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STATEMENT OF
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ACTING PRINCIPAL DEPUTY
UNDER SECRETARY FOR HEALTH

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good Morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I am pleased to provide the Department's views on 15 of the 20 bills under consideration by the Committee. I will briefly describe each bill, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

Unfortunately, we are unable to comment on the five other bills (i.e., S. 1233, S. 1326, S. 1384, S. 1396, and S. 1441) because we only recently received them and learned they would be on today's agenda. However, we will evaluate those bills and provide our views and estimates for the record.

Mr. Chairman, I will begin by discussing four bills on today's agenda that would address the delivery and type of VA health care services available to veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) and future combat operations.

S. 117: Lane Evans Veterans Health and Benefits Improvement Act of 2007

The first of these is S. 117. We testified regarding certain benefits-related provisions on May 9, 2007. Today I will discuss three sections of that bill that relate to health care benefits: sections 101, 202, and 203.

Section 101 of the bill would make combat-theater veterans eligible for a VA mental health evaluation within 30 days of the veteran's request. The veteran would be able to request and receive such an examination up to five years after the date of the veteran's discharge or release from active military service. In addition, such veterans would be eligible for hospital care, medical services, nursing home care, and family and marital counseling for any mental health condition identified during that examination, notwithstanding that the medical evidence is

insufficient to conclude that the mental health condition is attributable to the veteran's combat service. Eligibility for medical services needed to treat the veteran's identified mental health condition would continue for two years, beginning on the date VA begins to provide such services. The bill would not, however, cover any mental health disability found by the Under Secretary for Health to have resulted from a cause other than the veteran's combat service.

VA supports section 101. However, we note that this bill would be wholly unnecessary should the Congress pass S. 383, which is discussed below.

Section 102 would amend the statutory requirements applicable to the mandated post-deployment examinations conducted by the Department of Defense (DoD). As to this provision, we defer to the views of DoD.

Section 202 would require VA to establish an information system designed to provide an elaborate and comprehensive record of the veterans of the Global War on Terrorism (GWOT) who seek VA benefits and the benefits they receive. Section 203 would mandate that VA submit a quarterly report to Congress on the effects of participation in GWOT on both veterans and the Department. The first of these reports would be due not later than 90 days after this Act's enactment. Each quarterly report would include aggregated information on VA health, counseling, and related benefits to GWOT veterans, including information on the enrollment status of GWOT veterans; the number of inpatient stays they experienced and the related cost of that care (by both enrollment status and condition); the number of outpatient visits they experienced and the related cost of such services (again by enrollment status and by condition); and the number of visits to Vet Centers and the related cost of providing them readjustment counseling and services.

As we testified on May 9, 2007, this bill's requirements to compile and frequently report to Congress massive amounts of data, much of which are not currently available, in the detail and manner specified, would force VA to divert considerable resources from our primary responsibilities. Health care data on these veterans are currently collected and tracked through the Veterans Tracking Application, which is specific to injured service members who transition to VA care. However, that information is considered only in the aggregate. Therefore, collection and tracking the individual-specific data mandated by the bill would require considerably expanded administrative personnel and resources. But again first and foremost, complying with these sections would require resources that would otherwise be devoted to the medical mission of VA. For this reason, we cannot support sections 202 and 203 of the bill. We remain very mindful of this Committee's oversight responsibilities and would welcome the opportunity to work with staff to identify information that is currently lacking that would be most helpful to the Committee in meeting its responsibilities.

We are, as yet, unable to reliably estimate the costs of compliance [in terms of both manpower and potential for detracting from the primary mission of the Veterans Health Administration], but we believe that they would be substantial.

S. 383 Extension of Treatment Authority for Combat-Theater Veterans

S. 383 would amend existing law to increase to five the number of years a combat-theater veteran is eligible for free VA health care for illnesses or conditions that might be associated with combat service. The five-year window of eligibility would begin on the date of discharge or separation from active military, naval, or air service. Currently, the law provides these veterans with two years of such eligibility.

VA supports S. 383. When these veterans seek care from VA they are placed in priority Category 6 and make no co-payments for covered conditions. When the special treatment authority for combat-theater veterans was originally enacted, it was generally assumed that two years was sufficient. However, experience has shown that this is not always the case. In caring for OEF/OIF veterans we have discovered that the onset of symptoms, or adverse health effects, related to Post-Traumatic Stress Disorder (PTSD), and even Traumatic Brain Injury (TBI), are often delayed, or do not manifest clinically, for more than two years after a veteran has left active service. As a result, many OEF and OIF veterans do not seek VA health care benefits until after their two-year window of eligibility has closed. Without eligibility for enrollment in priority Category 6, many, i.e., those with higher incomes and non-service connected conditions, would not be eligible to enroll because they would be in priority Category 8.

In addition, many OEF/OIF veterans are non-career military members who are unfamiliar with veterans benefits and the procedures for obtaining them. For that reason many fail to enroll in a timely fashion. Providing combat-theater veterans with an additional three years within which to access VA's health care system would help to ensure that none of them is penalized because of reasons beyond their control or because they have been unable to navigate through VA's claims system in time.

VA estimates the costs associated with enactment of S. 383 to be $14.1 million in FY 2008 and $289 million over a 10-year period. These estimates include both expenditures and lost co-payment revenue.

S. 479 Joshua Omvig Veterans Suicide Prevention Act

S. 479 would require the Secretary to develop and implement a comprehensive program (comprised of 10 specific elements) for reducing the incidence of suicide among veterans. First, the program would include a national mental health campaign to increase awareness in the veteran community that mental health is essential to overall health and that effective modern treatment can promote recovery from mental illness. Second, it would call for mandatory training on suicide prevention for appropriate employees and contract personnel (including all medical personnel) who interact with veterans. This training would require the provision of information on the recognition of risk factors for suicide, protocols for responding to crisis situations involving veterans who may be at high risk for suicide, and best practices for suicide prevention. Third, the comprehensive program would include outreach programs and educational programs for veterans and their families, in particular OEF/OIF veterans and their families. The educational programs would serve to help: eliminate or overcome stigmas associated with mental illness; further understanding of veterans' readjustment issues; identify signs and symptoms of mental health problems; and encourage veterans to seek assistance for these types of problems.

Fourth, the program would include a peer counseling program in which veterans are trained as peer-counselors to assist other veterans suffering from mental health issues. (Training of these veterans would have to include specific education on suicide prevention.) The peer-counselors would also be responsible for conducting outreach on mental health matters to veterans and their families. The legislation would require the Secretary to make this peer-program available in addition to other mental health services already offered by VA (including those that would be established by this Act).

Fifth, the Secretary would be directed, as part of the comprehensive program, to encourage all veterans applying for VA benefits to undergo a mental health assessment at a VA medical facility or Vet Center.

Sixth, the program would include the provision of referrals, as appropriate, to veterans who show signs or symptoms of mental health problems.

Seventh, the Secretary would need to designate a suicide prevention counselor at each VA medical facility (other than a Vet Center). These counselors would work with a variety of local non-VA entities to engage in outreach to veterans about available VA mental health services. They would also be responsible for improving the coordination of mental health care furnished to veterans at the local level.

Eighth, VA's program would have to include research on best practices for suicide prevention among veterans. Moreover, the Secretary would need to establish a steering committee to advise on such research. Such committee would be comprised of representatives from the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC).

Ninth, the Secretary would have to ensure the availability of VA mental health services on a 24-hour basis.

Finally, the Secretary would be authorized to establish a continuously operational, toll-free telephone number that veterans could call for information on, and referrals to, appropriate mental health services.

This legislation would permit the Secretary to include any other activities in the comprehensive program that the Secretary deems appropriate. It would also require the Secretary to submit, not later than 90 days after the date of enactment, a detailed report to Congress on all of the Department's suicide prevention programs and activities. (Any suicide prevention programs VA establishes afterwards would have to be developed in consultation with NIMH, SAMHSA, and CDC.)

We appreciate the purpose of this legislation; however, we do not support this bill. It is unnecessary because it duplicates many efforts already underway by the Department. Indeed, many of the bill's requirements are already being addressed and implemented through VA's current Mental Health Strategic Plan. (As you will recall, this Strategic Plan was designed to both ensure that our Department continues as a leader in the area of mental health and to implement the goals of the President's New Freedom Commission on Mental Health.) We

therefore ask that the Committee forbear in its consideration of S. 479. In the meantime, we will be happy to brief the Committee on the myriad initiatives we have right now and explore with you additional measures that could supplement these efforts.

Should the Committee proceed to act on this measure, we note our objection to the bill's requirement to train and use veterans as peer counselors for other veterans with mental health issues. The use of adult veterans as peer-counselors in caring for other veterans who suffer from mental health issues is simply not advisable. Data on the efficacy of these types of programs do not reflect favorable results. Although well-intended, we believe such an approach to clinical care lacks scientific support. We strongly believe that VA mental health care services, including counseling, should continue to be provided by our capable, experienced, and appropriately-trained cadre of mental health care professionals.

In addition, we do not think the bill's requirement that we encourage every veteran seeking any type of VA benefit to obtain a mental health assessment is justified, and it may cause veterans to believe they have been stigmatized.

S. 882 Veteran Navigators Transition Assistance Program

Mr. Chairman, the fourth bill on today's agenda that would have particular significance for those returning from deployment in OEF/OIF is S. 882, although it would, in fact, apply to all service members of the Armed Forces who are transitioning from DoD's health care system to VA's.

S. 882 would require the Secretary, in consultation with the Secretary of Defense, to establish and carry out a five-year pilot grant program to assess the feasibility and advisability of using eligible entities to assist members of the Armed Forces in applying for, and receiving, VA health care benefits and services after completion of military service.

The mandated pilot grant program would focus on eligible entities that provide assistance to members with serious wounds or injuries; members with mental disorders; female members; and members of the National Guard and the Reserves. Eligible entities would include non-VA, non-DoD entities or organizations that possess, or which can acquire, the capacity to provide the described transitional assistance. The entities would provide the assistance through "Veteran Navigators," qualified individuals who would provide assistance to members on an individual basis. The legislation would establish very specific qualifications for, and responsibilities of, Veteran Navigators.

S. 882 would require the Secretary to establish at least one pilot site in the vicinity of a military treatment facility that treats members of the Armed Forces who are seriously wounded or injured in Afghanistan or Iraq, another in the vicinity of a rural VA medical center, and one in the vicinity of an urban VA medical center. To add additional sites, the Secretary would need to consult with the grant application evaluation panel, which would be established by this legislation.

Grants awarded under this pilot program could not exceed three years, although a grant could be renewed for one year. Eligible entities seeking grants would be required to submit a detailed application to the Secretary, which addresses all of the specified information set forth in the bill.

A grant could not be awarded, however, to an eligible entity that is receiving federal funds for the same activities on the date on which the eligible entity submits an application to VA, unless the Secretary determines that the entity will use the grant authorized under this bill to expand services or provide new services. The bill would permit these grants to be used to recruit, assign, train, and employ Veteran Navigators.

The grant application panel would be comprised of VA employees, DoD employees, and representatives from both Veterans Service Organizations and organizations that provide services to members of the Armed Forces. It would evaluate all grant applications and make recommendations to the Secretary. Finally, S. 882 would create reporting requirements for both the grant recipients and the Department.

The measure would authorize $2 million to be appropriated to carry out the program for FY 2008; $5 million for FY 2009; $8 million for FY 2010, $6.5 million for FY 2011; and $3.5 million for FY 2012. Any amount authorized to be appropriated would remain available for obligation through the end of FY 2012.

Mr. Chairman, VA does not support S. 882 because it is unnecessary and duplicative of ongoing outreach services and seamless transition efforts currently underway by VA and DoD. It would also duplicate responsibilities of Veterans Service Organizations and State veterans' offices and agencies.

S. 815 Veterans Health Care Empowerment Act of 2007

Mr. Chairman, we next address S. 815, a bill that would significantly change the nature of the VA health care system. S. 815 would authorize veterans with a service-connected disability to obtain their health care at VA-expense from any provider eligible to receive payment under Medicare or TRICARE. This authority would cease after September 30, 2009.

VA strongly opposes enactment of S. 815. We fully concur in the views of several of the major VSOs, who recently wrote to the Chairman of the Senate Committee on Veterans' Affairs in opposition to S. 815. (We will provide this letter to the Committee for the record.) At bottom, S. 815 could lead to the undoing of the VA health-care system - a world-class health care system - as we know it today. For this fundamental reason, we must oppose this bill.

We also have other concerns. The proposal would fragment the care of our veterans. VA would no longer have a complete record of all the care a covered veteran has received. This could lead to VA duplicating care already provided in the private sector or providing care that conflicts with what the veteran is receiving in the private sector. As you are aware, some in the private sector rely on paper records while the VA uses a comprehensive electronic health record. Electronic records promote patient safety. We are concerned that the bill, if enacted, could jeopardize continuity of care for our patients. Lastly, unlike the private sector, VA screens all returning combat-theater veterans for TBI, PTSD, depression, and substance abuse.

Although we have not completed our cost projections for this bill, we underscore that the bill could have significant cost implications. As soon as the cost estimates become available, we will supply them for the record.

S. 1146: Rural Veterans Health Care Improvement Act of 2007

We now turn to S. 1146, which is intended to improve VA's ability to meet the health care needs of rural veterans. Section 2 of this bill would amend VA's beneficiary travel program by making VA pay or reimburse eligible veterans at the same per diem rates and mileage rates that apply to Federal employees using privately owned vehicles for official travel. This section would also repeal existing deductible requirements that apply to the receipt of VA beneficiary travel benefits.

Section 3 would require the Secretary, through the Director of the Office of Rural Health, to establish up to five Rural Health Research, Education, and Clinical Centers of Excellence ("Centers"). The bill sets forth detailed requirements that would govern the Secretary's designation and placement of such Centers. It also would limit designation of Centers to those facilities found by a peer review panel to meet the highest competitive standards of scientific and clinical merit and also found by the Secretary to have met the requirements specified in the legislation.

Section 4 would require the Secretary to establish a grant program for State Veterans' Service Agencies and Veterans' Service Organizations for purposes of providing veterans living in remote rural areas with innovative means of travel to VA medical centers (and to assist them with their other medical care needs). A grant awarded under this section could not exceed $50,000. Grant recipients would not be required to provide matching funds as a condition for receiving a grant. This section would require the Secretary to prescribe regulations to implement this program and also authorize to be appropriated $3 million for each of FYs 2008 through 2012 to carry out this program.

Section 5 would require the Secretary, through the Director of the Office of Rural Health, to carry out demonstration projects to examine alternatives for expanding care to veterans in rural areas. In so doing, the Secretary would be required to establish partnerships with the Department of Health and Human Services (HHS) to coordinate care for veterans in rural areas at both critical access hospitals and community health centers. VA would also be obliged to coordinate with HHS' Indian Health Service to expand care for Native American veterans.

The bill would institute annual reporting requirements, the first of which would have to include the results of the statutorily mandated assessment of VA's fee-basis program on the delivery of care to veterans residing in rural areas, along with the results of VA's extensive outreach program to OEF/OIF veterans living in rural veterans.

Mr. Chairman, in accordance with Congress' mandate in the "Veterans Benefits, Health Care, and Information Technology Act of 2006," VA recently established the Office of Rural Health (ORH) within the Veterans Health Administration. Part of that office's charge is to determine how we can best continue to expand access to care for rural veterans.

Indeed, VA has already done much to remove barriers to access to care for enrolled veterans residing in rural areas and is continuing a robust rural health program. Currently, over 92 percent of enrolled veterans reside within one hour of a VA facility, and 98.5 percent of all enrollees are within 90 minutes. Still, we continue our efforts to try to ensure that all enrolled veterans living

in rural areas have adequate and timely access to VA care. We expect the data for this year to be even better.

Community-Based Outpatient Clinics (CBOCs) have been the anchor for VA's efforts to expand access to veterans in rural areas. CBOCs are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area. In addition, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans, and several additional outpatient clinics are positioned to provide care for veterans in surrounding rural communities. VA's authority to contract for care under 38 U.S.C. §1703 provides a local VA Medical Center director with another avenue through which to meet the needs of many rural veterans.

These efforts have borne fruit. Rural veterans tell us that they are satisfied with the services and high-quality care we are providing to them. This is substantiated by their reporting even higher satisfaction with VA services than their urban counterparts. Moreover, performance measure data indicate that as a result of our intensive efforts to expand services for rural veterans, veterans have access to services much nearer to home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away. In addition, quality of care in the rural environment matches that of urban care on 40 standard measures.

Mr. Chairman, VA shares the Committee's concern for ensuring that rural veterans have adequate access to needed health care and services. However, for the aforementioned reasons, we do not support S. 1146 and we recommend that no legislative action be taken in this area until VA has had sufficient time to complete and review the internal assessments currently underway by ORH and other Department components. We will of course share ORH's findings and recommendations with the Committee. On the changes proposed for beneficiary travel, we note that similar provisions are found in S. 994. We therefore address these changes in our comments on S. 994, below.

S. 1147 Termination of the Administrative Freeze on Enrollment of Veterans in Category 8

Mr. Chairman, S. 1147 would require VA to enroll all eligible veterans in Category 8. As you and the Subcommittee are well aware, VA suspended the enrollment of new veterans in the lowest statutory enrollment priority (priority category 8 - veterans with higher incomes and no compensable service-connected disabilities) in January of 2003. This action was taken to protect the quality and improve the timeliness of care provided to veterans in higher enrollment-priority categories.

VA strongly opposes enactment of S. 1147. In 1996, Congress enacted Eligibility Reform legislation that allowed VA to provide comprehensive care to veterans in the most appropriate treatment setting. Additionally, in order to protect the traditional mission of VA (to cover the health care needs of service-disabled and lower-income veterans), that law originally defined seven priority levels (PL) of veterans - PL 7 veterans (higher income and not service-disabled) were the lowest priority. The law mandated that beginning in FY 1999, VA use its enrollment decision to ensure that care to higher-priority veterans was not jeopardized by the infusion of

lower priority veterans into the system for the first time. In FYs 1999 through 2002, the VA Secretary determined in each year that all veterans were able to enroll. Prior to 1999, PL 7 veterans' care was not funded in budgets, but they could use the system on a space available basis. Consequently, they were only about 2% of the annual users. In FY 2001, 25% of enrollees and 21% of users were PL 7 veterans (using 9% of the resources). In 2001 PL 7 veterans were split into two parts- those making above the geographic-specific HUD threshold for means-tested benefits were moved to a new PL 8 category. More than half of the 830,000 new enrollees in FY 2002 were in Priority Group 8 and VA was not able to provide service-connected and lower income enrolled veterans with timely access to health care services because of the unprecedented growth in the numbers of the newly eligible category of users. When the appropriation was finally enacted for FY 2003, VA's Secretary made the decision that the Department would not enroll any new PL 8 veterans - but those currently in the system would retain their right to care. Every appropriation since 2003 has supported this enrollment decision.

S. 1147 would essentially render meaningless the prioritized enrollment system, leaving VA unable to manage enrollment in a manner that ensures quality and access to veterans in higher priorities. VA would have to add capacity and funding to absorb the additional workload that this bill would entail, and so the quality and timeliness of VA health care to all veterans, including service disabled and lower income veterans, would unavoidably suffer until this capacity is added.

We note VA has authority to enroll combat-theater veterans returning from OEF/OIF in VA's health care system and so they are eligible to receive any needed medical care or services.

S. 994 Disabled Veterans Fairness Act

Like S. 1146, S. 994 would amend VA's beneficiary travel benefits program by repealing the statutory deductible-requirements and requiring the Secretary to reimburse all beneficiary travel benefits and allowances at the same rates that apply to Federal employees. Beneficiary travel benefits would be paid out of amounts appropriated or otherwise made available to VA specifically for this purpose. S. 994 would provide that these changes apply to travel expenses incurred after the 90-day period beginning on the date of enactment.

Although S. 994 would appear to prevent payment of beneficiary travel allowances and payments from funds appropriated to VA for direct patient care, we believe the cost of S. 994 would be utterly prohibitive. The cost of this bill would be significantly increased without the buffering effect of deductibles. As you know, deductibles play an important cost-sharing function and help contain costs by discouraging needless travel. Increased funding in the amount this bill would require could be put to better use on the provision of direct patient care to our veterans, particularly on our aging veterans and new cohorts of OEF/OIF veterans. We are unique among health care providers in that we already provide beneficiary travel benefits to eligible veterans.

S. 692 VA Hospital Quality Report Card Act of 2007

Mr. Chairman, S. 692 would require VA to establish a Hospital Quality Report Card Initiative to, among other things, help inform patients and consumers about the quality of care in VA

hospitals. Not later than 18 months after the date of enactment, the Department would be mandated to establish a hospital Quality Report Card Initiative. Under the Initiative, the Secretary would be required to publish, at least bi-annually, reports on the quality of VA's hospitals that include quality-measures data that allow for an assessment of health care effectiveness, safety, timeliness, efficiency, patient-centeredness; and equity.

In collecting and reporting this data, the Secretary would have to include very extensive and detailed information (i.e., staffing levels of nurses and other health care professionals; rates of nosocomial infections; volume of various procedures performed, hospital sanctions and other violations; quality of care for specified patient populations; the availability of emergency rooms, intensive care units, maternity care, and specialty services; the quality of care in various hospital settings, including inpatient, outpatient, emergency, maternity, and intensive care unit settings; ongoing patient safety initiatives; and, other measures determined appropriate by the Secretary). However, VA would be allowed to make statistical adjustments to the data to account for differences relating to characteristics of the reporting hospital (e.g., size, geography, and teaching status) and patient characteristics (e.g., health status, severity of illness, and socioeconomic status). In the event VA makes such adjustments, there would be a concomitant obligation to establish procedures for making that data available to the public.

The bill would permit the Secretary to verify reported data to ensure accuracy and validity. It would also require the Secretary to disclose the entire methodology (for the reporting of the data) to all relevant organizations and VA hospitals that are the subject of any information prior to making such information available to the public.

Each report submitted under the Initiative would have to be available in electronic format, presented in an understandable manner to various populations, and presented in a manner that allows, as appropriate, for a comparison of VA's hospital quality with local hospitals or regional hospitals. The Department would also need to establish procedures to make these reports available to the public, upon request, in a non-electronic format (such as through a toll-free telephone number).

In addition, S. 692 would require the Secretary to identify and acknowledge the analytic methodologies and limitations on the data sources used to develop and disseminate the comparative data and to identify the appropriate and inappropriate uses of such data. The bill would further mandate that, at least an annual basis, the Secretary compare quality measures data submitted by each VA hospital with data submitted in the prior year or years by the same hospital to identify and report actions that would lead to false or artificial improvements in the hospital's quality measurements.

This measure would further require the Secretary to develop and implement effective safeguards to: protect against the unauthorized use or disclosure of VA hospital data reported under this measure; protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective VA hospital data; and ensure that identifiable patient data is not released to the public. In addition, the Secretary would need to evaluate and periodically report to Congress on the effectiveness of this Initiative and its effectiveness in meeting the purposes of this Act. And such reports would have to be made available to the public. Finally, this legislation would direct the Secretary to use the results of the evaluations to increase the usefulness of this Initiative.

S. 692 would authorize to be appropriated to carry out this section such sums as may be necessary for each of FYs 2008 through 2016.

Mr. Chairman, we do not support S. 692 because it is overly prescriptive and largely duplicative of existing activities. As such, we believe this legislation is unnecessary. Relevant information on VA hospital quality is already available to the public through several mechanisms, including our compliance with Executive Order 13410 that requires transparency of quality measures in Federal health care programs. (Because of our efforts in meeting the Executive Order, we are way ahead of the private sector in making our health care system and outcomes data transparent; there exist no bases for comparison with the private sector.)

Information on the quality of VA hospital care is also available from the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). JCAHO provides standardized comparative data in a form that has been tested for consumer understandability and usefulness.

We believe the design of such a program, such as this, is best left to industry experts, including VA. We further believe that highly technical health care matters such as this are not well-suited to detailed statutory mandates. For example, the proposed measures set forth in the bill are less reliable, robust, and helpful than those currently used by VA. Further, they are indicators of process, not of patient outcomes. We would be pleased to meet with the Committee to discuss how we comply with Executive Order 13410, identify the sources of information currently available on the quality of VA hospitals, and demonstrate how such information may be accessed.

S. 610 Clarification of Effective Date of § 132 of the Department of Veterans Affairs Health Care Programs Enhancement Act (relating to Computation of Retirement Annuity for Certain Health-Care Personnel)

Mr. Chairman, another bill under consideration by the Committee is S. 610, which would retroactively change retirement benefits to certain VA health-care personnel. VA defers to the Office of Personnel Management on this issue and notes that it is contrary to Administration policy to make such changes retroactively.

S. 874 Services to Prevent Veterans Homelessness Act of 2007

Mr. Chairman, I will next discuss S. 874, which is a measure intended to prevent low income veterans transitioning to, or residing in, permanent housing from falling back into their former homeless condition. Subject to the availability of appropriations provided for the bill's purpose, S. 874 would require the Secretary to provide financial assistance in the form of per diem payments to eligible entities to provide and coordinate the provision of supportive services for very low-income veteran-families occupying permanent housing or transitioning from homelessness to permanent housing.

S. 874 would establish the amount of per diem payment as the amount of the daily cost of care estimated by the eligible entity. Yet, in no case could that amount exceed the per diem rate that VA pays to State homes for domiciliary care. The bill would permit the Secretary to adjust the per diem rate by excluding from the entity's cost-estimate any costs it incurs in furnishing

services to homeless veterans for which the entity already receives funding from another source (both public and private). It would further require that such financial assistance be equitably distributed across geographic regions, including rural communities and tribal lands.

To receive such financial assistance, eligible entities would have to submit an application including all of the detailed information specified in the bill. It would also require the Secretary to consult with the Secretaries of Housing and Urban Development and Health and Human Services when selecting the recipients. S. 874 would also require the Secretary to provide training and technical assistance to participating entities on the planning, development, and provision of supportive services. Such assistance could be provided either directly, or through grants or contracts with appropriate public or nonprofit private entities.

S. 874 would define "supportive services" to include, among other things, outreach services, health care services, transportation, educational services, assistance in obtaining income support, legal assistance, fiduciary and representative services, and child care services.

As to funding, the proposed law would make available out of the amounts appropriated for medical care $15 million for FY 2008, $20 million for FY 2009, and $25 million for FY 2010. Of these amounts, not more than $750,000 in any FY could be used to provide technical assistance.

Finally, this bill would require the Secretary to conduct a study of the effectiveness of this program in meeting the needs of very low-income veteran-families. As part of the study, the Secretary would have to compare the results of this program with other VA programs dedicated to the delivery of housing and services to veterans.

VA opposes S. 874 as currently configured. We understand there is a high demand for supportive services for these vulnerable low-income veterans and their families who are at risk of becoming homeless. However, it is inappropriate to provide such assistance in the form of per diem payments. We recommend that the bill be modified so that financial assistance is furnished in the form of grants, similar to all other Federal programs that provide financial assistance to entities providing supportive services to homeless persons.

We also note other concerns with this legislation. First, the list of supportive services should not include health care services because this would be duplicative of those already furnished to homeless veterans through VA and/or Medicaid. Second, the term "habilitation and rehabilitation services" is not defined, and supportive services provided under VA and other federal programs for homeless persons typically include referrals to legal services, not actual legal services. Third, the application requirements are inadequate as they fail to require the applicants to demonstrate the need for the services they propose to provide. Fourth, because of the administrative costs involved, it would be more efficient to disburse the very small amount of funding available for technical assistance directly and apart from the grant program. Fifth, the definition of "private nonprofit organization" should not include for-profit partnerships, as it presently does. Finally, the definition of veteran-family differs from that used in the McKinney-Vento Homeless Assistance Act (42 U.S.C. §11302).

S. 472 Major Medical Facility Project for Denver, Colorado

Mr. Chairman, the last four bills on today's agenda relate to construction and real property matters. The first of these is S. 472, which would authorize the Secretary to carry out a major medical facility project for a replacement facility for the Denver Veterans Affairs Medical Center in an amount not to exceed $523,000,000. It would also authorize the Secretary to obligate and expend any unobligated amount in the "Construction, Major Projects" account to purchase a site for, and for the construction of, that replacement facility.

VA supports S. 472. Authorization in the amount of $98,000,000 was provided for this project in P.L.109-461; however additional authorization in the amount of $548,000,000 is required to complete the project, bringing it to the total of $646,000,000, which is consistent with the President's budget submission request.

S. 1026 Renaming of VA Medical Center in Augusta, Georgia

The second of these bills is S. 1026, which would designate the Department of Veterans Affairs Medical Center in Augusta, Georgia as the "Charlie Norwood Department of Veterans Affairs Medical Center." Captain Norwood helped develop the military's Dental Corps while serving in Vietnam. After his military service, he continued to provide needed dental care to military personnel and dependents through his private practice. Later, as a distinguished Congressman, he was key in advancing the military's health and dental programs.

The Department defers to Congress in the naming of federal property.

S. 1043 Use of Lands at VA West Los Angeles Medical Center

S. 1043 would require the Secretary to submit a report on the master plan relating to the use of Department lands at West Los Angeles mandated by Public Law 105-369. Such report would have to include the master plan, if it exists; a current assessment of the master plan; any Departmental proposal for a veterans' park on such lands; any VA proposal to use a portion of these lands as dedicated green space; and, an assessment of any such proposal. In addition to establishing new reporting requirements for the master plan, S. 1043 would require that the master plan be completed before the adoption of the plan under the Capital Asset Realignment for Enhanced Services (CARES) initiative.

VA shares the Committee's desire to have a short term and long term strategy to address how we are to manage our capital assets and operational needs for the care of more than 78,000 enrolled veterans in the Los Angeles area. However, VA opposes S. 1043. As you are aware, since the enactment of Public Law 105-368, VA has embarked upon the CARES Business Plan Studies generally, and specifically the CARES Business Plan Study (Study) of the West Los Angeles campus. In the Study, options will be identified for use of any underutilized capital assets, as well as modernizing the campus to provide care to veterans now and in the future at the safest state-of-the-art facilities possible. VA's contractor has completed the initial steps in preparing planning options for public input through Local Advisory Panel (LAP) public meeting sessions. The third LAP session is presently expected to be held this summer and will be well advertised. The LAP sessions allow for input from those on the reviewing panel, veterans, as well as the community at large. All LAP and community input will be considered when formulating final recommendations for the Secretary, as well as during the Secretary's decision-making process.

The development of the master plan for the West Los Angeles campus must be done in conjunction with this CARES study to ensure that operational needs are met into the future. Indeed, the CARES study, with some refinement, is designed to meet the requirement for a master plan as set forth in the Public Law. We will continue to keep the Committees informed as the process continues.

S. 1392 Major Medical Facility Project Pittsburgh, Pennsylvania

S. 1392 would authorize an increased amount, $248,000,000 instead of $189,205,000, for the consolidation of the Department's medical facilities in Pittsburgh, Pennsylvania (at University Drive and H. John Heinz III divisions). VA supports S. 1392, as the bill's increased amount is consistent with the President's budget submission request.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Committee may have.