 3202, the "Dignified Burial of Veterans Act of 2012." Under current law, VA is not authorized to purchase a casket or urn for veterans who have no designated next-of-kin or who lack the resources to provide and appropriate, dignified burial to properly memorialize the deceased veteran. The proposed legislation would ensure that VA furnishes a casket or urn to a deceased

veteran when VA is unable to identify the veteran's next-of-kin and determines that sufficient resources are not otherwise available to furnish a casket or urn for burial in a national cemetery. This provision is consistent with the requirements that would be placed on the VA if the provisions of S. 2244, the "Veterans Missing in America Act," were enacted. Additionally, this bill would require VA to issue a report to Congress on the industry standard for urns and caskets and whether burials at VA's national cemeteries are meeting that standard.

S. 3084, THE "VISN REORGANIZATION ACT OF 2012"

PVA opposes S. 3084, a bill that would establish a new organizational structure for the alignment of the Veterans Integrated Service Networks (VISN) around the country. PVA has serious concerns about the precedent that this legislation would set. The VA currently uses the VISN structure as a management tool for the entire VA health care system. It makes no sense for the Congress to legislate how the VA should manage its system. Furthermore, this sets a dangerous precedent whereby any member could decide that the VA's VISN alignment is not satisfactory (in their opinion), and that it should be redrawn in such a way to support his or her own state or district.

However, we believe that the current network alignment could be reassessed and possibly realigned. There is certainly nothing that suggests that 21 service networks is the optimal structure. But where does the VA draw the line when establishing its health care system structure? With the current 21 VISN's, the VA seems to do a good job of managing a massive health care system. This is not to suggest that the administration of these networks is not bloated, but the alignment itself seems satisfactory.

Meanwhile, it is our understanding that the Veterans Health Administration is already considering a realignment of its VISN structure. If this is in fact the case, then we believe the VA should provide more information on this plan.

S. 3052

PVA supports the provisions of S. 3052. This legislation affirms the important role that veterans' service organizations (VSO) play in assisting veterans with their claims for benefits. It would ensure that veterans who choose to file a claim for benefits electronically are informed about their options for representation from a VSO national service program. We would offer one suggestion about the proposed language of the bill. We believe that the qualifier—"to the degree practical"—at the beginning of the new Section 5103B should be removed from the bill. We see no reason why it would not be practical to inform veterans of their representation options. However, this language gives the VA an excuse should it choose not to provide this information.

S. 3049

PVA supports S. 3049, a bill that expands the legal definition of "homeless veterans" to align with the commonly accepted legal standard for homelessness that exists in this country. Due to an oversight in the law, the legal definition of "homeless veterans" differs significantly from the existing definition of homelessness. Specifically title 38 U.S.C. does not recognize as being homeless an "individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation" (42 U.S.C. § 11302b). The wording change proposed by S. 3049 would allow veterans who experience a domestic violence situation, and choose to leave that situation, to access the same benefits available to all other homeless veterans. Currently, in order to qualify for benefits offered to homeless veterans through the VA, an individual must only meet the definition of homeless in outlined by 42 U.S.C. § 11302a. It only makes sense that the VA's definition for homelessness align with the larger Federal standard.

S. 2320, the "Remembering America's Forgotten Veterans Cemetery Act of 2012" Since 1991, the veterans' cemetery at Clark Air Force Base in the Philippines has remained unattended and seriously deteriorated. Volunteers have over the years tried to do some minor maintenance, but those efforts have proven futile at best. No Federal assistance has been provided to upkeep the Clark Veterans Cemetery. Meanwhile, the remains of more than 8,300 servicemembers and their dependents remain interred there.

The fact that the final resting place for those who have served and sacrificed is in such a state of decay is wholly unacceptable. The American public would not stand for any national cemetery in this county to be maintained in this manner, and similar hallowed grounds outside of the United States should not be treated in this

way as well. PVA supports S. 2320 which would give the American Battle Monuments Commission (ABMC) authority to care for Clark Veterans Cemetery. The ABMC is the best suited to assume this authority with their experience in care for cemeteries and monuments in foreign lands. We must however emphasize that adequate additional resources must be provided to the ABMC to ensure that the proper care is given to the cemetery.

S. 2259, the “Veterans’ Compensation Cost-of-Living Adjustment Act of 2012” PVA supports S. 2259, the “Veterans’ Compensation Cost-of-Living (COLA) Adjustment Act of 2012,” that would increase, effective as of December 1, 2012, the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation (DIC) for the survivors of certain disabled veterans. This would include increases in wartime disability compensation, additional compensation for dependents, clothing allowance, and dependency and indemnity compensation for children. PVA continues to oppose the provision of this legislation that would round down any benefit to the next lower whole dollar amount.

Last year marked the first time in three years that veterans (and Social Security recipients) received a COLA increase. While our economy continues to struggle, veterans’ personal finances have been affected by rising costs of essential necessities to live from day to day and maintain a certain standard of living.

S. 2045

PVA does not support the proposed legislation. We believe that imposing the locality residence requirement would lead to the negative impression across the country that the Court of Appeals for Veterans Claims is an “inside the beltway club,” a common concern often raised by people on many issues outside of the Washington metropolitan region. Perhaps more importantly, we are concerned that imposing this locality restriction could eliminate some of the most qualified judges from consideration for the Court. In fact, we understand that one of the currently sitting judges works remotely from his home in another state and continues to be one of the most productive judges on the Court.

S. 2244, THE “VETERANS MISSING IN AMERICA ACT OF 2012”

The purpose of the Missing in America (MIA) Project is to locate, identify and inter the unclaimed cremated remains of American veterans through the joint efforts of private, state and Federal organizations. The non-profit organization seeks to “provide honor and respect to those who have served this country by securing a final resting place for these forgotten heroes.” The proposed legislation would require the VA to assist entities in possession of unclaimed or abandoned human remains in determining if any such remains are the remains of veterans or other individuals eligible for burial in a national cemetery. Additionally, the legislation would require the VA to cover the cost of funeral expenses and burial in the event that no next-of-kin can be identified. PVA fully supports this legislation. We would only emphasize that Congress must provide any additional resources necessary to allow VA to provide burial services.

S. 1849, THE “RURAL VETERANS HEALTH CARE IMPROVEMENT ACT”

PVA supports S. 1849, a bill that requires a five year strategic plan for the VA Office of Rural Health (ORH) to improve access and the quality of health care services for veterans in rural areas. Approximately 40 percent of veterans who utilize VA health care services live in rural areas, with a significant proportion of this population residing in “highly rural” areas. If enacted, S. 1849 would require the VA to create a strategic plan for the ORH that includes identifying goals and objectives for recruitment and retention as well as for improving timeliness of care provided to veterans living in rural areas.

PVA believes that attracting and retaining adequate staff within the Veterans Health Administration (VHA) is one of the most critical elements to providing quality health care in a timely manner. However, recruiting and retaining medical professionals in rural settings continues to be a challenge as the population of veterans residing in rural areas continues to grow. PVA believes that the requirements of S. 1849 to provide specific goals and objectives to improve rural health care for veterans has the potential to further develop and expand upon the improvements that VA has already made in the area of rural health care. Particularly, PVA is pleased that this bill requires VA leadership to define specific goals and objectives in the areas of recruitment and retention, and enhance the use of current programs using technology to increase veterans’ access to VA health care services.

While PVA supports S. 1849, it must be noted, that this bill requires the VA ORH to develop a strategic plan that includes goals and objectives for ensuring timeliness and improving the quality of health care services provided through contract and fee-basis providers. PVA believes that non-VA providers serve a purpose in meeting the health care needs of veterans residing in rural areas and are an essential component of the VA providing timely care in remote settings. However, such options should not be used as a method or course to eliminate VA facilities. PVA believes that the greatest need is still for qualified VA health care providers to be located in rural settings. We believe that the VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Over the years, VA has earned a reputation as a leader in the medical field for its quality of care and innovation in providing "veteran-specific" health care.

Providing quality health care in rural settings is a continuous challenge for the VA, however, Congress, the VA, and stakeholders such as veteran service organizations must continue to develop innovative strategies to meet the health care needs of rural veterans. PVA believes that the strategic plan proposed in S. 1849 is a step in the right direction.

S. 1838

While PVA has no specific position on this proposed legislation, we believe that it could be beneficial therapy for veterans dealing with Post-Traumatic Stress Disorder (PTSD) and other mental health issues. A model program for this service was created in 2008 at the Palo Alto VA Medical Center in conjunction with the Assistance Dog Program. This program, maintained by the Recreational Therapy Service at the Palo Alto VAMC, is designed to create a therapeutic environment for veterans with post-deployment mental health issues and symptoms of PTSD to address their mental health needs. Veterans participating in this program train service dogs for later placement with veterans with hearing and physical disabilities. As we understand it, in 2006, Walter Reed Army Medical Center conducted a similar, privately-funded, pilot program where service dogs were used in therapeutic settings.

In these programs, training service dogs for fellow veterans is believed to be helping to address symptoms associated with post-deployment mental health issues and PTSD in a number of ways. Specifically, veterans participating in the programs demonstrated improved emotional regulation, sleep patterns, and sense of personal safety. They also experienced reduced levels of anxiety and social isolation. Further, veterans' participation in these programs has enabled them to actively instill or re-establish a sense of purpose and meaning while providing an opportunity to help fellow veterans reintegrate back into the community. Given the apparent benefit to veterans who have participated in similar programs as the one proposed by S. 1838, we see no reason to oppose this legislation.

S. 1799, the "Access to Appropriate Immunizations for Veterans Act of 2011"

PVA supports S. 1799, which proposes to amend title 38, United States Code to provide for requirements related to the immunization of veterans. It is accepted fact that proper and timely administration of immunizations can prevent the onset of more significant medical issues. By requiring the Secretary to ensure these immunizations are administered in compliance with the recommended adult immunization schedule, and requiring quality measures to ensure this is done, it can be expected that veterans using the VA will be healthier and less likely to suffer potential medical ailments. The Department of Defense (DOD) follows these procedures to ensure a more ready military force. It only makes medical and economic sense that the health gains achieved by the DOD program for individuals prior to leaving service should be continued to maintain and benefit the health of veterans. Proper and timely immunizations are a guarantee of better medical health in the VA patient population.

S. 1755

PVA strongly supports S. 1755, a bill to amend title 38, United States Code, to provide certain disabled veterans coverage under the beneficiary travel program of the VA when seeking services for special disabilities rehabilitation. Currently, the Department of Veterans Affairs (VA) does not provide travel reimbursement for catastrophically disabled non-service-connected veterans who are seeking inpatient medical care. PVA believes that expanding VA's beneficiary travel benefit to this population of severely disabled veterans will lead to an increasing number of catastrophically disabled veterans receiving quality comprehensive care, and result in long-term cost savings for the VA.

Under S. 1755, Section 111 of title 38 U.S. Code would be amended to extend travel reimbursements benefits for inpatient care to catastrophically disabled non-service-connected veterans who have incurred a spinal cord injury or disorder, visual impairment, or multiple amputations. For this particular population of veterans, their routine annual examinations often require inpatient stays, and as a result, significant travel costs are incurred by these veterans. Eliminating the burden of transportation costs as a barrier to receiving health care, will improve veterans' overall health and well being, as well as decrease, if not prevent, future costs associated with both primary and long-term chronic, acute care.

Too often, catastrophically disabled veterans choose not to travel to VA medical centers for care due to significant costs associated with their travel. When these veterans do not receive the necessary care, the result is often the development of far worse health conditions and higher medical costs for the VA. For veterans who have sustained a catastrophic injury like a spinal cord injury or disorder, timely and appropriate medical care is vital to their overall health and well-being.

S. 1707, THE "VETERANS SECOND AMENDMENT PROTECTION ACT"

Regarding S. 1707, the "Veterans Second Amendment Protection Act," PVA has no formal position on this legislation.

S. 1705

PVA's National office has no position on naming the VA medical center in Spokane, Washington, as the "Mann-Grandstaff Department of Veterans Affairs Medical Center. PVA believes naming issues should be considered by the local community with input from veterans organizations within that community. With that in mind, we would defer to the views of PVA's Northwest Chapter.

S. 1631

PVA generally supports the intent of S. 1631, legislation that authorizes the VA to establish a center for technical assistance for non-VA health care providers who furnish care to veterans in rural areas. As previously stated, we believe that the VA is the best health care provider for veterans. However, when veterans reside in rural areas and do not have timely access to VA health care services, it is important that the care provided outside of the VA meet the proper standards of quality and can be properly coordinated with VA medical professionals. S. 1631 proposes to improve collaboration on veterans' health care matters between VA and non-VA providers serving veterans in rural areas by encouraging exchange of health care information between providers, creating shared internet-based information databases to collect information on mechanisms to improve health care for veterans in rural areas, and creating systems to monitor fee expenditures of the VA relating to non-VA provider services.

PVA recognizes that veterans frequently seek health care services from non-VA providers independently and through VA purchased care and contract care programs. Therefore the VA must continue its efforts to increase care coordination, as this bill proposes, with private providers to ensure that veterans receive the best possible health care services available. With this in mind, PVA is concerned that the creation of the Rural Veterans Health Care Technical Assistance Center will contribute to growing VA administrative costs and perhaps will result in a duplication of efforts, as it appears that the purpose of the center is in direct alignment with VA's Office of Rural Health. It is unclear in the bill exactly where the supervisory authority of the center will come from; therefore, PVA recommends that the center be housed within the ORH to most efficiently utilize VA resources.

S. 1391

PVA supports S. 1391. According to reports, sexual assault in the military continues to be a serious problem, despite several actions by the Department of Defense (DOD) to combat the issue, including required soldier and leader training. As the military works to reduce the threat and incident of military sexual trauma (MST), it is important that victims of MST, both women and men, have the ability to receive care from the VA and receive timely, fair consideration of their claims for benefits. This is particularly important given the number of MST occurrences that go unreported. While current policies allowing restricted reporting of sexual assaults should reduce the number of incidents which have "no official record," it can still be anticipated that there are those who will not report the incident out of shame, fear of reprisals or stigma, or actual threats from their attacker. To then place a high burden of proof on the veteran who has experienced MST to prove service-con-

nection, particularly in the absence of an official record, would add further trauma to an already tragic event.

One particular recommendation that PVA would like to make about the proposed language is a clarification on what constitutes a “mental health professional.” We would hope that the intent of this legislation is not to limit “mental health professionals” to only VA health care professionals.

S. 1264, THE “VETERAN VOTING SUPPORT ACT OF 2011”

PVA supports S. 1264, the “Veteran Voting Support Act of 2011.” PVA advocates for the rights of veterans, persons with disabilities, and all Americans, which enable them to participate in the election process. Making the voting process accessible and available for paralyzed veterans has been a priority for our organization.

PVA supports the requirement of the VA to provide information relating to requesting an absentee ballot and making absentee ballots available upon request. PVA also supports the provision of the bill that would permit nonpartisan organizations to provide voter registration information at facilities of the VA.

THE “HOMELESS VETERANS ASSISTANCE IMPROVEMENT ACT OF 2012”

PVA generally supports the provisions of the draft legislation, the “Homeless Veterans Assistance Improvement Act.” Many of the grant programs outlined in the legislation will help veterans who are homeless or are facing the prospect of homelessness to overcome the hurdles that they may face. PVA is disappointed to see that the annual amount authorized the Secretary of Veterans Affairs to carry out homeless veterans programs is being decreased from \$200 million to \$150 million. This step reflects a concern that we raised in the past that changing authorization levels for funding homeless programs would likely be an empty gesture.

PVA is particularly pleased to see the extension of the Homeless Veterans Reintegration Program (HVRP). However, we are concerned that this extension only provides for one additional year. The HVRP program is perhaps one of the most cost-effective and cost-efficient programs in the Federal Government. Despite being authorized \$50 million per year, it generally is appropriated less than half of that authorized level every year. And yet, it continues to serve a large number of veterans who are taking the necessary steps to overcome homelessness.

Ultimately, in order to ensure that the myriad of homeless programs are successful, fully sufficient resources must be provided to these programs. Otherwise, overcoming homelessness becomes a policy without the possibility of true success.

THE “MENTAL HEALTH ACCESS ACT OF 2012”

PVA supports the proposed legislation, the “Mental Health ACCESS Act of 2012.” The proposed bill would improve and enhance the programs and activities of the VA regarding suicide prevention and resilience, and behavioral health disorders for veterans and servicemembers. While the VA has made tremendous strides in the quality of care and variety of services provided to veterans in the area of mental health, PVA believes that issues involving access to mental health care continue to exist and more must be done to make certain that all veterans receive timely and effective services. It is for this reason that we thank the Committee for reviewing this important piece of legislation.

Under the proposed bill, the VA is required to conduct a comprehensive assessment of VA mental health care services with particular attention to the areas of timeliness of care, mental health staffing, and the availability and furnishing of evidence-based therapies. The bill goes a step further and requires the VA to establish a “Study Committee” to assist in developing and implementing the aforementioned improvements in mental health care delivery. PVA believes that a comprehensive assessment of VA mental health services is much needed, and we also support the requirement to have the VA develop and implement guidelines for the staffing of general and specialty mental health care services, including community-based outpatient clinics. Such staffing guidance is especially important in light of VA’s recent announcement to hire additional mental health professionals.

One of the most significant provisions of the bill is the proposal to amend title 38, United States Code, Section 1712A to expand eligibility for readjustment counseling and related mental health services. If enacted, this bill will enable VA to provide certain members of the Armed Forces, and their family members, with counseling services through VA Vet Centers. PVA strongly supports these amendments as we understand that servicemember deployments and veteran readjustment to civilian life not only affects the individuals who served their country, but also their family members, loved ones, and others that serve as close support networks. Nonetheless, with such a significant expansion of services now becoming available to this

new population, PVA is concerned that the cost increases associated with this change have the potential to limit the quality and availability of services for the intended groups. PVA recommends that the VA and Congress conduct an assessment that evaluates the ability of Vet Centers to provide the services needed by veterans, servicemembers, and their family members to best determine if and when these services can be provided.

Additionally, the draft legislation gives the VA Secretary the authority to furnish mental health care through facilities other than Vet Centers to immediate family members of servicemembers deployed in connection with a contingency operation. Again, PVA supports and understands the intended purpose of this provision, however, should the VA provide the prescribed services, both VA and Congress must work to ensure that adequate resources are made available to meet the new demand.

PVA would once again like to thank the Committee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care and benefits services available to veterans, servicemembers, and their families. We look forward to working with the Committee to ensure quick enactment and implementation of these important changes.

This concludes PVA's statement. We would be happy to receive any questions that you may have.

LETTER FROM BARBARA COLLURA, PRESIDENT, RESOLVE

THE NATIONAL INFERTILITY ASSOCIATION,
McLean, VA, June 26, 2012.

Hon. PATTY MURRAY,
Chairman,
Committee on Veterans' Affairs
U.S. Senate, Washington, DC.

RE: TESTIMONY FOR HEARING ON S. 3313

DEAR CHAIRMAN MURRAY: On behalf of the 7.3 million Americans who are diagnosed with infertility, I commend you for introducing S. 3313, the "Women Veterans and Other Health Care Improvements Act of 2012." Infertility is a devastating diagnosis to receive and it is further complicated by lack of insurance coverage for most Americans. As you know, TRICARE, and other medical benefits for active duty military and veterans, does not include coverage for infertility treatments including assisted reproductive technologies, such as in vitro fertilization (IVF). This places an added hardship on our servicemen and women and veterans with infertility that is unnecessary.

RESOLVE: The National Infertility Association applauds your efforts to provide fertility counseling and medical treatment to veterans wounded in the line of duty. These veterans have many necessary medical services available to them upon returning home, yet if their military service has rendered them infertile, they have no access to medical treatment to have a child. This is an injustice that your bill seeks to correct. By providing this coverage, veterans have a chance at the family they always dreamed of. For many wounded veterans, assisted reproductive technologies such as IVF may be their only hope of ever having a biological child with their spouse. IVF has been practiced for over 30 years and is a safe and effective treatment for many types of infertility that cannot be treated with medication or surgical procedures. In recent years, professional guidelines have made IVF even safer and more effective through reducing the incidence of multiple births, improving egg and embryo freezing technologies, and improving pregnancy rates through embryo quality.

RESOLVE would like to suggest that infertility coverage be expanded to include all veterans and active duty military so that all those with infertility in our Armed Forces have access to the care they need. Infertility affects men and women equally, and some infertility is unexplained. It is important that men and women receive access to care at the same level. Many couples find that they need to utilize third party reproduction to have a child, such as using donated sperm, eggs (oocytes), or embryos. Others can have a biological child but need a gestational carrier surrogate to carry the pregnancy. The cost for these medical services should be included in this legislation.

Our wounded veterans deserve access to the best medical care that is available for their medical condition, and this bill will do just that. So much has been taken

away from our wounded veterans; don't take away their dream of having a child, especially when medical treatment exists to help them. RESOLVE stands ready to assist the Department of Veterans Affairs in providing the necessary support and information to our veterans who pursue care for their infertility.

Thank you again for introducing this bill.

Sincerely yours,

BARBARA COLLURA,
President.

LETTER FROM RON SIMS, SEATTLE, WASHINGTON

June 23, 2012

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

Dear Senator Murray:

I am writing in support of S. 2320, "Remembering America's Forgotten Veterans Cemetery Act of 2012", directing the American Battle Monuments Commission (ABMC) to provide for the ongoing maintenance of Clark Veterans Cemetery in the Republic of the Philippines.

The care and maintenance of the Clark Veterans Cemetery by the U.S. government ended when the U.S. Air Force evacuated Clark Air Force Base in 1991. Volunteers have not been able to provide adequate custodial care to the hallowed grounds where more than 8,300 members of the U. S. Armed Forces and their families are buried.

Our debt of gratitude to these fallen heroes can never be repaid. Let us at least honor their service with a dignified and honorable resting place. I urge your committee to pass S. 2320.

On a personal note, in an Associated Press article last year (attached) exposing the degradation at Clark Veterans Cemetery the reporter mentioned a gravestone engraved with a tribute: "Daughter, sister, wife and mother of veterans." This is the gravestone of my mother-in-law's sister.

She belonged to a military family. Her father arrived in the Philippines during the Spanish-American war, served in the U.S Army for 30 years, was a World War II prisoner of war, and is buried at Arlington National Cemetery. Her brother was in the Bataan death march. Her husband, a U.S. Air Force sergeant, was killed in World War II and was posthumously awarded a purple heart. She died before the end of World War II leaving behind two orphaned sons who later served in the U.S. Navy and U.S. Air Force during the Vietnam conflict. She was proud to be the daughter, sister, and wife of veterans. She would have been proud to have seen her sons in their uniforms.

I hope you will support this bill and authorize ABMC to take responsibility to restore, operate and maintain Clark Veterans Cemetery so that those who lie buried there are in a respectful place of remembrance.

Sincerely,



Ron Sims

Ron Sims • 3227 Hunter Blvd S • Seattle, WA 98144 • ph: 206.722.7467 • email: ron@ronsims.com

Enclosures

ENCLOSURES FROM RON SIMS REGARDING CLARK VETERANS CEMETERY

http://today.msnbc.com/id/3362940/x/1.1/1.1/news/1/veterans_cemetery_sims_forgot

'The veterans' cemetery that America forgot'

By *JIM GOMEZ*
CLARK, Philippines —

MSNBC.msn.com

Walking along the rows of tombstones here offers a glimpse of the wars America has fought and the men and women who waged them.

But most of the grave markers have been half-buried for 20 years, and there is little hope that the volcanic ash obscuring names, dates and epitaphs will be cleared any time soon.

Clark Veterans Cemetery was consigned to oblivion in 1991, when Mount Pinatubo's gigantic eruption forced the U.S. to abandon the sprawling air base surrounding it.

Retired U.S. soldiers, Marines and sailors volunteer to keep watch, relying on donations to try to maintain the grounds, but they lament that they're short on funds to fix things, and that Washington is unwilling to help.

"It's the veterans' cemetery that America forgot," Vietnam War veteran and ex-Navy officer Robert Chesko said.

Workers at the cemetery north of Manila recently dug to fully expose a gravestone for an Army sergeant who died in World War II in the Philippines.

They discovered his wife's name engraved under his and a long-hidden tribute: "Daughter, sister, wife and mother of veterans."

It's impossible to say what else remains hidden at the 17-acre (seven-hectare) cemetery.

It holds the remains of 8,600 people, including 2,200 American veterans and nearly 700 allied Philippine Scouts who saw battle in conflicts from the early 1900s to the resistance against brutal Japanese occupation troops in WWII.

Clark's dead also include military dependents, civilians who worked for the U.S. wartime government and at least 2,139 mostly unidentified soldiers whose marble tombstones are labeled "Unknown."

As America marks Independence Day, the veterans caring for the cemetery renewed their calls for Washington to fund and take charge of the work.

"People celebrate on the Fourth of July but they forgot the 8,600 who helped make that freedom happen," said former Navy Capt. Dennis Wright, who saw action in Vietnam and is now a business executive.

'Nickels and dimes'

"We're trying to get the U.S. government to assume responsibility for maintaining the cemetery so we can get it up to standards ... not on nickels and dimes and donations and gifts," said retired Air Force Chief Master Sgt. Larry Heilhecker, who served as cemetery caretaker for five years until last month.

Clark was a U.S. base for nearly a century, and was once the largest American Air Force installation off the U.S. mainland. It served as a key staging area for U.S. forces during the Korean and Vietnam wars.

The Clark cemetery, which can accommodate at least 12,000 remains, was developed between 1947 and 1950, when it was used to collect the remains and tombstones from four U.S. military cemeteries as American officials sorted out their dead from WWII and previous wars.

An American cemetery at the then Fort McKinley in Manila became the exclusive burial ground for all Americans and allied Philippine Scouts who were killed in WWII combat. The 152-acre (61-hectare)

http://day.in.mlb.com/stories/id/4362946/its-today-today-news/1/veterans-cemeteries-sun-america-orig/



Manila, Philippines — AP Photo/John DeWitt
A soldier in the ash-covered jungle of Clark Air Force Base in the Philippines, June 1991, after the eruption of Mount Pinatubo. The soldier is seen in the foreground, looking at a grave site. The soldier is seen in the foreground, looking at a grave site.

Manila cemetery collected 17,202 dead, the largest number of American casualties interred in one place from the last world war.

Now closed to burials, the stunningly landscaped Manila cemetery became one of 24 American burial grounds outside the U.S. mainland.

Nearly 125,000 Americans who perished in WWI and WWII and the Mexican War are interred in those U.S.-funded overseas cemeteries, regarded as among the most beautiful war memorials in the world. The overseas burial sites are administered by the American Battle Monuments Commission, or ABMC.

Graves date back to 1903
 The dead at Clark are not limited to World War II casualties — they date as far back as 1903. Also unlike the Manila cemetery, it continues to accept

burials. One U.S. veteran who lives in the area had his son buried here after he was killed in Iraq in 2005. But Clark is not administered by the ABMC.

The Air Force managed Clark cemetery from 1947 to 1991, when it abruptly left after nearby Pinatubo roared back to life from a 500-year slumber.

Even before the eruption, negotiations with the Philippine government for a new U.S. military lease on Clark had bogged down after nearly a century of presence in the Philippines, according to the veterans.

Philippine authorities failed to look after the cemetery. In 1994, American veterans were shocked to find it had become an ash-covered jungle of weeds, overgrown grass and debris. Half of its old steel fence had been looted.

Today, a pair of U.S. and Philippine flags flutter in the wind over the graves. A recently restored marble obelisk, pockmarked by World War II gun and artillery fire, venerates the unknown dead. A small sign at a new steel gate ushers in visitors with a tribute to the war dead: "Served with honor."

All the improvements came from donations. Wright's company spent \$90,000 to construct a new concrete and steel fence and a parking lot and make other improvements. An old veteran, confined to a nursing home in Florida, sent one dollar in a touching act, Heilhecker said.

Forlorn
 Still, the Clark gravesites look forlorn compared to the American cemetery in Manila.

A U.S. government decision to take control of the Clark cemetery could shed light on the fate of still-missing Americans, Wright said, citing the case of a U.S. Army Staff Sgt. Hershel Lee Covey, whose name is on a Clark cemetery tombstone that declared him as having died on July 17, 1942 in the Philippines.

A check by The Associated Press showed ABMC lists Covey as "missing in action or buried at sea."

Dashing the hopes of the American veterans, the ABMC and the Department of Veterans Affairs, which manages 131 U.S. mainland cemeteries through an agency, both said Clark was outside their mandate.

"Whether the U.S. government should take on responsibility for maintaining such a foreign, private cemetery is a veterans' benefits issue outside the scope of our authority," ABMC public affairs director Michael Conley told the AP in an e-mailed reply to questions.

<http://odan.usatoday.com/story/news/veterans/2012/06/23/2012-06-23/19623960>

U.S. Ambassador to Manila Harry Thomas, who has visited the Clark cemetery twice, praised the American veterans for looking after the burial grounds, which he said volunteer embassy staff and visiting U.S. sailors have helped clean up.

But he said the U.S. Congress only appropriates funds for official cemeteries overseas through the ABMC, Thomas said.

Philippine officials have authorized an American veterans' group led by Chesko to manage the Clark cemetery up to 2030, and have said they are open to allowing any U.S. agency to manage it.

"Without them, we wouldn't have this freedom now," said Felipe Antonio Remollo, president of the state-run Clark Development Corp., which oversees the former base, now a industrial and commercial hub.

'We're getting old'

Once developed and possibly turned into a war memorial, the cemetery could draw in tourists, Remollo said.

Clark's elderly veterans, some of whom become teary-eyed when reminiscing days with fallen comrades, worry about who will look after the cemetery as their ranks dwindle. Two passed away and were buried last week.

"We're getting old. We can feel it in our bones, you know, in mind and everything," said 65-year-old Chesko. He has wondered whether fallen soldiers' sacrifices still matter to young Americans.

"What bothers me sometimes is, will they still remember?" Chesko said.

The new cemetery caretaker, John Gilbert, said the veterans were not trying to pass the responsibility.

"We're proud to do it, don't get me wrong, but we do not have the resources to do it," said Gilbert. They would have no choice if Washington ignores their pleas, he said.

"We are not ready to let this cemetery be taken back by the jungle," he said. "If we have to do it ourselves, we will do it. We don't leave our brothers behind."

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PREPARED STATEMENT OF MORRIS KLEIN, ESQ., ATTORNEY AT LAW, BETHESDA, MARYLAND, AND LOIS ZERRER, ZERRER ELDER LAW OFFICE, LLC, SPRINGFIELD, MISSOURI, ON BEHALF OF THE SPECIAL NEEDS ALLIANCE

Chairwoman Murray, Senator Burr and Members of the Committee, Thank you for inviting the Special Needs Alliance (SNA) to submit testimony this morning.

The SNA is a national, not-for-profit organization of attorneys dedicated to the practice of disability and public benefits law. Our mission is to maintain a professional organization of attorneys skilled in the complex areas of public entitlements, estate, trust and tax planning, and legal issues involving individuals with physical and cognitive disabilities, including veterans with disabilities. SNA membership is based on a combination of relevant legal experience in the disability and elder law

fields, direct family experience with disability, active participation with national, state and local disability advocacy organizations, and professional reputation.

It is our privilege to provide comments on S. 3270, legislation that will impose a “look-back” period for veterans and their spouses who transferred countable assets and then seek a Non-Service-Connected Disability Pension for assistance to pay for their care needs.

NEED TO SPECIFY RESOURCE STANDARD

We respectfully request that the bill ultimately include a provision requiring the VA to specify the maximum amount of resources an applicant may retain to be eligible for benefits.

The VA does not have a clear, fixed standard as to what amount of resources an applicant may possess to be eligible for benefits. Other means-tested programs that consider resources, particularly SSI and Medicaid, have specified maximum amounts of resources (the amount for SSI is \$2,000 and the amount for Medicaid is determined by the state, usually between \$2,000 and \$4,000). Administrators at the VA apparently have discretion in determining whether a particular applicant has sufficient resources to qualify for the program. This can result in unequal treatment between applicants. A veteran can only “guess” whether the resources he or she has is low enough to be eligible for benefits. Moreover, a veteran in one region may qualify for benefits while a veteran in another region would not be eligible. This lack of consistency makes it difficult for a veteran to determine whether or not to apply for benefits. The lack of consistency is particularly disquieting now that an applicant may face a “penalty” for transferring resources. Ironically, the smaller the benefit the veteran receives, the greater the penalty (up to the 36 month maximum).

CONSIDERATION OF SPECIAL NEEDS TRUSTS

We respectfully request that the bill ultimately include a provision exempting special needs trusts from consideration as a countable resource.

The GAO suggested an eligibility scheme that is similar to other means-tested programs. Other means-tested programs, such as SSI and Medicaid, do carve out an exception for special needs trusts. A special needs trust is different than the purchase of annuities that the GAO has criticized in a recent report, and is not the type of trust contemplated or discussed as abusive. Only a person who has suffered a disability can become a beneficiary of a special needs trust. Specifically, a special needs trust allows a person who has a physical or mental disability to have assets held in trust to help pay for care needs that would not be covered by public benefits. Special needs trusts had been used for many years. In 1993, Congress explicitly authorized the use of special needs trusts for the benefit of individuals who are under the age of 65 and disabled as defined by the Social Security Administration. The assets of an individual with a disability that are placed in a properly drafted special needs trust are not considered available for purposes of qualification for SSI and Medicaid. Such trusts are irrevocable and require funds to be used only for the sole benefit of the beneficiary, and any funds remaining in the trust after the beneficiary dies must be “paid back” to the state Medicaid agency to the extent the agency paid for the beneficiary’s care. See 42 U.S.C. Section 1396d4(A).

Congress has heretofore not taken a position on special needs trusts as they apply to VA benefits. A VA General Counsel opinion (*VAOPGCPREC 33-97, VA General Counsel Opinion dated August 2, 1997*) concluded that funds in a special needs trust are counted as resources. Thus, unlike applicants for other government needs-based benefits, veterans who are applicants for the improved pension and Aid and Attendance benefits who are also beneficiaries of special needs trusts will have the funds in the trust counted as an available resource. This in effect discriminates against the veteran who is treated differently than non-veterans in their ability to set aside such funds.

We believe that there is no meaningful distinction between the treatment of special needs benefits for other public benefit programs and the VA program, and we respectfully urge the Committee to extend the current treatment of special needs trusts to VA benefits.

TRANSFERS TO CHILDREN WITH DISABILITIES

The legislation should ultimately carve out an exemption for transfers to blind and disabled children.

Continuing with the GAO suggestion that the VA eligibility standards follow other public benefit programs, this legislation should also exempt transfers to the children of veterans who are blind or disabled. Federal law for Medicaid and SSI

eligibility have exempted such transfers to blind and disabled children. See 42 U.S.C. Section 1396p(a)(2)(B) and 1396p(c)(2)(A) and (B).

ELIGIBILITY DATE AS APPLIED TO REDETERMINATIONS

The law should only apply to transfers made after the law goes into effect.

It appears clear from the language of the legislation that the imposition of a look-back period is to be applied prospectively, as the changes go into effect one year after the bill is signed into law. However, the law applies to annual redeterminations as well, and since there is a three-year look back, a beneficiary may lose benefits resulting from transfers made two years before the effective date of the law. We therefore suggest that the law be clarified to state that transfers made prior to the effective date of the law shall not be subject to the look-back period.

Thank you again for the opportunity to share these thoughts on S. 3270. The Special Needs Alliance looks forward to working with the Committee to address these technical issues in the legislation. Please let us know if we can be of further assistance.

PREPARED STATEMENT OF ANU BHAGWATI, EXECUTIVE DIRECTOR,
SERVICE WOMEN'S ACTION NETWORK

Chairman Murray and Members of the Committee: Thank you for the opportunity to present the views of the Service Women's Action Network (SWAN) concerning three bills included in this legislative hearing: S. 1391, S. 3049 and S. 3313.

SWAN is a nonprofit service organization founded to improve the welfare of current U.S. servicewomen and to assist all women veterans. SWAN offers personal support and guidance to fellow women veterans, provides legal and counseling services from military law experts and caseworkers, recommends sound policy reform to government officials, and educates the public about servicewomen's issues through various media outlets. Conceived as a support network by and for women veterans, SWAN serves all military women, regardless of era, experience, or time in service.

SWAN has been working on improving benefits for women veterans, both within the VHA and VBA as an ongoing policy priority for many years and is extremely encouraged by the engagement and leadership shown by the Committee over the years on key issues that are critical to ensuring that women veterans receive the very best in care and benefits. It is with that goal in mind that SWAN provides hearing testimony on the following bills:

S. 1391—TO AMEND TITLE 38, UNITED STATES CODE, TO IMPROVE THE DISABILITY COMPENSATION EVALUATION PROCEDURE OF THE SECRETARY OF VETERANS AFFAIRS FOR VETERANS WITH POST TRAUMATIC STRESS DISORDER OR MENTAL HEALTH CONDITIONS RELATED TO MILITARY SEXUAL TRAUMA, AND FOR OTHER PURPOSES.

SWAN fully supports S. 1391. In 2010, the VA adopted a new evidentiary standard for combat-related Post Traumatic Stress Disorder (PTSD) claims. Prior to this change, veterans filing a claim for combat-related PTSD had to demonstrate they were traumatized by a specific event by supplying incident reports, witness statements or other evidence. Since the policy change, the evidence required has been reduced to having the veteran's trauma claim related to fear of hostile military or terrorist activity and that it is consistent with the veteran's service record. The intent behind this change was to expedite and increase access to much needed disability benefits for servicemembers suffering from the invisible wounds of war.¹

However, when making these changes, the VA did not include PTSD caused by Military Sexual Trauma (MST), even if that trauma was a result of sexual assault or sexual harassment in a combat zone. By excluding MST-based PTSD claims in this procedural reform, the VA has created a double-standard and an unfair burden on women veterans who must submit additional evidence to support a service connection. This has a particularly disparate impact on women since MST is the leading cause of PTSD among women veterans, while combat trauma is the leading cause of PTSD among men.² SWAN has recently worked with a woman who had both an MST-based PTSD claim and a combat PTSD claim pending. She abandoned her MST PTSD claim and only pursued her combat PTSD claim after her MST

¹ <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1922>

² Street et al. 2008. "Sexual harassment and assault experienced by reservists during military service: Prevalence and health correlates." *Journal of Rehabilitation Research and Development* 45: 409–420; Kang et al. 2005. "The role of sexual assault on the risk of PTSD among Gulf War veterans." *Annals of Epidemiology* 15(3):191–195.

claim was repeatedly rejected even after she provided the additional evidence requested by the VA.

Additionally, SWAN has discovered through data obtained from the VA through a Freedom of Information Act (FOIA) request that there is a disparity in the approval rates of MST-based PTSD claims as compared to all other PTSD Claims, to include combat PTSD claims. Between 2008 and 2010, only 32% of MST PTSD claims were approved whereas 53% of all other PTSD claims were approved, and nearly 50% of PTSD claims from Iraq and Afghanistan veterans were approved.³

The end state of the current policy is this: For 2 out of 3 veterans who are survivors of in-service sexual assault they receive no disability benefits related to their PTSD. This lack of benefit care results in tremendous hardship for MST survivors, leading to untold mental and physical suffering, destroyed families, homelessness and suicide. This is not conjecture, it is supported by the facts: 40% of homeless women veterans report they were victims of military sexual assault,⁴ and the VA reports that the increase risk for sexual assault in the military is a factor in increased suicide among veterans.⁵

In 2011 SWAN began working with Under Secretary for Benefits, Allison Hickey to correct this disparity and create a fair policy. Initially, General Hickey was amenable to changing the policy due to the clear difference in language found in 38 CFR § 3.304(f)(3). She soon moved away from that position and instead issued a letter to the Regional Offices which did absolutely nothing to help. The RO letter simply reiterated the current policy with an added emphasis on giving the veteran's application the benefit of the doubt. She also issued instructions to increase training for claims officers but in practice, this has done nothing to improve the process. The claims officer is free to disregard the new instructions and still be justified in rejecting a MST-based PTSD claim based on the policy.

What is not understood by the VA is in many cases, it is exceedingly difficult for a veteran suffering from MST-related PTSD to produce evidence to satisfy the subjective standards of the reviewing officer. This is due in part to the nature of sexual trauma—it often takes years after the initial assault for survivors to begin to seek out help many months or years after that to begin the arduous claims process. This extended amount of time between the event and the claim is a leading cause of rejections.

Additionally, there a lack of official paperwork generated in most MST investigations, and although new policy changes have been made, there has existed for years and years, poor DOD-wide document retention policies for those forms that are produced. A new claim has the advantage of the new document retention policies, but any claim prior to 2011 does not. Finally, according to the DOD, in 2011 only 15 percent of sexual assaults are reported, which means in 85% of sexual assault cases no official paperwork even exists to support a claim. In spite of current VBA rules which allow for non-DOD evidence to aid in the determination of a service-connected disability, the VBA still routinely denies MST-related claims, even in cases where non-DOD evidence is in abundance.

Due to these systemic shortcomings that lead to ever increasing issues for veterans, in lieu of requirements for victims of in-service sexual assault to submit the corroborating evidence under the current policy, Committee support of S. 1391 is critical. The VA must extend to these claimants the same evidentiary relief it has recently afforded to veterans who experienced trauma due to operational deployment-related stressors.

S. 3049—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.

The U.S. Department of Housing and Urban Development recently changed their definition of “homeless” to include persons who flee their home due to domestic violence or sexual violence. S. 3049 would align the VA's definition of “homeless” with

³In conjunction with the ACLU, SWAN filed a Freedom of Information Act (FOIA) request to obtain data concerning gender differences in approval for MST-related PTSD claims. Based on data analyzed for fiscal years 2008–2010 SWAN discovered that only 32% of all PTSD claims related to sexual trauma are accepted. Conversely, 53% of PTSD claims overall are accepted. About half of PTSD claims filed by Iraq and Afghanistan veterans are accepted.

⁴Williamson, Vanessa and Erin Mulhall. 2009. “Invisible Wounds: Psychological and Neurological Injuries Confront a New Generation of Veterans.” New York: IAVA. ; Mulhall, Erin. 2009. “Women Warriors: Supporting She ‘Who Has Borne the Battle.’” New York: IAVA.

⁵http://www.charleston.va.gov/features/Female_Veterans_at_Higher_Risk_for_Suicide.asp

HUD's definition, pursuant to the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.⁶

SWAN supports S. 3049 and feels that aligning these definitions among Federal agencies is critical for two reasons: 1) There are established partnerships between the VA and HUD at the state level, and having parity in the definition would ensure an increased efficiency when operating together; 2) More specifically, the way in which the VA defines a "homeless person" can preclude them from getting emergency shelter or other services if they are a victim of domestic violence.

Domestic violence is a leading cause of homelessness, particularly among women and families. According to a 2008 report by the US Conference of Mayors, 28% of families were homeless due to domestic violence and 39% of cities cited domestic violence as the primary cause of family homelessness.⁷ In spite of a decrease in overall veteran homelessness, women veterans are accounting for an increasing number of homeless. According to the GAO, the number of homeless women veterans has doubled from 3.89% in 2006 to 6.32% in 2010.⁸ It is critical that the Committee support S. 3049 in order to ensure that all veterans, including those who flee unsafe and abusive situations have adequate access to emergency and transitional housing.

S. 3313—WOMEN VETERANS AND OTHER HEALTH CARE IMPROVEMENTS ACT OF 2012

SWAN fully supports S. 3313, the Women Veterans and Other Health Care Improvement Act. The provisions in this bill that would establish VA reproductive and infertility research and treatments, improve the VA's women call center, increase the number of women's counseling retreat locations from three to 14 and extend the pilot programs for assistance for child care all address extremely important issues facing women veterans, and would markedly improve the veteran's ability to receive and sustain much needed medical assistance and care. SWAN would like to comment further on the infertility provisions found in the bill.

Two weeks prior to the introduction of this bill, SWAN received a letter from a supporter named Heidi who lives in Illinois. Heidi described in detail her difficult, painful and ultimately disfiguring journey through the VA system in an effort to correct a fertility issue. She eventually sought help out-of-pocket at a non-VA hospital. There, her doctors struggled to correct the damage that had already been done. "I'm sure he did all he could," Heidi wrote, "but I was too damaged. I decided that I am not going to be able to have kids so I need to forget about it."

There is a critical need in the VA for proper research and treatment for infertility, particularly in light of the high rates of genitourinary issues including urinary tract infections (UTIs) experienced by military women. According to a study conducted in 2008 by the Defense Advisory Committee on Women in the Services (DACOWITS), for deployed female servicemembers the most common health risk is urinary tract infection.⁹ This has the long-term effect of increasing infertility specifically among military women due to the operational nature of the military. The National Institute of Health has found a vast amount of evidence linking the presence of genitourinary infection with infertility.¹⁰ It is therefore incumbent upon the VA to provide proper research and treatment for infertility for these women, and critical for the Committee to support S. 3313.

I thank the Chair and the Committee for their time and attention in reading this testimony. I am available to answer any further questions if needed.

PREPARED STATEMENT OF CHARLES HUEBNER, UNITED STATES OLYMPIC COMMITTEE

S. 3206—TO EXTEND THE AUTHORIZATION OF THE U.S. PARALYMPIC INTEGRATED ADAPTIVE SPORTS PROGRAM AND TO PROVIDE A MONTHLY ASSISTANCE ALLOWANCE TO DISABLED VETERANS TRAINING OR COMPETING FOR THE PARALYMPIC TEAM

Chairman Murray and Ranking Member Burr, and Members of the Committee, my name is Charlie Huebner and I am the Chief of Paralympics for the United States Olympic Committee ("USOC"). Thank you for the opportunity to submit a statement in support of S. 3206, which extends the authorization for the highly successful partnership between the USOC and the Department of Veteran Affairs to provide Paralympic sports activities for disabled veterans in their communities.

⁶ <http://www.hudhre.info/hearth/>

⁷ <http://www.nationalhomeless.org/factsheets/domestic.html>

⁸ GAO, *Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing*, GAO-12-182 (Washington, DC: Dec 2011).

⁹ <http://www.defense.gov/news/newsarticle.aspx?id=48827>

¹⁰ <http://www.ncbi.nlm.nih.gov/pubmed/360560>

Paralympic programs are sports for physically disabled athletes. These adaptive sports activities have become an integral part of their recovery to a full and healthy life after completing their service to our country.

In 2008 Congress passed the Veterans Benefits Improvement Act, which authorized the Department of Veterans Affairs to award grants to the United States Paralympics to “plan, develop, manage, and implement an integrated adaptive sports program for disabled veterans and disabled members of the Armed Forces.” The program did not commence until Fiscal Year 2010 and the authorization expires at the end of Fiscal Year 2013. It is imperative that Congress act this year to extend the authorization for this program to ensure there is no interruption in the services being provided to our disabled Veterans.

The USOC, which itself was created by Congress, is one of only four National Olympic Committees that manage both Olympic and Paralympic sport. We are one of only a handful of National Olympic Committees that are 100% privately funded, with our major competitors outspending us often as much as 5-to-1.

Beginning in 2003, the USOC, at the request of Congressional leaders, and the Military and Veteran community began providing technical assistance, training and leadership in providing programs to injured servicemembers and Veterans, with a focus on developing sustainable programming at the community and installation level.

The USOC has a strong history and expertise in more than 47 sports (including non-Paralympic sports). We have expertise in serving persons with a variety of physical disabilities. The USOC has inspiring Olympic and Paralympic ambassadors that compel partners and competing organizations to collaborate for a common cause. With more than 50 member organizations like the National Recreation and Parks Association and USA Hockey, we have a membership infrastructure of community sport organizations that touch thousands of U.S. communities, and allow for financial and programmatic efficiencies and significant private sector investment.

Because of the extraordinary increase in need, in 2008 the USOC began accepting Federal funding for these programs, while continuing to expend considerable private resources in support of these efforts. The majority of these funds are distributed via grants to community sport organizations to implement and develop local program.

The Paralympic Movement began shortly after World War II utilizing sports as a form of rehabilitation for injured military personnel returning from combat. Injured military personnel and Veterans are the soul of the Paralympic movement. When discussing the Paralympic movement, we are not just talking about a small number of elite athletes that will make future Paralympic teams. Rather, we are referring to the thousands of disabled active duty military personnel and Veterans that have participated in the growing number of physical activity programs created throughout the United States under the leadership of the USOC and our community partners—like Paralyzed Veterans of America, Disabled Sports USA, USA Shooting, and Metro Tacoma Parks and Recreation—that allow Veterans with physical disabilities an opportunity to re-engage in life by simply skiing with their buddies or playing in the backyard with their kids. As programming expands daily, we see a population that has lower secondary medical conditions, higher self-esteem, lower stress levels and higher achievement levels in education and employment. Increasingly, empirical research specific to this population is beginning to bear this out. More importantly, we see a population that inspires all Americans to pursue excellence, in sports and in life.

We cannot emphasize enough the importance of our more than 200 partner organizations located in more than 170 communities and 47 states, and the District of Columbia. The Federal funding that the Veterans Integrated Adaptive Sports program has provided has enabled these organizations to leverage many millions of dollars more to provide the full range of Paralympic sports programming to our Veterans. We are proud to have the support and partnership of groups including the American Legion, The Fisher House Foundation, the Blinded Veterans Association, and the USO in endorsing S. 3206.

We are also proud that our leadership, and our partners, accepted the responsibility to serve those who have served us. Because of your leadership in developing and providing funding for this USOC and VA partnership, we are able today to report on the several accomplishments that have been reached since the launch of the program in June 2010. Our primary emphasis in the first two years was to meet the immediate need to develop programming for the thousands of disabled Veterans returning to their communities and hometowns. Since June 2010, the VA, USOC and our more than 200 partners have:

- Distributed more than 300 grants to community sport organizations to develop sustainable activity programs for disabled Veterans returning to their hometowns.

- These community programs are investing millions of dollars in private resources, combined with grants from the VA-USOC grant pool, to reach thousands of veterans with a focus on sustainable and consistent physical activity at the local level.
- The VA and USOC have emphasized and led an effort to promote collaboration between the DOD, VA, and community sport organizations to recognize and enhance programmatic and financial efficiencies. To date, grant recipients have collaborated and partnered with over 70 VA and DOD medical facilities across the country.
- Created the Paralympic Resource Network, an online database of Paralympic programs nationally which is designed to link individuals with physical and visual disabilities to sports programs in their communities.
- Launched successful regional Pilot programs to test approaches for veteran recruitment and programming strategies that can be replicated in other areas in five locations including: Chicago-land area; New England; Northern California; Georgia/Southeast region; and Texas/Gulf State area.
- Inaugurated the VA Rehabilitative Adaptive Sports Conference that provided VAMC personnel and leadership with the tools, resources, and training necessary to successfully develop and implement adaptive sport and recreation programs for disabled veterans at VA facilities by collaborating with external community partners.
- Distributed training stipends to over 90 Veteran athletes; 40 of these athletes have met the national team standard in their respective sports.

Again, we felt it was imperative in the first two years to focus the majority of our efforts on development and expansion of sustainable programs at the community due to the significant volume of Veterans returning home. Based on our experience in collaborating with the VA and feedback from the congressional committees of jurisdiction and our community partners, we recognized that program development should shift to a more regional focus and enhanced oversight and monitoring needed to be put in place with respect to program resources, generally, and the growing number of sub-recipients. While sustainable and consistent program development is a continued focus, we have already proactively made adjustments in collaboration with the VA to accomplish the following:

- Increase resources devoted to program oversight and monitoring in light of the expanded number of grant participants. This includes increasing our oversight beyond a self-reporting system, with desktop and personal site visits to grantees. With pro-bono services provided by a leading consultant firm, the USOC and VA have developed and instituted a new grant monitoring process, initiated internal audits of grant sub-award recipients, and re-deployed three USOC staff members to focus 100% on monitoring and oversight. In year one and two, staff that was also focused on developing programming, were also responsible for monitoring and oversight. We have determined that with more than 200 program partners and an estimated 150 grant recipients, it was not feasible for the program staff to also be responsible for monitoring and oversight. Please find attached the updated monitoring plan that the re-deployed staff are aggressively implementing and will meet.
- In 2011 and 2012, the USOC declined to accept the federally-allowed administrative fee of five percent (5%), allowing an estimated \$700,000 to be re-invested into programming and grants.
- Enhance awareness and educational materials of the impact and importance of consistent physical activity for Veterans at the national, regional and local level. For example, in a recent public and privately-funded initiative around the USOC-hosted Warrior Games, the USOC and VA reached more than 67.0M Americans with educational programming about the importance of sport in the rehabilitation process.
- Recommend additional resources to support VA—USOC regional coordinators that can enhance collaboration and impact of programs in targeted regions throughout the United States. The emphasis on developing and sustaining collaboration among competing entities is a critical and time-consuming aspect to this cost efficient strategy. We believe a neutral entity must lead this effort.
- Continue to increase the number of community partners that are providing much-needed sport and recreation programs, primarily at their cost, at the local level for the disabled Veteran population.

In closing, I would like to highlight one program that embodies all of our strategies, collaboration, training, technical assistance, awareness and financial support, along with an emphasis on hiring Veterans. Joe Brown is originally from Arizona. His family has a strong military history. His grandfather died as a POW during the Korean War. His father was an Air Force fighter pilot. Joe played football at the Ohio State University and three years in the NFL. But the Army Rangers were con-

tinually calling, so he joined the Army, the Rangers, and deployed to Iraq in 2004 and again in 2007.

During his 2007 tour he was calling in air strikes atop a three-story building, trying to help a unit in trouble. As his unit was leaving the building, Brown fell down a 30-foot shaft, suffering a severe brain injury. Brown knew the importance of physical activity and sport in the rehabilitation process. He attended the USOC VA Paralympic Leadership Conference to gain valuable training and connect with other organizations and agencies in his region. He pursued a position in the parks and recreation industry near a military facility so he could serve injured servicemembers and Veterans. He was hired by Harker Heights Parks and Recreation outside of Ft. Hood, Texas. Harker Heights was awarded a \$23,000 VA-USOC grant in 2010. Joe leveraged that initial grant and has built a sustainable, on-going program that serves more than 80 veterans who can now participate in an array of physical activity programs under Joe's leadership.

I would like to thank the Committee, the VA leadership, particularly Secretary Eric Shinseki; Mike Galloucis, Executive Director of the Department of Veterans Affairs' Office of Public and Intergovernmental Affairs; Chris Nowak, the Director of the VA's National Veterans Sports Programs and Special Events; our organizational partners in carrying out this program; of course, Senators Boozman and Begich, who introduced S. 3206, and other Members of the Committee who have joined them in cosponsoring this legislation that extends a program that is so critical to supporting our Nation's finest.

LETTER FROM HEATHER L. ANSLEY, ESQ., MSW, VICE PRESIDENT OF VETERANS
POLICY, VETSFIRST

VETSFIRST, A PROGRAM OF UNITED SPINAL ASSOCIATION,
Washington, DC, July 5, 2012.

Hon. BARBARA BOXER
*112 Hart Senate Office Building
U.S. Senate, Washington, DC.*

DEAR SENATOR BOXER: VetsFirst, a program of United Spinal Association, wishes to express our support for S. 1806, which would allow individuals to designate tax overpayments as contributions to a fund for homeless veterans. This legislation would supplement the efforts of the Department of Veterans Affairs (VA) and other agencies that assist homeless veterans and their families.

Homelessness among veterans and their families is a critical problem that requires the attention of all Americans. Homeless veterans represent all eras of military service, including those who served in Iraq and Afghanistan. Our nation must provide the services and supports needed by homeless veterans to ensure that current and future generations of veterans will no longer endure homelessness.

VetsFirst believes that this legislation will allow Americans the opportunity to personally invest in our nation's homeless veterans. The creation of the Homeless Veterans Assistance Fund will provide a new source of revenue to help our homeless veterans and their families, not supplant current efforts by VA and other agencies. Ending homelessness among our nation's veterans will require access to housing, health care, and employment. The additional funds provided through this legislation will give an important boost to already occurring assistance.

We appreciate your leadership on this issue and urge swift passage of this critical legislation that will help to eliminate and prevent homelessness for our nation's veterans and their families. If you have any questions, please contact Heather Ansley, Vice President of Veterans Policy, at (202) 556-2076, ext. 7702 or by e-mail at hansley@vetsfirst.org.

Sincerely,

HEATHER L. ANSLEY, ESQ., MSW,
Vice President of Veterans Policy.

LETTER FROM DENNIS L. WRIGHT, CAPTAIN, U.S. NAVY (RETIRED),
CHAIRMAN, CLARK VETERANS CEMETERY RESTORATION ASSOCIATION



**Written Statement for the Record
Of the Clark Veterans Cemetery Restoration Association (CVCRA)**

**Submitted to the U.S. Senate, Committee on Veterans Affairs,
Wednesday, June 27, 2012**

**Submitted by
Captain Dennis L. Wright, U.S. Navy (Retired)
Chairman, Clark Veterans Cemetery Restoration Association (CVCRA)**

Chairman Murray, members of the Committee, I am Chairman of the Clark Veterans Cemetery Restoration Association (CVCRA) speaking on behalf of S2320 which was introduced by Senators Kelly Ayotte and Mark Begich with ten additional bipartisan co-sponsors, a bill aptly named "Remembering America's Forgotten Veterans Cemetery Act of 2012".

This Act is a simple piece of legislation. It will correct a tragic oversight by our government when it abandoned and then forgot over 8,300 veterans and their dependents who were interred in the Philippines during the period from 1900 to 1991. The facts are irrefutable:

- The Clark Veterans Cemetery (CVC) is, was, and always has been a military post cemetery
- For 91 years it was exclusively managed by a Branch of our U.S. Armed Forces
- There are Veterans buried in the cemetery that served in every war since the Civil War
- There are 1,054 Unknown Dead "Soldiers, Sailors and Marines" who died during the Spanish and Philippine American Wars (SAW/PAW) with a Monument dedicated in 1908 to commemorate their service
- The CVC was created in 1948 to consolidate multiple older non-WWII military cemeteries scattered throughout the Philippines, and more importantly, to make room for the new WWII Memorial and Cemetery in Manila - - which would not exist today if over 5,000 veterans and dependents who died 1900-1945 and already buried there were not disinterred and reinterred in the new military cemetery for non-WWII dead at Clark
- When the USAF closed Clark AFB in 1991, no provision was made for its perpetual care
- In 1994, after being embarrassed by the decay and deterioration of the cemetery, volunteers from local VFW Post 2485 did their best to restore a minimum level of dignity
- VFW Post 2485 continues to administer the cemetery today solely through donations with several American companies lending their support to build a new perimeter fence and gates, provide security, erect a new memorial plaza, conducted research and creation of an on-line data base with photos of each headstone and history as the research is completed.

- Since the VFW assumed responsibility in 1994, they have buried 400 additional veterans, including one killed in action in Fallujah, Iraq in 2004.
- The annual out-of-pocket cost VFW Post 2485 expends is \$25,000 per year for the six day laborers who maintain the landscaping and assist with burials of veterans.

The solution is equally simple. Congress must do the right thing and direct the American Battle Monuments Commission to assume responsibility for the perpetual care and administration. There is no real budget impact unless one imagines \$25,000 per year, today raised solely through donations, to be a budgetary impact.

We know ABMC will object to this bill. Please do not be misled. ABMC does maintain another active cemetery in Panama, which is virtually identical to the situation at Clark, except Clark is much more historic with SAW/PAW war dead. It also manages another non WWI/WWII site in Mexico. Further, ABMC presently manages two other existing sites in the Philippines, the Cabanatuan POW Memorial 90 minutes to the north, and the Manila WWII Memorial and Cemetery 90 minutes to the south. This “is” ABMC’s mission and ABMC “is” authorized today in 36 USC 21 if they chose to do it or more importantly interpret it that way. Don’t let ABMC throw up a smoke screen. Also, please do not get distracted by red herrings. There is no cost impact for ABMC to accept the cemetery today in its “AS IS” condition. Then over time, with their expertise and professional management team, ABMC can properly develop a plan to restore the CVC to its rightful place in history with dignity and respect for those who “Served With Honor”, the motto of the cemetery.

In summary, thanks to the VFW volunteers and the generosity of several small American companies, the cemetery has been restored to a modest level of decorum and dignity. It is not a difficult task then for the Senate to task AMBC to assume what volunteers have done for the past two decades - - immediately assume responsibility and then plan for an orderly restoration in the out-years.

A bi-lateral agreement will be required between the U.S. and Philippine Government, and the Philippine Government has already asserted, that while it will not cede control or ownership, it will honor a request by the U.S. Government to “care and administer” the cemetery and to take over from the VFW volunteers. Again, please to not be misled by smoke screens from ABMC or others. Senate Resolution 481 has set the framework for bi-lateral cooperation. **The solution is quite simple.** It ranges from a simple Usufruct Agreement to a Diplomatic Note or other form of a Memorandum of Agreement. Also please keep in mind that the majority of ABMC sites, including both of those in the Philippines, are covered by similar Memorandums of Agreement or Diplomatic Notes.

I urge the Committee to take note of the broad base and overwhelming level of support for the CVC from across the nation. Of note are written letters, resolutions and deeds to include:

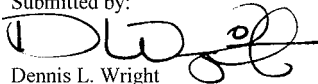
★ ★ ★ ★ ★

The American People Thank

- Senate Resolution 481 with specific language in support of CVC
- American Legion National Resolution 60
- TMC letter of support - - signed by 32 of their affiliated organizations
- NMVA letter of support
- AFSA letter of support
- MOAA letter of support
- Okaloosa Country Republican Executive Committee Resolution
- 21 organizational Allies declaring their support on our web site at www.cvcra.org with direct links and use of their logos
- VFW Department of the Pacific Resolution which will be presented at the VFW National Convention next month and is expected to pass
- CALVETS Flags for the Fallen Project with local northern California schools donating and sending 1,500 flags for CVC graves
- A young 5th Grader from Avon, Indiana who has gathered over 800 signatures on a CVC Petition of support

Madam Chairman, I thank you and your Committee for your on-going stewardship of important issues in support of, and on behalf of, our Veterans. Please keep in mind that this issue is very, very important to our Military, our Veterans, their families and their friends as attested in the overwhelming support, resolutions and endorsements I have just shared with you. We are asking you and your colleagues to do the right thing - - to see and recognize this as **a simple issue, with a simple solution**. Please approve S2320, Remembering America's Forgotten Veterans Cemetery Act of 2012, as written.

Submitted by:



Dennis L. Wright
Captain, U.S. Navy (Retired)
Chairman, Clark Veterans Cemetery Restoration Association
US: 703-362-3212 or Philippines: +63-999-888-1111 and email: dwright@peregrinedc.com

Attachments:

1. Senate Resolution 481
2. American Legion National Resolution 60
3. TMC letter of support - - signed by 32 of their affiliated organizations
4. NMVA letter of support
5. AFSA letter of support
6. MOAA letter of support
7. Okaloosa Country Republican Executive Committee Resolution
8. Excerpt page from CVCRA web site with other organizations of support
9. VFW Department of the Pacific Resolution
10. CALVETS Flags for the Fallen Project
11. Frequently Asked Question (FAQ) about CVC

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"LET US NOT FORGET THEM"

[Attachments listed were not submitted to the Committee.]

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

Chairman Murray, Ranking Member Burr and Members of the Committee: Wounded Warrior Project (WWP) welcomes your consideration today of the Mental Health Access to Continued Care and Enhancement of Support Services (ACCESS)

Act of 2012, and is very pleased to offer our views on its important provisions to improve and enhance VA behavioral health programs.

This Committee's painstaking and patient conduct of a series of hearings regarding the performance of VA's mental health care system has made clear that—despite the dedicated efforts of its mental health clinicians—the Department of Veterans Affairs (VA) is not meeting its fundamental obligation of providing timely, effective mental health care to veterans of Operations Enduring Freedom, Iraqi Freedom and New Dawn (OEF/OIF/OND) who are struggling with combat-related mental health conditions.

We applaud the Committee's oversight work and welcome VA's recent plan to increase its mental health staffing. While an important initiative, it is only a partial, and still-untested step, in the context of addressing wide-spread challenges.

For years, VA has reported to Congress on the health care utilization of OEF/OIF/OND veterans. These data indicate that a relatively high percentage of these veterans have accessed VA medical facilities, and a significant percentage have been "seen" and diagnosed (or provisionally diagnosed) with a mental disorder. But these often updated and somewhat misleading reports are silent as to whether, for example, veterans have continued in treatment or reported improved. In that regard, one of the leading researchers on the mental health toll of the conflicts in Iraq and Afghanistan, Dr. Charles W. Hoge, has provided a more disturbing snapshot, underscoring real gaps in the VA mental health system:

"* * * veterans remain reluctant to seek VA care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out * * * With only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."¹

The Committee's oversight has most effectively identified, documented, and sparked VA action on some of the most glaring problems of timeliness and access. But VA's responses—initially denying staffing problems, and subsequently hurriedly reversing course—create the impression of reactionary work with little substantive strategic planning. VA does not provide confidence that effective systems are in place or will be put in place to assure that wider gaps in the system will be closed or even that warriors will not re-experience in a year or two the kind of timeliness and access problems the Committee identified over the course of three hearings. We concur, therefore, that strong legislation is needed, and welcome the Committee's consideration of Title II the bill which offers promise of markedly improving veterans' access to needed treatment. WWP strongly supports those provisions.

This legislation addresses important issues, while also implicitly recognizing the need for further and perhaps deeper analysis. Given the complexity of VA's mental health system, the variability of veterans' experience from facility to facility, the unreliability or absence of key data (as discussed in your most recent hearing on VA mental health), it is critical that VA seek a comprehensive independent, expert assessment to help assure that warriors will have reliable access to timely, effective mental health care across the system. We, therefore, applaud the inclusion in this measure of a requirement that VA contract with the National Academy of Sciences (NAS) to conduct a comprehensive assessment of VA mental health care (to include assessing barriers to care for OEF/OIF/OND veterans, the quality of care, and the range of services provided) and to provide VA specific detailed recommendations. NAS has served VA well in the past. We believe it can provide very helpful recommendations on overcoming barriers and improving access to timely, effective mental health care as well as on improving the effectiveness and efficiency of VA mental health services. Recommendations from a prestigious body (which under the bill would rely on a panel including members with VA expertise and experience) should provide a strong foundation for closing critical gaps that result in warriors never seeking needed treatment, dropping out of treatment prematurely, or simply not thriving despite getting some care. We also see real benefit in the bill's requiring VA to consult with NAS in developing and implementing staffing guidelines and other measures to assess timeliness, patient-satisfaction, capacity and provision of evidence-based therapies.

Importantly, warriors consistently express high satisfaction with the experience of getting help from Vet Centers. They cite relatively unique aspects of that experience, including the opportunity to work with clinicians who are themselves are often combat veterans and understand the warrior-experience; Vet Centers' outreach-fo-

¹ Charles W. Hoge, M.D., "interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," *JAMA*, 306(5): (August 3, 2011) 548.

cused approach; and access to family services. As such, we appreciate the bill's focus on Vet Center services and the organizational status, funding and planning for the Readjustment Counseling Service. We also applaud the bill's clarifying that Vet Center staff can play an important outreach role and foster warriors' readjustment by participating in recreational, rehabilitative programs such as WWP's Project Odyssey.

This bill is also important in recognizing that communities can play an important role in providing veterans access to needed mental health services and fostering their reintegration, and that VA can be an invaluable partner in such community efforts. We welcome the encouragement the bill provides VA to partner with community groups in support of those efforts, as well as the important direction that VA provide training in military culture and combat experience to clinicians who would be providing mental health services through such community initiatives.

Finally, we applaud the bill's requirement that every VA medical center provide for peer outreach and peer support services. With too many veterans either still reluctant to seek mental health care or dropping out of care, the importance of peer-outreach and peer-support cannot be overemphasized.

We look forward to working with the Committee to advance these important provisions in furtherance of ensuring that warriors are able to get timely, effective mental health care.

TESTIMONY SUBMITTED BY SENATOR BARBARA BOXER OF CALIFORNIA
LETTER FROM AMVETS DEPARTMENT OF CALIFORNIA SERVICE FOUNDATION



"Committed To Serve...Those Who Served"™

June 8, 2012

The Honorable Barbara Boxer
United States Senate
Washington, D.C. 20510

Re: Check the Box Homeless Veterans Act

Dear Senator Boxer:

On behalf of the membership of the AMVETS Department of California and Department of California Service Foundation, I am proud to offer our organization's support for S. 1806, known as the Check the Box for Homeless Veterans Act. This important legislation will give taxpayers the opportunity to support funding for vital programs that aim to eliminate homelessness among veterans.

As you may know, AMVETS Department of California is a veterans' service organization that includes veterans from wars of all eras who received an honorable discharge, as well as current service members. We have more than 12,000 members statewide and maintain more than 50 posts across the Golden State. Our organization receives financial support from our Service Foundation, which generates revenue through the operation of several thrift stores in the state.

Over the past year, our members have given our leadership a mandate to advocate for policies that will reduce homelessness among veterans statewide, with a particular emphasis on the severe homeless veterans problem in the Los Angeles area. As you know, approximately 10 percent of all homeless veterans nationwide are located in the Los Angeles region. Therefore, remedying the homeless veterans problem in L.A. is essential to meeting Secretary Shinseki's goal of eliminating homelessness among veterans.

Over the past year, we have advocated for state and federal officials to devote more resources to reducing veterans' homelessness in L.A. We are pleased that the current array of programs to combat veterans' homelessness has helped reduce the number of homeless veterans over the past three years, in Los Angeles, in California, and across the United States. Even as we encourage lawmakers to consider new, innovative methods to further reduce veterans' homelessness, we recognize that current programs – including HUD-VASH supportive housing vouchers, the Grant and Per Diem program, and the Supportive Services for Veteran Families program – are having a significant impact and must be augmented.



We are pleased that your Check the Box for Homeless Veterans Act will provide an alternate stream of funding for current and future homeless veterans programs to ensure that they are unaffected by the unpredictable congressional appropriations process. Specifically, S. 1806 would give taxpayers the option to check a box on their annual tax return (or at any other time allowed under federal regulations) and to voluntarily donate any amount above \$1.00 to a new Homeless Veterans Assistance Fund. The donations to the fund would be used to provide assistance to homeless veterans through the programs administered by the Departments of Veterans Affairs, Housing and Urban Development, and Labor. To ensure accountability, these three departments will describe how they used the funds from the Homeless Veterans Assistance Fund during the previous fiscal year and will propose future use of such funds for the upcoming fiscal year in the President's annual budget submission.

We appreciate your decision to take the initiative in introducing this important legislation with your colleagues, Senators Begich and Merkley. Your introduction of this bill serves to reaffirm the strong support you have shown for California's veterans over the years. Our leadership and our members look forward to working with you to promote the Check the Box for Homeless Veterans Act and to encourage your colleagues in the Senate to advance it through the legislative process.

Thank you for your strong support for reducing homelessness among our fellow veterans.

Yours in Team AMVETS,



Jim Pidgeon
President
AMVETS Department of California Service Foundation



PREPARED STATEMENT OF BRIAN A. HAMPTON, MAJ. USAR (RET.), PRESIDENT,
CENTER FOR AMERICAN HOMELESS VETERANS, INC.



California Association of Veteran Service Agencies

★ *Training, Housing & Counseling for California Veterans* ★

Swords to Plowshares ★ New Directions ★ Vietnam Veterans of California, Inc. ★ U.S. Veterans Initiative ★ Veterans Village of San Diego

June 6, 2012

Stephen Peck
President
U.S.VETS

Phil Landis
Vice President
Veterans Village
of San Diego

Michael Blecker
Secretary
Swords to Plowshares

Peter Cameron
Member
Vietnam Veterans
of California

Gregory Scott
Member
New Directions

The Honorable Barbara Boxer
United States Senate
112 Hart Senate Office Building
Washington, D.C. 20510

RE: Support for S.1806

The California Association of Veteran Service Agencies (CAVSA) is writing in support of S.1806; *Check the Box for Homeless Veterans Act of 2011*, introduced by Senator Barbara Boxer. A consortium of five non-profit veterans' service providers, CAVSA provides housing, employment, training, education, and mental health services to address the needs of veterans and their families. Annually, CAVSA serves over 10,000 veterans throughout the state from Eureka to San Diego - the majority of whom suffers or is at risk of suffering the devastating effects of homelessness.

If enacted, the *Check the Box for Homeless Veterans Act of 2011*, will establish in the U.S. Treasury the *Homeless Veterans Assistance Fund*. Taxpayers will have the opportunity to voluntarily contribute to the fund by "checking the box" on their annual tax return. The donations collected in the Treasury will be used to supplement Congressional appropriations directed to the Department of Veterans Affairs, Department of Housing and Urban Development, and Department of Labor initiatives with the goal of eliminating veteran homelessness.

Not only is S.1806 a simple yet effective way to raise funds to combat the epidemic of homelessness among veterans, but it also provides an opportunity for all Americans to show their support and appreciation for our troops who have sacrificed so dearly in service to our great nation.

STEPHEN PECK
820 W. 6th Street, Ste. 1505
Los Angeles, CA 90017
213.542.2606
213.542.5195 FAX
speck@usvetsinc.org

CAVSA thanks you for your leadership in support of America's military veterans with the introduction of S.1806, and we contribute our efforts to ensure its passage.

Sincerely,

Michael Blecker
Secretary

LETTER FROM THE CALIFORNIA ASSOCIATION OF VETERAN SERVICE AGENCIES



210 F. Broad St., Suite 202
Falls Church, VA 22046

Telephone: (703) 237-8980
Fax: (703) 237-8976

Letter of Support

14 November 2011

Nationwide Veterans' Advocacy Group Cheers the Check the Box for Homeless Veterans Act of 2011

The Center for American Homeless Veterans gives its enthusiastic and unequivocal support to Senate Bill S.1806, also known as the *Check the Box for Homeless Veterans Act of 2011*. The simple addition of this checkbox to IRS tax forms will create a Homeless Veterans Assistance Fund that will specifically target the needs of our homeless veterans and go a long way toward alleviating their sufferings. Furthermore, the revenue neutral nature of the bill will ensure that veterans are provided with better services without adding to the Federal deficit.

On any given night, there are over 100,000 homeless American veterans on our streets. An additional 1.5 million are considered to be at risk of homelessness. With tens of thousands of troops returning from combat zones in Iraq and Afghanistan, this number is only set to grow.

Our veterans remain at high risk for homelessness for many of the same reasons as those who did not serve. However, several additional factors contribute to veteran homelessness. Many of our veterans return from overseas to find that their jobs have been taken and that the military skills they developed do not transfer to the civilian workplace. Worse yet, employers often refuse to hire members of the National Guard and Army Reserve on the grounds that they may be deployed overseas. Finally, the physical and psychological burdens of serving in combat zones have left many veterans unable to successfully transition to civilian life and unable to work.

The flagship enterprise launched in 1993, the Center for American Homeless Veterans has since held 200 forums/receptions and rallies nationwide featuring more than 100 leading members of Congress and over 30 top members of the U.S. Department of Defense to highlight the plight of our veterans. Along the way, the Center has highlighted dozens of transitional facilities that are at the forefront of a nationwide effort to provide better services to American veterans. The Center continues to work with leaders on Capitol Hill to ensure that our veterans are a top national priority and that their needs are met!

The Center for American Homeless Veterans cannot emphasize enough its support for the *Check the Box for Homeless Veterans Act of 2011*. *Check the Box* will allow taxpayers to give back to the men and women who fought to defend the freedoms we Americans enjoy and will provide our veterans with additional services at no additional cost to the government.

Sincerely,

Brian A. Hampton
MAJ USAR (ret.)
President
Center for American Homeless Veterans

LETTER FROM THE NATIONAL COALITION FOR HOMELESS VETERANS



NATIONAL COALITION FOR HOMELESS VETERANS
333 1/2 Pennsylvania Avenue, NE
Washington, DC 20003-1148
202-546-1969 / 800-VET-HELP
Website: www.nchv.org Email: info@nchv.org

Nov. 11, 2011

The Honorable Barbara Boxer
United States Senate
112 Hart Senate Office Building
Washington, DC 20510

Dear Senator Boxer:

The National Coalition for Homeless Veterans (NCHV) would like to formally indicate its support for S. 1806, the “Check the Box for Homeless Veterans Act of 2011.” This bill would serve a critical function in the homeless veterans assistance community, which is ramping up to end veteran homelessness by 2015.

Limited federal funds for homeless veterans assistance are often concentrated in heavily populated areas. A significant number of community- and faith-based service organizations that already serve veterans – particularly those outside of metropolitan areas – are at a disadvantage when competing for federal funds. Yet the veterans served by these organizations require the same help to reintegrate into society.

The Homeless Veterans Assistance Fund created through this act could be authorized to support several high-demand activities, such as:

- Short-term housing stability for homeless, extreme low-income veterans
- Child care assistance for single veterans in employment assistance programs
- Transportation assistance to medical and employment services
- Security deposits and utility hook-up fees for housing placements
- Clothing, uniforms and tools for employment

The simple act of checking a box would enable taxpayers to prevent and end homelessness for those who have served this country in a way increasingly few Americans ever will. By supplementing proven federal programs, the “Check the Box for Homeless Veterans Act of 2011” will have a strong and lasting impact in communities nationwide.

Thank you for your commitment to serving our veterans in crisis. We are proud to stand as your ally.

Sincerely,

John Driscoll
President & CEO

Mission: The National Coalition for Homeless Veterans will end homelessness among veterans by shaping public policy, promoting collaboration, and building the capacity of service providers.

LETTER FROM MICHAEL BLECKER, EXECUTIVE DIRECTOR, SWORDS TO PLOWSHARES



VETS HELPING VETS SINCE 1974

Board of Directors

June 6, 2012

The Honorable Barbara Boxer
United States Senate
112 Hart Senate Office Building
Washington, D.C. 20510

RE: Support for S.1806

Swords to Plowshares is writing in support of S.1806; *Check the Box for Homeless Veterans Act of 2011*, introduced by Senator Barbara Boxer. Swords to Plowshares has provided permanent/supportive housing, employment/training, and supportive services for homeless veterans since 1974. Historically, veterans are disproportionately represented among the homeless population throughout the country. California is certainly no exception – veterans account for 11% of the states population, however nearly one out of three Californians suffering from homelessness has served in the military.

If enacted, the *Check the Box for Homeless Veterans Act of 2011*, will establish in the U.S. Treasury the *Homeless Veterans Assistance Fund*. Taxpayers will have the opportunity to voluntarily contribute to the fund by “checking the box” on their annual tax return. The donations collected in the Treasury will be used to supplement Congressional appropriations directed to the Department of Veterans Affairs, Department of Housing and Urban Development, and Department of Labor initiatives with the goal of eliminating veteran homelessness in communities throughout the country.

Advisory Board

Not only is S.1806 a simple yet effective way to raise funds to combat the epidemic of homelessness among veterans, but it also provides an opportunity for all Americans to show their support and appreciation for our troops who have sacrificed so dearly in service to our great nation.

I thank you for your leadership in support of America’s military veterans with the introduction of S.1806, and I contribute our efforts to ensure its passage.

Sincerely,

A handwritten signature in dark ink, appearing to read "Michael Blecker", is written over a light blue horizontal line.

Michael Blecker
Executive Director
Swords to Plowshares

LETTER FROM RAYMOND C. KELLEY, DIRECTOR,
NATIONAL LEGISLATIVE SERVICE, VFW



VETERANS OF FOREIGN WARS OF THE UNITED STATES

www.vfw.org | info@vfw.org

June 14, 2012

The Honorable Barbara Boxer
United States Senate
112 Hart Senate Office Building
Washington, DC 20515

Dear Senator Boxer,

On behalf of the over 2 million members of the Veterans of Foreign Wars and our Auxiliaries, I would like to offer support for your draft legislation that would amend the Internal Revenue Code of 1986 to allow taxpayers to designate overpayments as a contribution to the homeless veterans' assistance fund.

This important legislation would help continue many homeless veterans programs that are critical today to keeping veterans off the streets. On any given night, more than 67,000 veterans are homeless, and this fund will help support the programs that assist those veterans. We are pleased to know that the intent of this bill is to increase funding for combating veterans homelessness, rather than supplanting existing appropriations.

We believe this legislation is a great way to honor and give back to those who have sacrificed so much for our Nation. Thank you for concentrating on the changes that can make all the difference in the lives of veterans and their families. The VFW commends you and we look forward to working with you and your staff to ensure the passage of this most important legislation. Thank you for your continued support for America's veterans

Sincerely,

Raymond C. Kelley, Director
VFW National Legislative Service

TESTIMONY SUBMITTED BY SENATOR DEAN HELLER OF NEVADA
LETTER FROM FANG A. WONG, NATIONAL COMMANDER, THE AMERICAN LEGION



★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 263-2986 ★



OFFICE OF THE
NATIONAL COMMANDER

June 26, 2012

The Honorable Dean Heller
United States Senate
361-A Russell Senate Office Building
Washington, DC 20510

Dear Senator Heller:

On behalf of the 2.4 million members of The American Legion, I would like to express support for S. 3308, *the Women's Homeless Veterans Act*, which would expand two grant programs administered by the Department of Veterans Affairs (VA): the Homeless Providers Grant and Per Diem (GPD) Program, and the Grant Program for Homeless Veterans with Special Needs, which is available to GPD Program grantees.

The GPD Program has been the foundation of community-based homeless veteran assistance since 1992. With more than 14,000 beds nationwide, the GPD Program is most often the first and most significant step toward recovery for about 30,000 veterans experiencing homelessness each year. By helping homeless veterans attain adequate income support, independent housing and self-sufficiency, the program is largely accountable for the more than 60 percent reduction in veteran homelessness since 2004.

Currently, the GPD Program lacks the authority to directly serve veterans' dependent children. As a result, veteran families are either forced to split up or denied entry into the program. S. 3308 would amend the GPD Program's regulations to allow veterans' dependent children to directly receive services through the program. S. 3308 would also address a deficiency in the Special Needs Grant Program, which is currently authorized at \$5 million. This funding level is not sufficient to adequately serve the program's target populations—particularly veterans with dependent children.

Furthermore, S. 3308 would raise the Special Needs Grant Program's authorization to at least 15 percent of the total authorization for the Grant and Per Diem Program. This would help to ensure that the necessary capital funding is available to provide safe, private and secure facilities for homeless women veterans and single homeless veterans with dependent children.

Once again, The American Legion fully supports this legislation and we appreciate your leadership in addressing the issues that are important to America's veterans and their families.

Sincerely,

A handwritten signature in black ink, appearing to read "F. Wong".

FANG A. WONG
National Commander

LETTER FROM MATT GORNICK, POLICY ASSISTANT DIRECTOR,
NATIONAL COALITION FOR HOMELESS VETERANS



NATIONAL COALITION for HOMELESS VETERANS
337 M Pennsylvania Avenue NE
Washington, DC 20003-1159
202-546-1969 / 800-NCHV-4433 P
Website: www.nchv.org Email: info@nchv.org

June 25, 2012

The Honorable Dean Heller
361-A Russell Senate Office Building
Washington, DC 20510

Dear Senator Heller,

The National Coalition for Homeless Veterans (NCHV) would like to formally indicate its support for S. 3308, a bill to improve the furnishing of benefits for homeless veterans who are women or single veterans with dependent children. The bill would directly impact two grant programs administered by the Department of Veterans Affairs (VA): the Homeless Providers Grant and Per Diem (GPD) Program, and the Grant Program for Homeless Veterans with Special Needs, which is available to GPD Program grantees.

The GPD Program has been the foundation of community-based homeless veteran assistance since 1992. With more than 14,000 beds nationwide, the GPD Program is most often the first and most significant step toward recovery for about 30,000 veterans experiencing homelessness each year. By helping homeless veterans attain adequate income support, independent housing and self-sufficiency, the program is largely accountable for the more than 60 percent reduction in veteran homelessness since 2004.

At present, however, the Grant and Per Diem Program lacks the authority to directly serve veterans' dependent children. As a result, veteran families are either forced to split up or be denied entry into the program. S. 3308 would amend the GPD Program's regulations to allow veterans' dependent children to directly receive services through the program.

S. 3308 would also address a deficiency in the Special Needs Grant Program, which is currently authorized at \$5 million. This funding level is not sufficient to adequately serve the program's target populations—particularly veterans with dependent children.

NCHV endorses S. 3308's proposal to raise the Special Needs Grant Program's authorization to at least 15 percent of the total authorization for the Grant and Per Diem Program. This would help to ensure that the necessary capital funding is available to provide safe, private and secure facilities for homeless women veterans and single homeless veterans with dependent children.

Thank you for your commitment to serving America's veterans in crisis. We are proud to serve as your ally in our nation's effort to end veteran homelessness by 2015.
Sincerely,

Matt Gornick
Policy Assistant Director

Mission: The National Coalition for Homeless Veterans will end homelessness among veterans by shaping public policy, promoting collaboration, and building the capacity of service providers.