Madhulika Agarwal, MD, MPH, Deputy Under Secretary for Health for Policy and Services, Veterans Health Administration, Department of Veterans Affairs and Thomas Murphy, Director, Compensation Service, Veterans Benefits Administration

STATEMENT OF
DR. MADHULIKA AGARWAL
DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
JUNE 27, 2012

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

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

S. 1264 Veteran Voting Support Act of 2011

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

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

Section 3 of this bill would require VA to provide a "mail voter registration application" to each Veteran seeking enrollment in VA health care and to all enrolled Veterans any time there is a change in enrollment status or address. It would also require VA to provide assistance with voter registration to Veterans unless they refuse such assistance, and would require VA to accept completed voter registration forms and transmit them to the appropriate state election official

within 10 days of receipt (unless they are received within 5 days of the registration deadline, in which case they must be sent within 5 days). Section 3 also would prohibit VA from influencing Veterans or displaying any political preference and would prohibit VA's use of this information for any purpose other than voter registration. The bill would allow anyone aggrieved to provide notice of the violation to the facility director or the Secretary and would require the director or the Secretary to respond within 20 days. If a violation is not corrected within 90 days, the aggrieved person may provide written notice to the Attorney General and Election Assistance Commission. Section 3 also authorizes the Attorney General to bring a civil action for violations.
Section 4 would require VA, consistent with state and local laws, to assist Veterans residing in VA facilities with absentee balloting. Section 5 would require the Secretary to permit nonpartisan organizations to provide voter registration information and assistance at Department health care facilities, subject to reasonable limitations.
Section 6 would similarly prevent VA from prohibiting any election-administration official from providing voter information to Veterans at any VA facility. Moreover, it would require VA to provide reasonable access to VA health care facilities to state and local election officials for providing nonpartisan voter registration services.
Section 7 would require VA to submit an annual report to Congress on the agency's compliance with this Act as well as the number of Veterans served by VA's health care system, the number of Veterans who requested information or assistance with voter registration, the number who received information or assistance, and information regarding notices of violations.

As noted previously, VA is committed to helping Veterans exercise their right to vote, and, especially in recent years, has increased the non-partisan assistance provided to Veterans. While VA applauds the bill's goals, it opposes S. 1264 as it is overly burdensome and, in some respects, duplicates the agency's existing voter assistance efforts.
As described above, Section 3 of the bill would require VA to provide a voter registration application form to each Veteran who seeks to enroll, and to enrolled Veterans any time there is a change in the enrollment status of that Veteran, or a change in the address of the Veteran. As VA facilities treat patients from multiple jurisdictions under a national system, implementing these requirements would be extraordinarily complicated. Under this national system, Veterans have the ability to use VA facilities not necessarily in their home jurisdiction. It would require VA to keep and apply authoritative information on elections, voter registration deadlines, and voter registration requirements in all 50 states.
The multi-jurisdictional nature of VA also creates complications for providing the assistance with absentee ballots outlined in Section 4 of S. 1264; however, Section 4 is limited to Veteran inpatients, those residing in Community Living Centers, and domiciliaries.
This bill would also require the Secretary to permit nonpartisan organizations to provide voter assistance at facilities of the VA health care system. In addition, S. 1264 provides that the Secretary shall not prohibit any election official from providing voting information to Veterans at any facility of the Department of Veterans Affairs. Though the legislation allows VA to set reasonable time, place and manner restrictions on visits by election officials and nonpartisan groups, it is not clear that VA could entirely exclude election officials from certain facilities. There are some places within VA, such as National Cemeteries, psychiatric facilities, and Vet Centers, which are not appropriate locations for voter information and assistance activities from outside entities. Moreover, the definition of election official is overly broad as it could be interpreted to include volunteer "election judges" or "election monitors" who are assigned by

campaigns or political parties to watch polling locations for irregularities on the day of an election. Directive 2008-053 currently provides nonpartisan organizations and election officials access to VA health care facilities for the purpose of providing voter information and assistance. The costs for the requirements of this bill are significant. They include an initial mail-out to approximately 8.2 million enrollees at a cost of $5.3 million and estimated recurring costs of $1.2 million annually. VHA would have to create a Voter Assistance Program in VA Central Office and in the field to support the proposed legislation. VA estimates the entire cost of implementing S. 1264 would be $26.0 million in FY 2013, $6.1 million in FY 2014, $113.3 million over 5 years, and $242.4 million over 10 years.

S. 1631 Bill to Authorize the Establishment of a Center for Technical Assistance for Non-Department Health Care Providers Furnishing Care to Veterans in Rural Areas

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

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

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

• Develop and disseminate information, educational materials, training programs, technical assistance and materials, and other tools (1) to improve access to health care services for Veterans in rural areas and (2) to otherwise improve health care provided to Veterans by non-VA health care providers;

• Improve collaboration on health care matters, including the exchange of health information, for Veterans receiving health care from both VA and non-VA providers serving rural populations;

• Establish and maintain Internet-based information on mechanisms to improve health care for Veterans in rural areas (including practical models, best practices, research results, and other appropriate information);

• Work with existing Government offices and agencies, including those specified in the bill, on programs, activities, and other mechanisms to improve health care for rural Veterans;

• Track and monitor fee expenditures incurred by VA in using non-VA health care providers to serve rural populations; and

• Evaluate the Center through the use of an independent entity that is experienced and knowledgeable about rural health care matters, non-VA providers serving rural populations, and VA programs and services.

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

and technical assistance relating to telehealth, reimbursement for health care, improvement of quality of care, and contracting with the Federal Government).

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

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

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

VA has also recently drafted a memorandum of understanding (MOU) between the Department of Veterans Affairs (VA's Office of Rural Health) and the Department of Health and Human Services (Offices of the National Coordinator for Health IT and Rural Health Policy) to ensure

interoperability between VA and rural health care providers to allow and promote the effective exchange of health information.

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

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

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

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

S. 1705 To Designate the Department of Veterans Affairs Medical Center in Spokane, Washington

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

S. 1707 Veterans Second Amendment Protection Act

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

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

public safety. Although VA has admittedly been slow in implementing this relief program, we now have relief procedures in place, and we are fully committed going forward to implement this program in a timely and effective manner in order to fully protect the rights of our beneficiaries.
We also note that the reliance on an administrative incompetency determination as a basis for prohibiting an individual from possessing or obtaining firearms under Federal law is not unique to VA or veterans. Under the applicable Federal regulations implementing the Brady Handgun Violence Prevention Act, any person determined by a lawful authority to lack the mental capacity to manage his or her own affairs is subject to the same prohibition. By exempting certain VA mental health determinations that would otherwise prohibit a person from possessing or obtaining firearms under Federal law, the legislation would create a different standard for veterans and their survivors than that applicable to the rest of the population and could raise public safety issues.
The enactment of S. 1707 would not impose any costs on VA.
S. 1755 Coverage Under Department of Veterans Affairs Beneficiary Travel Program of Certain Disabled Veterans for Travel for Certain Special Disabilities Rehabilitation.
S. 1755 would amend VA's beneficiary travel statute to ensure beneficiary travel eligibility for Veterans with vision impairment, Veterans with spinal cord injury or disorder, and Veterans with double or multiple amputations whose travel is in connection with inpatient care in a VA special disabilities rehabilitation program.
This legislation could be construed to apply for travel of specified Veterans only in connection with their inpatient care in special rehabilitation program centers, and would apply only to Veterans with the specified medical conditions who are not otherwise eligible for beneficiary travel under 38 U.S.C. § 111. VA provides rehabilitation for many injuries and diseases at numerous specialized centers, including programs for Closed and Traumatic Brain Injury (CBI +TBI), Post Traumatic Stress Disorder (PTSD), other mental health issues, Parkinson's Disease, Multiple Sclerosis, Epilepsy, War Related Injury (WRIIC), Pain Management, and various addictions. In addition, many of VA's specialized treatment centers, including blind, SCI, and amputee centers, provide rehabilitation - both initial and ongoing - on an outpatient basis using on and off-station lodging. This legislation clearly would not apply to travel for those specified Veterans receiving care on an outpatient basisand thus would provide disparate travel eligibility to a limited group of Veterans. Therefore, VA does not support S. 1755 as written.
VA does support expansion of travel benefits to a larger group of Veterans (including blind, SCI, and amputees) and those with other special needs who may not be otherwise eligible for VA travel benefits. VA welcomes the opportunity to work with the Committee to craft appropriate language as well as ensure that resources are available to support any travel eligibility increase that might impact upon provision of VA health care.
VA estimates that the total cost for S. 1755 would be $3 million during FY 2013, $17.6 million over 5 years and $43.1 million over 10 years. This estimate is based on workload projections for inpatient services at specialized SCI, Blind, and Amputee centers.
S. 1799 Access to Appropriate Immunizations for Veterans Act of 2011
S. 1799 would amend the definition of "preventive health services" in 38 U.S.C. 1701 to include the term "recommended adult immunization schedule" and define it to mean the schedule established by the Advisory Committee on Immunization Practices (ACIP). S. 1799 would also amend section 1706 of title 38, to require the Secretary to develop quality measures and metrics to ensure that Veterans receive immunizations on schedule. These metrics would be required to include targets for compliance and, to the extent possible, should be consistent and implemented

concurrently with the metrics for influenza and pneumococcal vaccinations. The bill would require that these quality standards be established via notice and comment rulemaking. S. 1799 would also require that details regarding immunization schedules and quality metrics be included in the annual preventative services report required by 38 U.S.C. 1704. VA notes that the effective dates under this proposal would be retroactive to July 1, 2011 for the publication of the proposed measures and metrics and January 1, 2012 for the implementation of the measures and metrics.
VA does not support this legislation, as VA now provides prevention immunizations at no cost to the Veteran. In addition, VHA is represented as an ex-officio member of the ACIP and follows its recommendations. VHA is also an ex-officio member of the Department of Health and Human Services (HHS) National Vaccine Advisory Committee.
VA develops clinical preventive services guidance statements on immunizations in accordance with ACIP recommendations (VHA Handbook 1120.05). All ACIP-recommended vaccines are available to Veterans at VA medical facilities. These vaccines currently include: hepatitis A, hepatitis B, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, tetanus/diphtheria, varicella, and zoster. As the recommendations change, VHA policy reflects those changes. The delivery of preventive care that includes vaccinations has been well established in the VHA Performance Measurement system for more than ten years with targets that are appropriate for the type of preventive service or vaccine. VA updates the performance measures to reflect changes in medical practice over time.
Adding the statutory requirement for regulations to the development of targets would be burdensome and lengthy. Moreover, the process does not allow for nimble and quick changes as new research or medical findings surrounding a vaccine come to light. Because the clinical indications and population size for vaccines vary by vaccine, blanket monitoring performance of all vaccines can be cost prohibitive and may not have a substantial positive clinical impact at the population level.
VA estimates the costs associated with enactment of S. 1799 to be as follows: $654,000 for FY 2013; $3.5 million over a 5-year period; and $7.7 million over a 10-year period.
S. 1806 Designation of Contributions to the Homeless Veterans Assistance Fund
S. 1806 would amend the Internal Revenue Code of 1986 to establish in the Treasury a trust fund known as the "Homeless Veterans Assistance Fund," and would allow taxpayers to designate a specified portion (not less than $1) of any overpayment of tax to be paid over to the Homeless Veterans Assistance Fund. Amounts in the Fund would "be available, as provided in appropriations Acts, to supplement funds appropriated to the Department of Veterans Affairs [(VA)], the Department of Labor [(Labor)] Veterans Employment and Training Service, and the Department of Housing and Urban Development [(HUD)] for the purpose of providing services to homeless veterans." S. 1806 would require that in the President's annual budget submission for fiscal year 2013 and each year thereafter, VA, Labor, and HUD include a description of the use of the funds from the Homeless Veterans Assistance Fund from the previous fiscal year and proposed use of such funds for the next fiscal year.
While S. 1806 is well-intended, VA is opposed to its enactment. VA views its services to homeless Veterans as an obligation of the Nation, earned by those Veterans by their service. That is also reflected in Congress' enactment of laws to allow VA to provide these services. The Secretary has made clear that this is in fact one of VA's most important obligations. While we appreciate sincerely the motive of bringing this issue before the taxpayers, we believe the presence of a check-off could lead some to see these obligations as a discretionary charity. VA

does involve charities and community organizations in its work, and they are vital. But VA prefers that all federal funding come from affirmative appropriations taken by the Congress, rather than voluntary apportionments through the tax code.

S. 1838 'Department of Veterans Affairs Pilot Program on Service Dog Training'

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

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

The bill also includes provisions concerning the service dogs themselves. The bill requires VA to ensure that each service dog in training is purpose-bred for this work with an adequate temperament, has a health clearance, and is age appropriate. Dogs in animal shelters or foster homes are not to be overlooked as candidates, but only if such dogs meet the service-dog candidate selection criteria under the bill. The Secretary must also ensure that each service dog in training is taught all basic commands and behaviors required of service dogs, that the service dog undergo public access training and receives additional training specifically tailored to address the mental health conditions or disabilities of the Veteran with whom the dog will be paired. In other words, that VA independently and internally train or produce service dogs for Veterans with mental health conditions or disabilities.

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

VA would be required to collect data on the pilot program and determine the effectiveness of the program in positively affecting Veterans with PTSD or other post-deployment mental health condition symptoms. The data must also indicate the feasibility and advisability of expanding the pilot program to additional VA medical centers. VA would be required to submit an annual report to Congress following the end of the first year of the pilot program and each year thereafter to

inform Congress about the details of the program and its effectiveness in specific areas. At the conclusion of the pilot program, the Secretary must submit to Congress a final report that includes recommendations with respect to the extension or expansion of the program.

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

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

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

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

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

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

The requirement to give a hiring preference to Veterans who have PTSD or other mental health conditions may be counterproductive to the goals and objectives of the pilot program. VA understands the pilot is aimed at creating a therapeutic treatment modality that will help patients currently suffering from and in treatment for PTSD and post-deployment mental health conditions. VA interprets the primary goal of the pilot to be finding better ways to improve the health of this Veteran population by exploring treatments, specifically Animal Assisted Therapy or Animal Facilitated Therapy that will prepare dogs to become service dogs for Veterans.

For these reasons, it is critically important that the trainers selected be experts at their job, which is to train Veterans to train dogs as a component of treatment and as a member of the treatment team. It would be beneficial if they also appreciated the importance of serving Veterans and possessed a working knowledge of the needs of this Veteran population, but it is necessary not to confuse the role of the clinical staff with the role of the trainer which is that of training the Veteran to train the dog. The bill also envisions VA hiring trainers as employees. Allowing VA to contract for these services would afford VA more flexibility and access to already available training experts, particularly as there is no Government Service (GS) occupation training service dogs for disabled individuals. Although on the surface this sounds reasonable, should the program prove to be inappropriate for expansion/spread there would be no position available for a dog trainer in the system.

VA is highly doubtful that the requirements of the bill can be accomplished within 120 days of the enactment. VA would have to establish selection criteria, advertise for sites (through a Request for Proposal), evaluate candidates and make selections. We are available to work with the Committee to provide advice on the components of what could be a workable program, and an appropriate mechanism to evaluate the current programs as to whether training service dogs is

a clinically appropriate form of treatment based on information gleaned from the Palo Alto program and other related animal therapy programs currently in place within the VA.
VA estimates the cost for the 3-year period of the pilot as follows: $635,281 in FY 2013; $658,151 in FY 2014; and $682,502 in FY 2015 for a total of $1,975,934.
S. 1849 Rural Veterans Health Care Improvement Act
Section 2(a) of S. 1849 would require VA's Director of the Office of Rural Health (ORH) to develop a 5-year strategic plan for improving access to, and the quality of, health care services for Veterans in rural areas. In developing this plan, the Director would be required to consult with the Director of VA's Health Care Retention and Recruitment Office, VA's Office of Quality and Performance, and VA's Office of Care Coordination Services. It would also require the Director to develop this plan not later than 180 days after the date of enactment, with the 5-year period beginning on the date of the plan's issuance.
Section 2(b) of the bill would require the strategic plan to include the following elements:
• Goals and objectives for the recruitment and retention of VA health care personnel in rural areas;
• Goals and objectives for ensuring timeliness and improving quality in the delivery of VA health care services furnished to Veterans in rural areas through the use of contract providers and fee-basis providers;
• Goals and objectives for the implementation, expansion, and enhanced use of VA telemedicine in rural areas (through coordination with other appropriate VA offices);
• Goals and objectives for ensuring the full and effective use of mobile outpatient clinics to provide health care services in rural areas;
• Procedures for soliciting from each VA facility that serves a rural area a statement of the facility's clinical capacity; its procedures in the event of a medical, surgical, or mental health emergency outside the scope of the facility's clinical capacity; and its procedures and mechanisms to provide (and coordinate) health care for women Veterans (including procedures and mechanisms for coordination with local hospitals and facilities, oversight of primary care and fee-basis care, and management of specialty care);
• Goals and objectives for modifying funding allocation mechanisms of the ORH to ensure that it distributes funds to Departmental components, to best achieve its goals and objectives in a timely manner;
• Goals and objectives for the coordination and sharing of resources between VA and the Department of Defense, Department of Health and Human Services, Indian Health Service, and other Federal agencies, as appropriate and prudent, to provide health care services to Veterans in rural areas;
• Specific milestones for the achievement of the goals and objectives developed for the plan; and
• Procedures for ensuring the effective implementation of the plan.
Section 2(c) of the bill would require, not later than 90 days after the date of the plan's issuance, that the Secretary transmit the strategic plan to Congress (along with any comments or recommendations that the Secretary considers appropriate).
VA does not believe that S. 1849 is necessary. VA's past and continuing efforts already provide a comprehensive approach to ensuring access to quality health care for Veterans in rural areas. Specifically, in 2010, VHA's ORH produced a 5-year strategic plan for fiscal years (FY) 2010-2014 to ensure that ORH programs and initiatives meet the health care needs of rural Veterans. That plan was refreshed in FY 2011, for FY 2012-2014, to better align ORH's

resources with identified health care needs, especially in light of new technologies and delivery systems for rural Veterans.

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

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

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

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

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

Finally, as discussed in connection with S. 1631, VA and the Department of Health and Human Services (HHS) are working on a memorandum of understanding (MOU) to address shortages in

the rural Health IT workforce and the need for the effective exchange of health care information between VA providers and rural providers furnishing care to Veterans. The MOU will serve to:
• Increase the number of trained health IT and health information management professionals;
• Diversify training programs to meet a wider range of training needs;
• Reach out to potential workers and employers to inform them about career pathways in health information management and technology;
• Support employers in staffing health IT positions; and
• Examine ways to leverage existing resources to develop potential pilot sites for Health Information Exchange between rural providers and VHA.

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

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

S. 2045 To Require Judges on the United States Court of Appeals for Veterans Claims to Reside Within 50 Miles of the District of Columbia

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

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

S. 2244 Veterans Missing in America Act of 2012

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

VA strongly supports the goal of ensuring that those who have earned the right to burial in a national cemetery are accorded that honor. VA commends organizations and volunteers who work to ensure that unclaimed and abandoned remains of our Nation's Veterans are identified and if eligible, receive a proper burial in a national cemetery. To ensure eligible Veterans receive burial in a national cemetery, VA currently works with States, counties, municipalities and private organizations to determine the eligibility of unclaimed and abandoned remains that are held at funeral homes or coroner's offices. In this regard, VA's National Cemetery Scheduling Office (NCSO) located in St. Louis, Missouri coordinates with Federal, State and local agencies to verify a deceased individual's military service and identity. NCSO also provides eligibility review assistance to entities such as the Missing In America Project (MIAP), to identify unclaimed remains and inter all eligible individuals.

In FY 2011, NCSO processed 663 requests for burial eligibility determinations that were submitted by the MIAP, which works on behalf of entities, such as city and county coroners'

offices, to ensure eligible Veterans receive proper burial. Currently, NCSO is working with the State of Oregon to identify unclaimed remains recently found in that state and determine eligibility for burial in a national cemetery.

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

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

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

S. 2259 Veterans' Compensation Cost-of-Living Adjustment Act of 2012

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

VA wholeheartedly supports this bill, which is consistent with the President's FY 2013 budget request. It would express, in a tangible way, this Nation's gratitude for the sacrifices made by our

service-disabled Veterans and their surviving spouses and children and would ensure that the value of their well-deserved benefits will keep pace with the increased cost of living.

VA estimates that this bill would result in first-year benefit costs of $772 million in FY 2013, five-year benefit costs of $4.9 billion, and ten-year benefit costs of $10.9 billion. However, as annual cost-of-living adjustments are assumed in the baseline for the Disability Compensation program, no PAYGO costs are associated with this proposal.

S. 2320 Remembering America's Forgotten Veterans Cemetery Act of 2012

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

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

S. 3052 Notice to Veterans of Availability of Services from VSOs

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

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

S. 3052 would not impose any costs on VA.

S. 3084 VISN Reorganization Act of 2012

Section 2 of S. 3084 would require VHA to consolidate its 21 Veterans Integrated Service Networks (VISN) into 12 geographically defined VISNs, would require that each of the 12 VISN headquarters be co-located with a VA medical center, and would limit the number of employees at each VISN headquarters to 65 FTE. VA does not support section 2 for a number of reasons. By increasing the scope of responsibility and span of control of each VISN headquarters while reducing the number of employees at each, the legislation would impede VA's ability to implement the national goals of the Department. Currently, VISN headquarters are capable of providing assistance to supplement resource needs at facilities and are able to support transitions in staff within local facilities when there are personnel changes; with a responsibility for oversight of more facilities and fewer staff, the VISN headquarters would lose the opportunity to provide this sometimes essential service.

VHA has already reviewed each VISN headquarters and is in the process of working with each to streamline operations, create efficiencies internal to each VISN, and to realign resources to facilities. This will achieve savings while not creating the negative outcomes of the restructuring

and new organizations proposed in S. 3084. Current VHA plans are to reduce VISN staffing levels.

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

This section's requirement that VISN budgets be balanced at the end of each fiscal year may have other unintended consequences. Currently, at the end of each fiscal year, each VISN's accounts must be balanced, and this is sometimes achieved by providing additional resources from VHA Central Office. Additional resources may be needed for a number of reasons, including greater than anticipated demand, a national disaster or emergency, new legal requirements enacted during the year, and other factors. By codifying a requirement that the VISN budget be balanced at the end of each fiscal year, VA may lose this flexibility to supplement VISNs with additional resources, and Veteran patient care would suffer as a result.

Section 2 also requires the Department to identify and reduce duplication of functions in clinical, administrative, and operational processes and practices in VHA. We are already doing this by identifying best practices and consolidating functions where appropriate. Furthermore, while section 2 describes how the VISNs should be consolidated, it fails to clearly articulate the flow of leadership authority. In fact, by moving certain oversight responsibilities to regional centers, S. 3084 would create no clear lines of authority from VHA Central Office, regions, VISNs, to medical centers, actually producing less oversight and more confusion.

Additionally, the proposed combination of VISNs simply combines VISNs to arrive at a reduction in the total number of Networks and employees without considering the underlying referral patterns within each VISN. The original VISN boundaries were drawn based upon local population health needs. Each VISN is charged with managing quality and access of health care while increasing the efficient delivery of population health. S. 3084 fails to take this into account in aligning VISN boundaries. For example, it is unclear why VISNs 19 and 20 should be consolidated, which would produce a single Network responsible for overseeing 12 states, 15 VA health care systems or medical centers, and a considerable land mass, while VISN 6, which oversees three states and eight health care systems or medical centers, remains its own entity. VA would appreciate the opportunity to review the Committee's criteria for determining these boundaries.

Lastly, Section 2 of S. 3084 seems to assume that locating the management function off campus from a medical center represents an inefficient organizational approach. We believe that assumption is not valid for all cases. Currently, six VISNs (1, 2, 3, 20, 21, and 23) are co-located with a VA medical center; the legislation's requirement for co-location with a VA medical center would require either construction to expand existing medical centers, using resources that would otherwise be devoted to patient care to cover administrative costs, or would require the removal of certain clinical functions to create space for VISN staff in at least nine VISNs given the bill's proposed realignment of VISNs 1, 2, and 3, as well as 20 and 21.

As a result of this legislation, Veterans may be forced to travel to different locations for services that were previously available at the new host facility, or may be unable to access new services that would have been available had construction resources not been required to modify existing facilities to accommodate VISN staff. While section 4 of the bill states that nothing in the bill

shall be construed to require any change in the location or type of medical care or service provided by a VA medical center, the logistical reality of required co-location with medical centers would necessitate this result.

VA also does not support section 3 of S. 3084. Section 3 would require VA to create up to four regional support centers to "assess the effectiveness and efficiency" of the VISNs. Section 3 identifies a number of functions to be organized within the four regional centers including:

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

This would present several challenges, as certain services are more appropriately organized as fully consolidated national functions instead of regional ones. The functions identified for homelessness and women Veterans would create capabilities that duplicate existing national services. The current structure (VISN accountability and national oversight) is directly linked with ensuring accountable leadership oversight that is much more proximate to health care services provided to Veterans in facilities. The proposed structure creates two national-level entities competing for oversight analysis relationships with facilities. Furthermore, the proposed functions may not be the most appropriate ones to offer for consolidation into four centers. VHA has created seven Consolidated Patient Account Centers to achieve superior levels of sustained revenue cycle management, established national call centers to respond to questions from Veterans and their families, and is assessing consolidation of claims payment functions to achieve greater efficiencies and accuracy. These types of functions are more appropriate to move off-station without damaging the necessary management/accountability relationship between leadership, line management, and staff. The rationale behind the selected functions does not appear to have been based on a thorough analysis of the types of functions best suited to consolidation.

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

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

S. 3202 Dignified Burial of Veterans Act of 2012

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

describe industry standards for caskets and urns, and assess compliance with such standards at VA national cemeteries.

VA does not object to enactment of the main feature of S. 3202, provided Congress identifies appropriate cost offsets, but believes its reporting requirement is unnecessary. Section 2 of the bill, would assist in ensuring that a suitable casket or urn is provided for interment in a national cemetery of the remains of any Veteran without family and necessary resources. This legislation is consistent with VA's continued efforts to address the needs of homeless Veterans – many of whom die as unclaimed and indigent individuals.

Section 3 of the bill, requiring a report on industry standards for caskets and urns and VA's compliance with such standards at national cemeteries, is unnecessary. Currently, NCA relies upon licensed funeral directors who prepare remains to comply with relevant Federal, State, and local laws regarding the preparation of Veterans' remains. When caskets or urns are presented for burial, NCA cemetery directors assess containers to determine any possible health or safety risks and whether the caskets or urns are sufficiently constructed to allow for necessary handling for burial. On rare occasions when caskets or urns do not meet these standards, NCA instructs the funeral director to return to the cemetery with remains in a proper container to facilitate burial. For the remains of Veterans with next of kin, NCA respects the wishes of families regarding their choice of containers so long as there are no public health or safety concerns.

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

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

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

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