THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 11, 2013

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

Dear Mr. Chairman:

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

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

Sincerely,

Eric K. Shinseki

Enclosure

S. 131 Woman Veterans and Other Health Care Improvement Act of 2013

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

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

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

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

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

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

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

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

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

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

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

Section 11(a) of S. 131 would add a new section 1709B to title 38, U.S.C. that would make permanent VA's authority to provide assistance to qualified Veterans to obtain child care so that such Veterans can receive certain health care services. VA would be required to carry out the program in no fewer than three Veterans Integrated Service Networks. This section would also identify certain forms of assistance that may be provided. VA's pilot program providing such services under section 205 of Public Law 111-163 would expire upon enactment of section 11(a).

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

on October 2, 2013, therefore, not affording three pilots the benefit of two full years of operation.

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

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

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

VA supports section 11(b) in principle. Some Veterans who use Vet Center services, especially those who have served in Iraq or Afghanistan, have voiced concern that a lack of child care has impacted their ability to use Vet Center services consistently. Although Vet Center staff are always searching for new initiatives to increase Veteran access to services, VA has concerns about implementing child care

assistance under section 11(b) without the opportunity to pilot this type of benefit. A pilot program is needed because VA currently is unable to predict utilization of this type of assistance. Comparisons to medical center pilots are not useful because Vet Centers provide services during non-traditional hours, including after normal business hours and on weekends when requested by the Veteran. This inability to predict utilization affects VA's ability to budget the program appropriately. VA recommends that section 11(b) be modified to authorize a pilot program to determine the feasibility, advisability, and costs of providing child care assistance to Veterans who utilize Vet Center services.

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

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

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

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

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

S. 287 Expansion of the Definition of Homeless Veteran

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

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

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

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

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

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

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

S. 422 Chiropractic Care Available to All Veterans Act of 2013

VA provided views on S. 422 in our testimony on May 9, 2013. In general, VA supports the intent of S. 422, but believes the decision to provide on-site or fee care should be determined based on existing clinical demands and business needs. Chiropractic care is available to all Veterans and is already part of the standard benefits package. As VA increases the number of VA sites providing on-site chiropractic care,

we will be able to incrementally assess demand for chiropractic services and usage, and to best determine the need to add chiropractic care at more sites.

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

S. 522 Wounded Warrior Workforce Enhancement Act

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

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

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

These centers provide a rich scientific environment in which clinicians work closely with researchers to improve and enhance care. They are not positioned to confer terminal degrees for prosthetic and orthotic care/research but they are engaged in training and mentoring clinicians and engineers to develop lines of inquiry that will have a positive impact on amputee care. Finally, the requirement to issue a request for proposals within 90 days of enactment would be very difficult to meet as VA would first need to promulgate regulations prior to being able to issue the RFP.

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

S. 800 Treto Garza Far South Texas Veterans Inpatient Care Act of 2013

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

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

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

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

S. 825 Homeless Veterans Prevention Act of 2013

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

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

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

VA does not anticipate that section 2(a) would lead to additional costs beyond the current authorization of appropriations (38 U.S.C. 2013). The provision would allow VA to allocate existing funds to support rehabilitating and maintaining existing GPD projects. Section 2(b) also would not result in any additional costs. If subsequent legislation provided more specific definitions of physical, privacy, safety and security, however, it is possible that VA could incur costs or costs that cannot presently be determined.

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

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

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

Section 5 would require VA to assess and measure the capacity of programs receiving grants under 38 U.S.C. 2011 or per diem payments under 38 U.S.C. 2012 and 2061 and to use the information to set goals, inform funding allocation decisions, and improve the referral of homeless Veterans to programs receiving funding. VA supports

the intent of section 5 but does not believe legislation is needed because VA conducts internal assessments of service programs.

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

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

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

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

Section 7 would strike section 2023(d) of 38 U.S.C. and replace it with section 2023(e). This would eliminate the September 30, 2013 end date for VA's Veteran Justice Outreach (VJO) Program and VA's Healthcare for Reentry Veterans (HCRV) Program, programs that provide referral and counseling services for Veterans who are transitioning out of penal institutions and are at risk of homelessness. VJO's goal is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans involved with the criminal justice system have timely access to VA's mental health and substance use services when

clinically indicated, and other VA services and benefits as appropriate. Similarly, HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment, and decrease the likelihood of re-incarceration for Veterans leaving prison.

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

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

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

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

VA supports section 8. Homeless and at-risk Veteran access to legal services remains a crucial but largely unmet need. Lack of access to legal representation for outstanding warrants or fines, child support arrearages, driver's license revocation, and other legal matters continues to contribute to Veterans' risk of becoming and remaining homeless. A demonstration project conducted by the Department of Veterans Affairs, the Department of Health and Human Services' Office of Child Support Enforcement, and the American Bar Association indicates that legal services are instrumental in assisting Veterans who have child support arrearages."

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

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

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

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

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

VA supports Section 10(a) in part. Under current law, the amount authorized to be appropriated for FY 2014 will be reduced from $250,000,000 to $150,000,000 and then remain the same for each subsequent fiscal year. We support section 10(a) to the extent that it would retain the program's current level of authorization for FY 2014. We have concerns, however, about decreasing the authorization level to $150,000,000 for

FY 2015 and each subsequent year. Such a decrease would be highly problematic. At the current rate, GPD expenditures would far exceed the amount authorized to be appropriated for the program for FY 2015 and thereafter. VA would require additional funding to support the existing projects at anticipated per diem and occupancy rates in FY 2015 and beyond. Otherwise, VA would be forced to cut per diem payments to GPD community providers or to summarily terminate GPD projects presently serving homeless Veterans.

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

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

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

Section 10(e) would extend through December 31, 2014, the Secretary's authority under section 2041 of 38 U.S.C. to sell, lease, or donate properties to nonprofit organizations that provide shelter to homeless Veterans. Under current law, the

authority will expire on December 31, 2013. VA supports section 10(e) because it will help VA meet the Secretary's goal of ending Veteran homelessness by 2015. While any extension of authority under 38 U.S.C. 2041 would result in a reduction in property sales proceeds, neither a one-year, nor a five-year extension would result in any significant loan subsidy costs.

Section 10(f) would require VA to make available (from amounts appropriated for Medical Services) $300,000,000 for FY 2013 for its program under section 2044 of 38 U.S.C. offering financial assistance for supportive services for very low-income Veteran families in permanent housing (Supportive Services for Veterans Families, or SSVF). VA has already budgeted $300 million for the SSVF Program in FY 2014. VA supports section 10(f), which would re-authorize appropriations for the SSVF Program, VA's premier prevention and rapid re-housing program. However, VA suggests that 38 U.S.C. 2044(e)(1) be amended by adding after subparagraph (E): "(F) Such sums as may be necessary for fiscal year 2014, and thereafter." This change would provide VA with the flexibility to devote the necessary funding to operations under the SSVF Program. SSVF is an essential part of VA's plan to end Veteran homelessness, and VA may need to devote more resources to SSVF as VA concludes the Veteran homelessness initiative. There are no costs associated with this section as it provides authorization for appropriations beginning in FY 2014.

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

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

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

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

S. 832 Improving the Lives of Children with Spina Bifida Act of 2013

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

Under the bill, a covered individual is any person who is entitled to health care under chapter 18 of title 38 and who lives in a rural area and does not have access to case management services. The Secretary would be responsible for determining the appropriate number of covered individuals to participate in the pilot. S. 832 would require VA to provide these individuals with coordination and management of needed

health care, monetary, and general care services authorized under Chapter 18; transportation services; and such other services as the Secretary considers appropriate. The bill would also require the Secretary to inform all covered individuals of the services available under the pilot program and to submit preliminary and final reports to the Senate and House Committees on Veterans Affairs.

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

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

As noted above, section 2(e)(1) would require VA to provide "[c]oordination and management of needed health care, monetary, and general care services authorized

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

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

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

enrollment. Section 3 of the bill would also specify preliminary and final reporting requirements.

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

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

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

Section 3(b) defines "covered individuals" for purposes of this section to be spina bifida beneficiaries who are entitled to health care under subchapter I or III of chapter 18 of title 38, United States Code. This would include many beneficiaries who do not need

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

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

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

Finally, this section does not provide for what happens to covered beneficiaries who are in assisted living when the pilot ends, who have no place else to go, and who

have insufficient personal funds to stay in their current location. Although VA does not support section 3 of S.832, if enacted we recommend authorizing VA to continue providing assisted living, group home care, or similar services to those who had received these services prior to the completion of the program to avoid adverse impact on this population.

S. 845 To Improve the Professional Educational Assistance Program

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

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

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

S. 851 Caregivers Expansion and Improvement Act of 2013

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law (P.L.) 111-163 (the Act), signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits under the Act were authorized only for qualified family caregivers of eligible Veterans

who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers, include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not eligible for TRICARE and not entitled to care or services under a health-plan contract.

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

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

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

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care

services. This is especially true as VA presses to buttress mental health services and ensure the fullest possible access to care in rural areas. VA is also mindful as we look ahead to the allocations for the Veterans Benefits and Services functions in the Senate-passed and House-passed FY 2014 budget resolutions (S. Con. Res. 8 and H. Con. Res. 25, respectively).

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

S. 852 Veterans Health Promotion Act of 2013

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

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

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

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

These pilots would also operate in conjunction with existing initiatives, including the Mental Health Innovations Committee, the VA-DoD Health Executive Council's Pain Management Work Group, VHA's National Pain Office, and IH pilot projects being undertaken at three Polytrauma Centers by OPCC&CT and the Physical Medicine and Rehabilitation Service National Program Office. Building on these pilots, VA recommends the legislation specify a total of "up to five" pilot projects at Designated Polytrauma Centers rather than five. The funding source for this proposed legislation is unclear, and implementation of sections 2 and 3 would be problematic without additional funding.

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

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

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

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

fitness center membership at a minimum of five locations; VA would cover half of the reasonable membership costs at a minimum of five other locations.

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

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

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

Costs for this bill are still under development, but we believe it could be challenging to implement the programs in this Bill on a system-wide scale. Constructing

space in medical centers and outpatient clinics for fitness centers may not be feasible in many locations. As noted above, we are committed to encouraging physical activity and VA will continue to develop cost effective and innovative ways to support active, healthy lifestyles for all Veterans.

Section 7 of S. 852 would require VA to enter into a contract to study the barriers encountered by Veterans in receiving CAM from VA. Specifically, VA would study the perceived barriers associated with obtaining CAM, the satisfaction of Veterans with CAM in primary care, the degree to which Veterans are aware of eligibility for and scope of CAM services furnished by VA, and the effectiveness of outreach to Veterans about CAM. The head of specified VA departments would be required to review the results of the study and to submit findings to the Under Secretary for Health.

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

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

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

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

S. 877 The Veterans Affairs Research Transparency Act of 2013

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

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

VA believes that transparency is most effectively accomplished using PubMed Central, an archive maintained by the NIH. VHA Office of Research and Development is negotiating with NIH with the objective of disseminating published findings using this

vehicle. Using this common platform to disseminate VA funded research would be more cost-effective and would better serve the needs of the federal and non-federal research community.

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