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SENATE

{ REPORT
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VETERANS TELEHEALTH AND OTHER CARE IMPROVEMENTS ACT OF 2010

SEPTEMBER 2, 2010.—Ordered to be printed

Filed, under authority of the order of the Senate of August 5, 2010

Mr. AKAKA, from the Committee on Veterans' Affairs,
submitted the following

R E P O R T

together with

SUPPLEMENTAL VIEWS

[To accompany S. 3325]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 3325), a bill to amend title 38, United States Code, to authorize the waiver of the collection of copayments for telehealth and telemedicine visits of veterans, and for other purposes, having considered an amendment to the bill in the nature of a substitute, unanimously reports favorably thereon with an amendment, and an amendment to the title, and recommends that the bill, as amended, do pass.

INTRODUCTION

On May 6, 2010, Senator Begich introduced S. 3325. S. 3325 would authorize the Secretary of Veterans Affairs (hereinafter, "the Secretary") to waive the collection of copayments for telehealth and telemedicine visits of veterans.

Earlier, on November 9, 2009, Senator Cornyn introduced S. 2751, to name the Department of Veterans Affairs medical center in Big Spring, Texas as the "George H. O'Brien Jr., Department of Veterans Affairs Medical Center."

On February 24, 2010, Senator Baucus introduced S. 3035, the proposed "Veterans Traumatic Brain Injury Care Improvement Act

of 2010.” S. 3035 would require the Secretary to report to the Congress on the feasibility and advisability of establishing a polytrauma rehabilitation center or polytrauma network site in the Dakotas or northern Rockies.

On May 5, 2010, Senator Brown of Ohio introduced S. 3314. S. 3314 would require the Secretary of Veterans Affairs and the Appalachian Regional Commission to carry out a program of outreach for veterans who reside in Appalachia.

On May 7, 2010, Senator Casey introduced S. 3330, the proposed “Veterans’ Health and Radiation Safety Act of 2010.” S. 3330 would require an annual report on low volume programs, training on use of radioactive isotopes, and enhanced oversight of care provided by contractors.

On May 12, 2010, Senator Klobuchar introduced S. 3355, the proposed “Veterans One Source Act of 2010.” S. 3355 would require the Secretary to establish an internet website designed to provide an interactive one-stop source of information on benefits, health care, and services for which veterans may be eligible.

On May 14, 2010, Senator Burr introduced S. 3377. S. 3377 would improve the multifamily transitional housing loan program of the Department of Veterans Affairs by requiring the Secretary of Veterans Affairs to issue loans for the construction of, rehabilitation of, or acquisition of, land for multifamily transitional housing projects instead of guaranteeing loans for such purposes.

On April 5, 2010, the Committee held a field hearing on benefits and services for veterans in Appalachia. Testimony was offered by: Kim Graves, Eastern Area Director, Veterans Benefits Administration, Department of Veterans Affairs, accompanied by Joyce Cange, Director, Cleveland Regional Office, Jack Hetrick, Director, VA Health care System of Ohio, and Jeffrey Gering, Director, Chillicothe VA Medical Center; Bill Hartnett, Director, Ohio Department of Veterans Services; Rich Greenlee, MSW, PhD, Dean, Ohio University Eastern Campus; Lucinda Maupin, Veterans Service Officer, Belmont County; Ed Acevedo, U.S. Army Veteran, Operation Enduring Freedom and Operation Iraqi Freedom; and Andrea Neutzling, U.S. Army Veteran, Operation Iraqi Freedom.

On May 5, 2010, the Committee held an oversight hearing on traumatic brain injury. Testimony was offered by: Lucille Beck, PhD, Chief Consultant, Rehabilitation Services, Department of Veterans Affairs, accompanied by Karen Guice, MD, MPP, Director, Federal Recovery Coordination Program, Joel Scholten, MD, Associate Chief of Staff for Physical Medicine and Rehabilitation, Washington DC VA Medical Center, and Sonja Batten, PhD, Deputy Director, Department of Defense Center of Excellence for Psychological Health and Traumatic Brain Injury; Colonel Michael S. Jaffee, MD, National Director, Defense and Veterans Brain Injury Center; Karen Bohlinger, Second Lady, State of Montana; Jonathan Barrs, Operation Iraqi Freedom Veteran; Bruce M. Gans, MD, Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation; Michael F. Dabbs, President, Brain Injury Association of Michigan; and Michelle C. LaPlaca, PhD, Associate Professor, Wallace H. Coulter Department of Biomedical Engineering, Georgia Institute of Technology.

On May 19, 2010, the Committee held a hearing on pending health and benefits legislation. Testimony was offered by: Thomas

J. Pamperin, Associate Deputy Under Secretary for Policy and Program Management, Veterans Benefits Administration, Department of Veterans Affairs, and Robert Jesse, MD, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, accompanied by Richard J. Hipolit, Assistant General Counsel, and Walter A. Hall, Assistant General Counsel; The Honorable Raymond Jefferson, Assistant Secretary of Veterans' Employment and Training Service, Department of Labor; Ian DePlanque, Assistant Director, Veterans Affairs and Rehabilitation Commission, The American Legion; Eric A. Hilleman, National Legislative Director, Veterans of Foreign Wars; Rick Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America, accompanied by Alan Oates, Chairman, Agent Orange/Dioxin and Other Toxic Substances Committee; and Tom Tarantino, Legislative Associate, Iraq and Afghanistan Veterans of America.

On June 16, 2010, the Committee held a hearing on VA health care in rural areas. Testimony was offered by: Robert Jesse, MD, Acting Principal Deputy Under Secretary for Health, Department of Veterans Affairs, accompanied by Glen W. Grippen, Network Director, Veterans Integrated Service Network 19; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; James F. Ahrens, Chairman, Veterans Rural Health Advisory Committee, Department of Veterans Affairs; Ronald Putnam, Veteran Service Officer, Haywood County, North Carolina; William Schoenhard, Deputy Under Secretary for Health for Operations and Management, Department of Veterans Affairs; Dan Winkelman, Vice President for Administration & General Counsel, the Yukon-Kuskokwim Health Corporation, Alaska; and Brigadier General Deborah McManus, Assistant Adjutant General of Air, Joint Forces Headquarters, Alaska, and Commander, Alaska Air National Guard, accompanied by Verdine Bowen, Director, Office of Veterans Affairs, Alaska Department of Military and Veterans Affairs.

COMMITTEE MEETING

After carefully reviewing the testimony from the forgoing hearings, the Committee met in open session on August 5, 2010, to consider, among other legislation, an amended version of S. 3325, consisting of S. 3325 as introduced and provisions derived from the other legislation noted above, as well as freestanding provisions. The Committee voted unanimously to report favorably S. 3325, as amended.

SUMMARY OF S. 3325 AS REPORTED

S. 3325, as reported (hereinafter, "the Committee bill"), would improve the quality of health care provided by the Department of Veterans Affairs (hereinafter, "VA" or "the Department"), to increase access to health care and benefits provided by the Department, to authorize major medical facility construction projects of the Department, and for other purposes.

TITLE I—QUALITY OF CARE AND ACCESS MATTERS

Section 101 would waive the collection of copayments from veterans for telehealth and telemedicine visits.

Section 102 would require the Secretary to carry out a program of outreach to veterans who reside in a region served by one of the Federally chartered regional commissions or authorities, as well as other non-Federally chartered development boards or authorities, and would authorize the Secretary to partner with such a commission or authority in order to carry out such a program of outreach.

Section 103 would require an annual report on low volume procedures involving the use of radioactive isotopes at Department facilities.

Section 104 would require all VA employees who handle or perform procedures utilizing radioactive isotopes to receive appropriate training.

Section 105 would provide further oversight of medical services provided by contractors at Department facilities.

Section 106 would improve the multifamily transitional housing loan program of the Department by requiring the Secretary to issue loans for the construction of, rehabilitation of, or acquisition of land for multifamily transitional housing projects.

Section 107 would require a report on the establishment of a Polytrauma Rehabilitation Center or Polytrauma Network Site of the Department in the northern Rockies or Dakotas.

Section 108 would authorize the Secretary to create an Internet website for information on benefits, resources, services, and opportunities for veterans and their families and caregivers.

TITLE II—CONSTRUCTION AND NAMING MATTERS

Section 201 would authorize fiscal year 2011 major medical facility projects previously appropriated, but not authorized.

Section 202 would make an additional authorization for a fiscal year 2007 major medical facility project previously authorized.

Section 203 would authorize fiscal year 2011 major medical facility leases.

Section 204 would authorize appropriations to carry out the provisions of sections 201 through 203.

Section 205 would require the Secretary to submit a report to Congress on the use of energy efficient technologies and best practices in Department facilities.

Section 206 would designate the VA medical center in Big Spring, Texas, as the “George H. O’Brien, Jr., Department of Veterans Affairs Medical Center.”

Section 207 would require that savings realized from bid negotiation be used for major medical facility projects already authorized.

BACKGROUND AND DISCUSSION

TITLE I—QUALITY OF CARE AND ACCESS MATTERS

Title I of the Committee bill contains a variety of provisions that are designed to improve VA outreach efforts to veterans and the quality of VA health care delivery.

Sec. 101. Waiver of Collection of Copayments for Telehealth and Telemedicine Visits of Veterans.

Section 101 of the Committee bill, derived from S. 3325 as introduced, would waive the collection of copayments from veterans for telehealth and telemedicine visits.

Background. For purposes of providing greater access to care and reducing the amount of travel required for patients, especially in rural areas, VA delivers care through telehealth modalities such as telephone consultations, videoconferencing, and use of robotic technology. Telehealth visits can be made from patient homes or community-based outpatient clinics.

In December 2008, Adam Darkins, MD, VA Office of Care Coordination Services, spearheaded a study entitled, “Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions.” That study found that VA patients using home telehealth experienced a 19 percent reduction in hospitalizations and a 25 percent reduction in days hospitalized. A RAND Corporation study, “Health Insurance and the Demand for Medical Care” (Manning et al, 1988), found that copayment rates were highly influential on the likelihood that an enrollee would use any medical care. Under current law, VA charges full copayments for care delivered through telehealth technologies. Currently, VA patients are charged fifteen dollars for primary care telehealth visits and fifty dollars for specialty care telehealth visits.

Committee Bill. Section 101 of the Committee bill would add a new section 1722B to title 38, United States Code. New section 1722B, entitled “Copayments: waiver of collection of copayments for telehealth and telemedicine visits of veterans,” would prohibit VA from collecting any copayments for a veteran’s utilization of telehealth or telemedicine. The new section 1722B would contain a five-year sunset on the waiver of these copayments, and would require the Secretary to report to the Committees on Veterans’ Affairs of the Senate and of the House of Representatives on whether the waiver of such copayments has resulted in higher utilization of telehealth by veterans, and on the costs or savings realized by the Department as a result of the waiver of such copayments.

Sec. 102. Program of Outreach to Veterans.

Section 102 of the Committee bill, which is derived from S. 3314 as introduced, would require the Secretary to carry out a program of outreach to veterans who reside in a region served by one of the Federally chartered regional commissions or authorities, as well as other non-Federally chartered development boards or authorities, and would authorize the Secretary to partner with such a commission or authority in order to carry out the required program of outreach.

Background. There are seven Federally chartered regional commissions or authorities: the Appalachian Regional Commission, established in 1965 by Public Law 89–4; the Delta Regional Authority, established in 1988 by Public Law 100–460; the Northern Great Plains Regional Authority, established in 1994 by Public Law 103–318; the Denali Commission, established in 1998 by Public Law 105–277; the Southeast Crescent Regional Commission, established in 2008 by Public Law 110–246; the Southwest Border Regional Commission, established in 2008 by Public Law 110–246; and the Northern Border Regional Commission, established in 2008 by Public Law 110–246.

These commissions are regional economic development entities that represent a partnership of federal, state, and local governments and are intended to coordinate the efforts of agencies and community organizations to promote economic development and infrastructure improvements in certain underdeveloped or economically distressed areas. A 2005 study by Ohio University's Appalachian Rural Health Institute found that:

Residents living in the ARHI project counties have health access problems related to availability of medical resources, especially health care providers and medical specialists * * *. Constraints to obtaining medical care related to access also include personal perceptions related to family traditions, cultural traits, and individual motivation * * *. Rural residents could benefit from the formation of collaborative partnerships with local agencies, institutions, and health care providers, faculty and researchers from academia, and consider possibilities of multi-county coalitions.

At a Committee field hearing on April 5, 2010, in Cambridge Ohio, Richard W. Greenlee, MSW, PhD, Associate Professor of Social Work and Dean of Ohio University Eastern Campus, stated:

Military veterans have been found to be less likely than the general population to seek mental health services due to perceived stigma (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). Combine this with the Appalachians' resistance to seeking mental health treatment or help of any kind (Behringer and Friedell, 2006), and the combination of the two cultures, one military, the other regional affiliation, and it is highly unlikely that Appalachian veterans will voluntarily seek help for depression, anxiety or post traumatic stress disorder that they may be experiencing upon returning home from the service.

There are other regions that have similar socio-economic characteristics to Appalachia, and consequently have poor access to, and low utilization of, health care. On June 16, 2010, at a Committee hearing on rural health, Dan Winkelman, Vice President for Administration and General Counsel of the Yukon-Kuskokwim Health Corporation, described remote western Alaska as a region faced with an unemployment rate of over 20 percent, an average per capita income of \$15,000, and where over 6,000 homes do not have access to safe drinking water. He stated:

This is the environment where many Alaska Native veterans were born and raised and then return to after serving our great Country. For Alaska Native/American Indian veterans, who serve at the highest per capita rate of any U.S. race, to lack access upon their return from duty to culturally appropriate and quality health care services by the Veterans Administration (VA) is a shame. In Alaska, highly rural veterans must break through several barriers in order to receive care. There are almost no VA facilities in rural Alaska. The existing IHS and tribal facilities, managed by tribal health organizations like YKHC, are

underfunded according to the IHS by approximately 50 percent.

Committee Bill. Section 102 of the Committee bill would require the Secretary to carry out a program of outreach for veterans who reside in a region served by one of the Federally chartered regional commissions or authorities, as well as other non-Federally chartered development boards or authorities located in areas that are severely economically distressed or face unusual economic challenges, such as areas separated from the mainland United States. In carrying out this program of outreach, the Secretary would be authorized to partner with such commissions or authorities. The program would be required to increase veterans' awareness of, access to, and use of benefits and services for which they are eligible. The commissions would be authorized to provide technical assistance, award grants, or enter into contracts with individuals or entities in their respective region for these purposes. The Department would be authorized to enter into agreements with Federal, State, or local agencies to achieve these purposes. There would be a five-year sunset on the program of outreach, and the Secretary would be required to provide a comprehensive report to the Committees on Veterans' Affairs of the Senate and of the House of Representatives on the Department's outreach activities and the efficacy of those activities. This program would be authorized to receive appropriations of an amount not to exceed \$7 million in the first year and of an amount not to exceed \$35 million over five years.

Sec. 103. Annual Report on Low Volume Procedures Involving Use of Radioactive Isotopes at Department of Veterans Affairs Medical Facilities.

Section 103 of the Committee bill, which is derived from S. 3330 as introduced, would require the Department to submit an annual report to Congress on low volume procedures that involve the use of radioactive isotopes, at each medical facility.

Background. On May 5, 2008, a patient of the Philadelphia VAMC (hereinafter, "PVAMC") underwent prostate brachytherapy in treatment for prostate cancer. Brachytherapy is a procedure in which radioactive metal seeds are implanted in a patient in order to kill cancerous cells. The patient was implanted with radioactive seeds of the wrong strength, and this error was not discovered until seven days later. An Office of Inspector General (hereinafter, "OIG") investigation, published on May 3, 2010 (hereinafter, "the report"), found that several patients at PVAMC were implanted with radioactive seeds of incorrect strength resulting in patients receiving a dose lower than was prescribed by the oncologist. This event triggered a comprehensive review of PVAMC's entire brachytherapy program by the Veterans Health Administration's (hereinafter, "VHA") National Health Physics Program (hereinafter, "NHPP"), the entity to which the U.S. National Regulatory Commission (hereinafter, "NRC") delegates responsibility for providing regulatory oversight of VA nuclear medicine.

NHPP found that of the 114 patients who underwent prostate brachytherapy at PVAMC, 97 experienced what are considered "medical events" wherein either patients received underdosing to the prostate, or, overdosing to non-prostatic tissue. On June 29, 2009, the Committee held a field hearing in Philadelphia, Pennsyl-

vania to examine the PVAMC cancer treatment program. Ultimately, VA suspended the PVAMC's prostrate brachytherapy program, and a \$227,500 fine was levied against the facility by the NRC, the second largest fine ever imposed by NRC to that date.

Committee Bill. Section 103 of the Committee bill would require the Department to submit an annual report for three years, beginning not later than 270 days after the enactment of the legislation, on low volume procedures involving the use of radioactive isotopes carried out in such year, at each medical facility.

For purposes of this section, the Secretary would establish a minimum threshold for each type of procedure involving radioactive isotopes, carried out at Department facilities. A "low volume procedure" would be defined as a procedure performed on fewer patients than the minimum threshold prescribed by the Secretary. It is the Committee's intent that in making such determination, the Secretary may consider the minimum number of procedures of a specific type that a provider must carry out annually to be considered competent in that procedure. Each annual report would be required to include evaluations of and findings regarding low volume procedures involving radioactive material, and how to incorporate consideration of such procedures in quality assurance plans at the facility level.

Sec. 104. Use of Radioactive Isotopes at Department of Veterans Affairs Hospitals.

Section 104 of the Committee bill, which is derived from S. 3330 as introduced, would require all employees who handle or perform procedures utilizing radioactive isotopes at a VA facility to receive appropriate training on what constitutes a medical event.

Background. VHA holds a Master Materials License issued by NRC. VA administers its nuclear medicine program under the authority of that license. Although VA establishes its own procedure for how and when a physician will measure the radiation dose given to a patient, it is the NRC's responsibility to ensure patients receive the physician's intended dose of radiation. Though VA has the authority and responsibility to ensure proper quality management and safety in using radioactive materials in medical treatment, the Department is also responsible for reporting medical events to the NRC. In the May 3, 2010 report OIG found a number of concerns on the part of both VA and NRC with respect to the operating definition of a "medical event," and recommended VA and NRC senior leadership work to resolve these discrepancies.

Committee Bill. Section 104 of the Committee bill would require every employee, including those hired under a contract with a non-government entity, who handles or performs procedures involving radioactive material, to receive appropriate training on the definition of a medical event, and when and to whom such a medical event should be reported. Under this section, should the Secretary find that a facility has failed to provide the required training to any employee, that employee would be barred from using radioactive isotopes until the training is completed.

It is the Committee's intent to ensure all VA employees involved in any procedure involving radioactive materials are aware of what constitutes a medical event, as a safeguard to ensure that any fu-

ture adverse outcomes for procedures involving radioactive isotopes are detected and resolved in a timely and efficient manner.

Sec. 105. Requirements Relating to Contracts for the Provision of Medical Services.

Section 105 of the Committee bill, which is derived from S. 3330 as introduced, would provide further oversight of medical services provided by contractors.

Background. Radiation therapy services have been provided by the University of Pennsylvania Health System (hereinafter, “UPHS”) to PVAMC since 1996. The first contract was awarded in May 1996 for one year with an additional two option years. However, OIG found that PVAMC paid UPHS for radiation therapy services from May 1999 to April 2005 without a contract or other agreement authorizing payment for such services, and from April 2005 through 2009, PVAMC paid UPHS for radiation therapy services under an Interim Agreement that violated VA policy limits on the length and extensions of contracts, as mandated in VA Directive 1663.

OIG also found that, “quality management processes pertaining to PVAMC’s practice of prostrate brachytherapy were deficient,” and that, “from 2002 to 2006, no peer review or quality assessments took place at PVAMC for prostrate brachytherapy.” OIG also found that, from November 2006 to November 2007, PVAMC experienced an information technology failure where brachytherapists were unable to perform a standard post-operative computed tomography scan so as to measure the amount of radiation given to the patient in order to ensure the procedure was properly performed. The OIG identified similar quality management deficiencies in other VHA brachytherapy programs as well. After a national assessment of VHA prostate brachytherapy programs, such programs were suspended at the Washington, DC VAMC in September 2008, the Philadelphia VAMC in June 2008, and the Jackson VAMC in September 2008, due to possible under-dosing of radiation. In October 2008, the program at the Cincinnati VAMC was suspended as well but was subsequently approved to restart in February 2010.

Committee Bill. Section 105 of the Committee bill would add a new section 1703A to title 38, United States Code, entitled “Oversight of medical services provided by contractors.” This new section would require that Department quality management include oversight of medical services provided under contracts with non-government entities. Such oversight would include periodic peer reviews, periodic written evaluations by supervisors of the individual providing services, and any other evaluation the Secretary deems necessary. The Secretary would also be required to gather and analyze data on the quality of medical services provided under contract at every Department facility and any Department contracting officer would be required to consider such data prior to extending or renewing a contract, 270 days after enactment of the legislation. The Committee expects that the collection of detailed information at this level of specificity will help avoid a similar future incident.

Sec. 106. Conversion of Multifamily Transitional Housing Loan Program to Loan Issuance Program.

Section 106 of the Committee bill, which is derived from S. 3377 as introduced, would improve the multifamily transitional housing loan program of the Department by requiring the Secretary to issue loans for the construction of, rehabilitation of, or acquisition of land for multifamily transitional housing projects.

Background. In section 601 of Public Law 105–368, the Veterans Programs Enhancement Act of 1998, Congress authorized, under subchapter VI of chapter 20 of title 38, the Loan Guarantee for Multifamily Transitional Housing Program. Under this program VA was authorized to guarantee up to 15 secured loans with an aggregate dollar amount of \$100 million to develop transitional housing with onsite supportive services for homeless veterans. In 1999, Public Law 106–74, the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 2000 provided \$48 million in appropriations for the original loan guarantee program. Because only one loan has been guaranteed since the program’s inception, most of that funding, approximately \$43 million, remains available for obligation.

The Loan Guarantee for Multifamily Transitional Housing Program was designed to encourage lenders to make low-interest loans, backed by a VA guarantee, available to homeless providers for the acquisition, construction, and improvement of transitional housing units. Only one provider, St. Leo Campus for Veterans in Chicago, Illinois, operated by Catholic Charities, received a VA-backed housing loan.

St. Leo Campus has been faced with numerous operational challenges that are typical for a provider servicing the homeless population. What exacerbates the challenge is the rigidity of the original VA loan program. Without flexibility in loan terms and conditions, St. Leo Campus struggles to make ends meet, which has brought into question the sustainability of the project. To provide the necessary services to homeless veterans, St. Leo Campus has relied on one-time grants and donations which, in a difficult economy, are a highly volatile source of revenue. Flexibility in the terms of its VA loan would give St. Leo Campus and other homeless providers a chance to weather cyclical funding challenges.

In 2009, VA terminated the Loan Guarantee for Multifamily Transitional Housing Program pursuant to a recommendation made in the 2008 Annual Report of its Advisory Committee on Homeless Veterans. However, prior to terminating the program, VA issued a report detailing how the program might be modified and made more attractive to providers. The Committee bill tracks the recommendations made in VA’s report.

Committee Bill. Section 106 of the Committee bill would transform the program under subchapter VI of chapter 20 of title 38 from a loan guarantee program to a program that actually issues loans. As a result, the title of this subchapter would be amended to read “Multifamily Transitional Housing.” Although this transformation of the program would not affect the validity of any loan guaranteed before the date of the enactment, it would prohibit, under subsection (a)(3) of section 106, the Secretary from guaranteeing any loans under this program from that date forward.

As part of the new loan issuing program, section 106 would create a revolving fund, under subsection (b), which would serve as the source of loans under the new authority. The assets of the new revolving fund would consist of all amounts received by the Secretary from operations relating to the issuance of loans under this program. These amounts include, among other things, any fees imposed on a loan recipient under any provision of law or regulation which is established by the Secretary. The revolving fund would also include all amounts previously appropriated for the loan guarantee program. This would allow the Secretary to access and utilize the \$43 million remaining from the terminated loan guarantee program to fund new issued loans.

In addition, section 106 would make improvements to the terms and conditions of the loan program. These improvements would give the Secretary greater flexibility in the types of loans VA may offer and the conditions attached to repayment. Subsection (a)(2) of section 106 would authorize the Secretary to delegate loan approval to a State or local government entity. Subsection (c) of section 106 would allow the Secretary to consider reasonable terms and conditions of the loan to include payment deferral, forbearance, and debt forgiveness. Subsection (d) of section 106 would clarify that projects financed with a VA loan may include space for job training programs, other types of residential units, neighborhood retail or other commercial activities, or other uses that the Secretary determines necessary for the sustainability of the multifamily transitional housing projects. Subsection (e) of section 106 would give VA the authority to sell, rent, operate, or otherwise dispose of a multifamily transitional housing project in the event of default. Lastly, subsection (f) of section 106 would preempt any Federal, State, or local housing statute that limits a project from offering preferential treatment to veterans.

Sec. 107. Report on Establishment of a Polytrauma Rehabilitation Center or Polytrauma Network Site of the Department of Veterans Affairs in the Northern Rockies or Dakotas.

Section 107 of the Committee bill, which is derived from S. 3035 as introduced, would require a report on the feasibility and advisability of establishing a VA polytrauma rehabilitation center (hereinafter, "PRC") or polytrauma network site in the northern Rockies or Dakotas.

Background. Polytrauma refers to the cumulative state of health resulting from exposure to a single event which has caused multiple and complex injuries. Such injuries can impact the brain, limbs, spinal cord, and musculoskeletal system, and in turn, can adversely affect hearing, vision, and cognition.

The VA Polytrauma System of Care provides treatment to veterans with polytrauma through four PRCs, located in Palo Alto, Tampa, Richmond, and Minneapolis, which offer comprehensive inpatient and outpatient treatment. A fifth PRC is, as of the date of this report, being constructed at the VAMC in San Antonio, Texas. There are also 22 polytrauma network sites which provide a full range of comprehensive follow-on medical and rehabilitative services, both inpatient and outpatient. This system of care covers most of the nation; however, according to testimony the Committee received during a May 5, 2010 hearing on VA care for traumatic

brain injury (hereinafter, "TBI"), there is a gap in availability of care in the northern Rockies and Dakotas, an area that encompasses approximately 740,000 square miles.

An April 2008 RAND Corporation study estimated that 320,000 veterans may have suffered brain injuries, from mild concussions to severe wounds, and that 57 percent of those who reported experiencing a probable TBI were never evaluated by a physician. Veterans with severe polytrauma who do not live in proximity of a polytrauma care presence face difficulties in receiving necessary treatment. In testimony before the Committee, Karen Bohlinger, Second Lady of Montana, testified that she had to fly from Montana to Seattle, Washington every ten days, at personal expense, in order to follow up on care for her son, an Army Special Forces officer who had sustained a TBI. She further testified that there were insufficient Department resources in Montana that would have allowed her son to be treated close to their home.

Committee Bill. Section 107 of the Committee bill would, in a freestanding provision, require the Secretary to conduct a study and report to the Congress, within 180 days after enactment, on the feasibility and advisability of establishing a PRC or polytrauma network site in the northern Rockies or Dakotas. This section would specify that the Fort Harrison VAMC be one of the sites evaluated for potential placement of a PRC or a polytrauma network site.

The report would be required to include an assessment of the adequacy of existing services provided at Department facilities, and of the availability of the types of services that would otherwise be provided by a PRC or polytrauma network site. The report would also be required to include a comparative assessment of the effectiveness of TBI rehabilitation programs in urban versus rural settings, an assessment of whether the low cost of living in the region could reduce the financial burden on families of a veteran undergoing TBI care and thereby improve that care, and whether any stress caused by living in an urban area can impede therapies to prevent or remediate the development of secondary neurologic conditions related to TBI. The Department would be required to consult with State and local government entities in preparing this report.

Sec. 108. One-Stop Internet Website for Information on Benefits, Resources, Services, and Opportunities for Veterans and their Families and Caregivers.

Section 108 of the Committee bill, which is derived from S. 3355 as introduced, would authorize the Secretary to establish an Internet website for information on benefits, resources, services, and opportunities for veterans and their families and caregivers.

Background. Currently, VA's website and other related sites have a wealth of information regarding the benefits for which veterans may be eligible, including health care services, education and employment assistance, pension, home loan guaranties, and life insurance. While an extensive array of benefits and services are available to veterans, there is no single-source information repository that veterans can use to easily find information on the benefits and services for which they may be eligible, or how to access such benefits and services. As veterans of Operation Enduring Freedom and

Operation Iraqi Freedom (hereinafter, “OEF and OIF”) return home, it is important that the Department help ease their transition and assist them in adapting to civilian life.

Committee Bill. Section 108 of the Committee bill would, in a freestanding provision, authorize the Secretary to create an interactive, comprehensive internet website to provide information on benefits, resources, services, and opportunities for veterans and family members. It is the Committee’s expectation that such a website be user-friendly and increase interoperability and the sharing of information.

This information would be required to include benefits provided by the Department, the Department of Labor, the Small Business Administration, as well as tax and social security benefits. Additionally, the website would be required to include information on resources for families, caregivers, education and mental health professionals, and others that provide services for veterans. Information on child care, home care, stress management, mental health care, discounts, volunteer opportunities, and community events, as well as links to state and local resources and veterans service organizations would also be required to be included. Finally, the website would be required to assist veterans and family members in applying for and receiving these benefits.

In implementing this section, the Secretary would be required to consult with the Secretary of Defense, the Secretary of Labor, the Secretary of Education, the Commissioner of Internal Revenue, the Commissioner of Social Security, the Administrator of the Small Business Administration, other Federal officials, appropriate advisory committees, and other appropriate individuals. Additionally, the Secretary would both report on the status and impact of the website, in the Department’s biennial plan for outreach, as mandated by Public Law 109–233.

It is the Committee’s intent that such a website be functionally similar to the Military One-Source website of the Department of Defense, and that it would serve as a single, all-inclusive source of information on, or references to information on, benefits, resources, services, and opportunities for veterans, and their families and caregivers.

TITLE II—CONSTRUCTION AND NAMING MATTERS

Title II of the Committee bill contains a variety of provisions that are designed to provide authorization for both leases and the construction of Department medical facilities.

Sec. 201. Authorization of fiscal year 2011 major medical facility construction projects previously appropriated but not authorized.

Section 201 of the Committee bill would authorize the Secretary to carry out the construction of a new major medical facility project in New Orleans, Louisiana for which some funding has been appropriated but for which only \$300,000,000 was authorized in Public Law 109–461.

Background. The VAMC in New Orleans, Louisiana sustained catastrophic damage as a result of Hurricane Katrina. The facility was closed and a system of leased clinics was created to continue the provision of outpatient services, while surgical procedures and

inpatient care are purchased through local providers or referred to VA facilities outside of New Orleans. The proposed project would be a tertiary care medical complex that would reestablish a full continuum of medical services, including acute and long-term inpatient beds, primary care, mental health, specialty care, surgical capabilities, expanded treatment, diagnostic, and ancillary services, and a parking structure, all in compliance with hurricane hardening and federal security standards.

This project received \$75,000,000 of budget authority in fiscal year 2006 through the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006, Public Law 109-148, and an additional \$550,000,000 through the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006, Public Law 109-234.

Committee Bill. Section 201 of the Committee bill would authorize appropriations of an amount not to exceed \$995,000,000 to construct a new major medical facility in New Orleans, Louisiana.

Sec. 202. Additional authorization for a 2007 major medical facility construction project previously authorized.

Section 202 of the Committee bill would authorize the Secretary to carry out seismic corrections for Buildings 7 and 126 at the Long Beach, California VAMC.

Background. The Long Beach, California Seismic Corrections for Buildings 7 and 126 project would involve the seismic upgrade and modernization of two seismically deficient buildings at the Long Beach VAMC. These buildings would house the pharmacy and multiple specialty medical and surgical outpatient clinics in line with the projected growth in outpatient demand and consolidate administrative, support service, and research administration staff in a single building. This project will also create a 24-bed Blind Rehabilitation Center adjacent to the Spinal Cord Injury Center.

This project received \$51,700,000 of budget authority in fiscal year 2001 through the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419; an additional \$10,300,000 of budget authority in fiscal year 2004 through the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, Public Law 108-170; and an additional \$107,800,000 of budget authority in fiscal year 2007 through the Veterans Benefits, Health Care, and Information Technology Act of 2006, Public Law 109-461.

Committee Bill. Section 202 of the Committee bill would authorize an amount not to exceed \$129,545,000 to conduct seismic corrections at the VAMC in Long Beach, California.

Sec. 203. Authorization of fiscal year 2011 major medical facility leases.

Section 203 of the Committee bill would authorize five leases for fiscal year 2011: a community based outpatient clinic (hereinafter, "CBOC") in Billings, Montana; an outpatient clinic in Boston, Massachusetts; a CBOC in San Diego, California; a research laboratory in San Francisco, California; and a mental health facility in San Juan, Puerto Rico.

Background. Section 8104 of title 38, United States Code requires authorization of any major medical facility construction project or lease. The Department has requested authorization for five pending leases in order to improve health care. The existing Billings CBOC is facing significant space shortages. According to the Department, expansion would enable the clinic to provide more comprehensive outpatient services and would allow veterans to get medical treatment locally rather than traveling to the Fort Harrison VAMC.

The Boston, Massachusetts replacement outpatient clinic lease would address the significant space shortage at the existing clinic and allow space for growing primary care and mental health programs.

The Administration has indicated that the San Diego, California replacement CBOC would enhance existing outpatient services by housing newly created programs such as a women's health clinic, blind services, dental services, and ambulatory surgery. It would also consolidate services into a single, larger location, closer to where veterans reside.

The San Francisco VAMC houses VA's largest research program but its facilities are deficient in terms of available space and compliance with VA's seismic safety policy. The Department determines the amount of space needed for research programs based on the amount of grant dollars awarded. Using that analysis, VA estimates a need for approximately 400,000 square feet of research space at the San Francisco VAMC. The proposed 50,000 square foot lease would not entirely resolve the current shortfall in space, but would help alleviate some of the pressure.

The San Juan, Puerto Rico VAMC currently lacks a mental health residential rehabilitation treatment program and a psychosocial residential rehabilitation center. Both programs are integral to assist veterans in transitioning between inpatient and outpatient services and the community. Veterans who need services from either program are currently referred to other VISN 8 facilities in the continental United States, where they sometimes lack the family support and linguistic fluency to fully profit from the programs. VA's proposed lease will allow the Department to provide more comprehensive care for the veterans who live in Puerto Rico.

Committee Bill. Section 203 of the Committee bill would authorize the lease of a replacement outpatient clinic in Billings, Montana. The new clinic will support the parent facility at the Fort Harrison VAMC through the acquisition of approximately 70,000 net usable square feet of clinical space. The Committee bill would fully authorize the lease in the amount of \$7,149,000.

The Boston, Massachusetts replacement outpatient clinic lease will support the Boston VA Health Care System through the lease of approximately 29,000 net usable square feet of clinical space. The Committee bill would fully authorize the lease in the amount of \$3,316,000.

The San Diego, California replacement CBOC lease will support the parent facility at the San Diego VAMC through the lease of approximately 164,000 net usable square feet for a replacement CBOC. The Committee bill would fully authorize the lease in the amount of \$21,495,000.

The San Francisco, California Biomedical Research Complex lease would consist of approximately 50,000 net usable square feet for wet labs and research space. This would partially alleviate the San Francisco VAMC's space shortage. The Committee bill would fully authorize the lease in the amount of \$10,055,000.

The San Juan, Puerto Rico Mental Health Residential and Psychosocial Rehabilitation Program lease will provide an approximately 52,000 net usable square foot facility that will house 40 beds and will provide a smoother transition from treatment back to the community. The Committee bill would fully authorize the lease in the amount of \$5,323,000.

Sec. 204. Authorization of appropriations.

Section 204 of the Committee bill would authorize appropriations for the projects authorized in sections 201 through 203 of the Committee bill.

Committee Bill. Section 204 of the Committee bill would authorize an appropriation for fiscal year 2011 of \$1,124,545,000 from the Construction, Major Projects account for projects authorized in sections 201 and 202 of the Committee bill. It would also authorize an appropriation for fiscal year 2011 of \$47,338,000 from the Medical Facilities account for the leases authorized in section 203 of the Committee bill.

Sec. 205. Report on use of energy efficient technologies and best practices in Department of Veterans Affairs medical facilities.

Section 205 of the Committee bill would require the Secretary to submit a report to Congress on the use of energy efficient technologies and best practices in Department facilities.

Background. On October 5, 2009, President Obama signed Executive Order 13514, "Federal Leadership in Environmental, Energy, and Economic Performance," which expanded on energy reduction and ecological performance requirements contained in Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management." Executive Order 13514 establishes targets for federal agencies regarding accountability and transparency, strategic sustainability performance planning, greenhouse gas management, sustainable buildings and communities, water efficiency, electronic products and services, fleet and transportation management, and pollution prevention and waste reduction. Such key targets include reducing government-wide greenhouse gas emissions by 28 percent by 2020 and for agency sustainability plans to be released in August 2010.

Committee Bill. Section 205 of the Committee bill would require the Secretary to submit a report to Congress regarding the use of energy efficient technologies and best practices in VA medical facilities. The report would include a description of the technologies and best practices the Department currently employs to make facilities more energy efficient; an assessment of the energy efficiency of VA medical facilities' heating, ventilation, air conditioning systems, lighting, elevators, water heating, information technology and electronics, and any other features related to energy efficiency the Secretary deems appropriate; and, a description of the Department medical facilities' compliance with current law, as it relates to energy efficiency. The Secretary would be required to collaborate

with private sector experts and industry leaders in energy efficiency, such as the American Society of Heating, Refrigeration, and Air-Conditioning Engineers, the Illuminating Engineering Society of North America, and the American Institute of Architects, in developing the report.

Sec. 206. Designation of George H. O'Brien Jr., Department of Veterans Affairs Medical Center.

Section 206 of the Committee bill, which is derived from S. 2751 as introduced, would designate the Department of Veterans Affairs medical center in Big Spring, Texas, as the George H. O'Brien, Jr., Department of Veterans Affairs Medical Center.

Background. George H. O'Brien, Jr. served as a seaman in the United States Merchant Marine from December 1944 until May 1946. In July 1946, while attending college at Texas Technical College (now known as Texas Tech University), he enlisted in the United States Marine Corps Reserve. After graduating college in 1950, he was ordered to active duty and served in the Korean War until September 1952. He was awarded the Medal of Honor for his heroic actions during the Battle of the Hook on October 27, 1952, as detailed in the citation accompanying his award. He also received the Purple Heart Medal with gold star in lieu of a second award, the Korean Service Medal with two bronze stars, and the United Nations Service Medal, among other military honors. After his active duty service, O'Brien began a career as a petroleum geologist in Texas, while serving on the Marine Corps Scholarship Foundation as well as in the Medal of Honor Society.

Committee Bill. Section 206 of the Committee bill would name the VAMC in Big Spring, Texas the "George H. O'Brien, Jr., Department of Veterans Affairs Medical Center." Since all members of the Texas Congressional delegation have expressed their support for naming this facility, in writing, and the Texas chapters of all veterans service organizations with national memberships of at least 500,000 individuals have endorsed this facility being named in honor of George H. O'Brien, this provision meets the Committee rules regarding the naming of Department facilities.

Sec. 207. Requirement that bid savings on major medical facility projects of Department of Veterans Affairs be used for other major medical facility construction projects of the Department.

Section 207 of the Committee bill would require that bid savings from major medical facility projects be utilized for other major medical facility construction projects.

Background. Due to a favorable bid environment, VA has been able to save money on several authorized major construction projects. As of May 2010, VA estimated that the Department would realize \$103 million in bid savings from 12 major construction projects. It is the Committee's intent, given the importance of long-term planning and the size of the Department's construction backlog, that projects that have already been vetted and prioritized be funded accordingly.

Committee Bill. Section 207 of the Committee bill would add a new section 8104(d) to title 38, United States Code. This section would require that, for any fiscal year, unobligated funds resulting from major medical facility project bid savings be obligated only for

other major medical facility projects authorized for that fiscal year or a previous fiscal year.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, "CBO"), estimates that implementing the bill would cost \$690 million over the 2011–2015 period, assuming appropriation of the specified and estimated amounts. CBO further estimates that enacting the bill would increase direct spending by \$43 million over the 2011–2015 period as a result of reallocating funds, but would not increase budget authority or affect revenues. Enactment of the Committee bill would not affect receipts and though the Committee bill would affect state and local laws, it would have minimal effect on the budget of state, local or tribal governments. The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 6, 2010

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 3325, the Veterans Telehealth and Other Care Improvements Act of 2010.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure.

S. 3325—Veterans Telehealth and Other Care Improvements Act of 2010

Summary: S. 3325 would authorize the construction, renovation, or leasing of several medical facilities and make other changes to health care programs offered by the Department of Veterans Affairs (VA). In total, CBO estimates that implementing the bill would cost \$690 million over the 2011–2015 period, assuming appropriation of the specified and estimated amounts. In addition, CBO estimates that enacting the bill would increase direct spending by \$43 million over the 2011–2020 period but would not affect revenues.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending.

S. 3325 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state and local laws. CBO estimates the cost of complying with the mandate would be small and would fall well below the threshold established in UMRA for intergovernmental mandates (\$70 million

in 2010, adjusted annually for inflation). S. 3325 contains no new private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 3325 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Basis of estimate: For this estimate, CBO assumes the legislation will be enacted in 2010, that the necessary amounts will be appropriated each year, and that outlays will follow historical patterns for similar and existing programs.

	By fiscal year, in millions of dollars—					
	2011	2012	2013	2014	2015	2011–2015
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Medical Construction Projects						
Estimated Authorization Level	547	25	25	25	25	647
Estimated Outlays	65	162	187	145	71	630
Outreach						
Estimated Authorization Level	7	7	7	7	7	35
Estimated Outlays	7	7	7	7	7	35
Loss of Copayments for Telehealth and Telemedicine Programs						
Estimated Authorization Level	2	3	4	6	8	23
Estimated Outlays	2	3	4	6	8	23
Veterans' Resources Web Site						
Estimated Authorization Level	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	1
Other Provisions						
Estimated Authorization Level	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	1
Total Changes						
Estimated Authorization Level	556	35	36	38	40	707
Estimated Outlays	74	172	198	158	86	690
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	0	0	0	0	0
Estimated Outlays	8	8	9	9	9	43

Note: * = less than \$500,000.

Spending subject to appropriation

S. 3325 would authorize funding for the construction, renovation, or leasing of several medical facilities and make other changes in VA health care programs. In total, CBO estimates that implementing the bill would add \$690 million to discretionary spending over the 2011–2015 period, assuming appropriation of the specified and estimated amounts.

Medical Construction Projects. Title II would authorize funding to construct, renovate, or lease several medical facilities. CBO estimates that implementing those provisions would cost \$630 million over the 2011–2015 period, assuming appropriation of the authorized and estimated amounts.

Section 204 would authorize the appropriation of \$995 million to construct a new medical center in New Orleans, Louisiana and \$130 million for seismic corrections at facilities in Long Beach, California. Public Laws 109–148 and 109–234 provided \$75 million and \$550 million respectively to plan and construct the New Orleans facility. Based on VA's current estimated construction costs for that facility of \$995 million, CBO estimates that VA would require

additional funding of \$370 million for the New Orleans facility. Adding in the specified authorization of \$130 million for the Long Beach facilities, CBO estimates a total authorization of \$500 million for both projects; carrying out those projects would cost \$485 million over the 2011–2015 period, assuming appropriation of the authorized and estimated amounts.

Section 204 also would authorize the appropriation of \$47 million for leasing five medical facilities. Based on information from VA's 2011 budget request for leasing medical facilities, CBO expects that VA would enter into 20-year lease agreements for those facilities. CBO estimates that in addition to the specified amounts authorized to be appropriated in 2011, VA would incur additional costs of \$25 million a year starting in 2012. (Costs are higher in the first year than in other years because VA would pay up front for necessary improvements.) CBO estimates that entering into those leases would cost \$145 million over the 2011–2015 period, assuming appropriation of the authorized and estimated amounts.

Outreach. Section 102 would require VA to establish an outreach program designed to increase veterans' awareness of and access to federal, state, and local programs providing compensation and benefits to veterans. Section 102 also would allow VA to enter into agreements with federal and state agencies for that purpose. VA also would be authorized to enter into agreements with and to provide technical assistance and award grants to certain commissions and authorities. Those commissions and authorities include the Appalachian Regional Commission; the Delta Regional Authority; the Denali Commission; the Northern Great Plains Regional Authority; the Southeast Crescent, Southwest Border, and Northern Border Regional Commission; and certain nonfederally chartered entities that serve Native Americans, Alaska Natives, or native Hawaiians.

Under this section, \$35 million would be authorized over the 2011–2015 period to carry out those programs. CBO estimates that implementing section 102 would cost \$35 million over the 2011–2015 period, subject to appropriation of the necessary amounts.

Loss of Copayments for Telehealth and Telemedicine Programs. Section 101 would prohibit VA from charging copayments to veterans for any telehealth or telemedicine consultations and would require VA to report to the Congress on the effects of that change. Under current law, VA charges copayments of \$15 for primary care visits and \$50 for specialty care visits. Based on information from the department, CBO estimates that in 2011 VA will have a workload of 60,000 such consultations for which it will receive \$2 million in copayments. In recent years those programs have experienced a 30 percent annual rate of growth in workload. Some of that growth represents new workload in terms of medical visits that would not have been made for reasons of distance or other difficulty in accessing VA care. The remainder of the growth is accounted for by veterans using telehealth and telemedicine in place of physical visits to a VA facility. CBO expects that eliminating the copayments for virtual visits will accelerate the shift from regular visits, which will still incur copayments. CBO estimates that implementing this provision would decrease collections by \$2 million in 2011, growing to \$8 million by 2015.

Such collections are offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA

authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, CBO estimates that implementing this provision would cost \$23 million over the 2011–2015 period, assuming appropriation of the necessary amounts.

Veterans' Resources Web site. Section 108 would grant VA the authority to establish and maintain a Web site with the purpose of providing information and links from other Web sites referring to benefits, resources, services, and opportunities for veterans. VA would be required to consult with other federal agencies to determine a comprehensive list of benefits and links for veterans' benefits and resources. CBO assumes that VA would either hire an individual to develop and maintain the Web site or hire a contractor to do so; therefore, we estimate that implementing section 102 would cost \$1 million over the 2011–2015 period, subject to appropriation of the necessary amounts.

Other Provisions. Several sections of the bill, when taken individually, would increase spending subject to appropriation by less than \$500,000 a year. Taken together, CBO estimates that implementing the following provisions would have a total cost of \$1 million over the 2011–2015 period, assuming availability of appropriated funds:

- Section 103 would require an annual report on the use of radioactive isotopes at VA medical facilities.
- Section 104 would require certain training on the use of radioactive isotopes; CBO estimates that VA would be able to incorporate those requirements into existing training programs at minimal cost.
- Section 105 would require certain oversight of medical services provided by contractors; VA already complies with most of those requirements.
- Section 107 would require a report on the feasibility of establishing a polytrauma center in the northern Rockies or the Dakotas.
- Section 205 would require a report on the use of energy-efficient technologies in VA medical facilities.

Direct spending

Section 106 would direct VA to provide up to five direct loans to help nonprofit organizations acquire, construct, modify, or rehabilitate transitional housing for veterans and their families. It also would establish the Multifamily Transitional Housing Loan Program Revolving Fund to cover the subsidy costs of those loans. (Transitional housing provides temporary lodging for homeless individuals and families, and is used in combination with services such as education, job training and placement, substance abuse counseling, and child care, to help residents transition to permanent housing.)

The Veterans Programs Enhancement Act of 1998 (Public Law 105–368) authorized VA to provide guaranteed loans for transitional housing and provided permanent, indefinite budget authority for the subsidy cost of those loans. Subsequently, the Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000 (Public Law 106–

74) provided \$48 million in mandatory budget authority for the loan guarantees, of which \$43 million remains available. The department has indicated that it will not use the remaining budget authority to guarantee any more loans for transitional housing because there are no applicants for the program. Section 106 would terminate the authority to guarantee loans and transfer the unobligated balances from the specific mandatory appropriation to the direct loan revolving fund.

Because the guaranteed loan program is moribund, CBO expects no further outlays for that purpose under current law. Thus, new outlays would arise from authorizing VA to use the remaining budget authority to make direct loans.

Section 106 would credit the repayments of principal and interest on the direct loans to the revolving fund, and make those amounts available for new direct loans, without further Congressional action. However, the concept of reusing loan repayments for new loans is inconsistent with the proper budgetary accounting of direct loans as specified in the Federal Credit Reform Act (FCRA). CBO estimates that redirecting those payments to a purpose other than retiring the debt for the original loan would increase the estimated subsidy costs of the loans to 100 percent of the face value of those loans.

Under FCRA, projected cash flows associated with direct loans—such as disbursements of loan proceeds, collections of principal and interest repayments, and recoveries of amounts subsequent to any defaults—are discounted using the average interest rate on Treasury securities of similar maturity to the loan cash flows. The net present value of those cash flows is recorded as the subsidy cost of the loans.

Repayments of loans are unavailable for spending and new loan obligations may be made only to the extent that new budget authority is provided in advance to cover anticipated credit subsidy costs. Thus, direct loan repayments are not available to “revolve” into new loans. Instead, such repayments are a means of financing the original loans, and the availability of repayments only for that purpose is implicit in the usual subsidy calculation. If principal and interest repayments are not returned to the Treasury, but are instead used for new loans, the net cost to the federal government is the total amount disbursed for the original loans.

CBO expects that VA would use the amounts transferred to the revolving fund to issue one direct loan annually over the next five years. Outlays are recorded in the year in which the loan is disbursed; thus, enacting section 106 would increase direct spending by \$43 million over the 2011–2015 period.

Pay-As-You-Go Considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget reporting and enforcement procedures for legislation affecting direct spending or revenues. S. 3325 would authorize VA to provide direct loans to organizations providing transitional housing to veterans. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

	By fiscal year, in millions of dollars—													
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2010– 2015	2010– 2020	
	NET INCREASE OR DECREASE (–) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	8	8	9	9	9	0	0	0	0	0	43	43	

Estimated impact on State, Local, and Tribal Governments

S. 3325 contains an intergovernmental mandate as defined in UMRA because it would preempt state laws that prohibit certain transitional housing programs from offering preferential treatment to veterans. While the preemption would limit the application of state and local laws, it would impose no duty that would result in significant additional spending. Consequently, CBO estimates that the costs would fall well below the threshold established in the UMRA for intergovernmental mandates (\$70 million in 2010, adjusted annually for inflation).

Estimated impact on the Private Sector

S. 3107 contains no new private-sector mandates as defined in UMRA.

Previous CBO estimate

On July 29, 2010, CBO transmitted an estimate for H.R. 5226, the Appalachian Veterans Outreach Improvement Act, as ordered reported by the House Committee on Transportation and Infrastructure on July 1, 2010. Section 102 of S. 3325 contains language similar to that in H.R. 5226 but also includes additional commissions and agencies for VA to partner with in order to improve their outreach efforts in various regions. Also, S. 3325 would authorize specified amounts to implement the outreach efforts while H.R. 5226 would not. The estimates reflect those differences.

Estimate prepared by: Federal Costs: VA Housing Loan Program—David Newman; VA Outreach Programs—Dwayne Wright; Other VA Programs—Sunita D'Monte. Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum. Impact on the Private Sector: Elizabeth Bass.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in

person or by proxy by members of the Committee on Veterans' Affairs at its August 5, 2010, meeting. On that date, the Committee ordered S. 3325, as amended, reported favorably to the Senate by voice vote with no dissent. One amendment was accepted by voice vote. The following senators were present: Mr. Rockefeller, Mrs. Murray, Mr. Sanders, Mr. Brown of Ohio, Mr. Webb, Mr. Tester, Mr. Begich, Mr. Burris, Mr. Specter, Mr. Burr, Mr. Isakson, Mr. Wicker, Mr. Johanns, Mr. Brown of Massachusetts, and Chairman Akaka.

AGENCY REPORT

On May 19, 2010, Thomas J. Pamperin, Associate Deputy Under Secretary for Policy and Program Management, Veterans Benefits Administration, and Robert Jesse, MD, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, appeared before the Committee and submitted written testimony on various provisions of S. 3325 incorporated into the Committee bill. Pursuant to Mr. Pamperin's request to provide official views on additional legislation, enumerated below, Secretary Shinseki submitted additional views in writing to the Committee on July 29, 2010. Excerpts of the testimony and the additional views are reprinted below:

STATEMENT OF THOMAS J. PAMPERIN, ASSOCIATE DEPUTY
UNDER SECRETARY FOR POLICY AND PROGRAM MAN-
AGEMENT, VETERANS BENEFITS ADMINISTRATION, U.S.
DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, I am pleased to be here today to provide the Department of Veterans Affairs' (VA) views on pending legislation. Also testifying this morning is Dr. Robert Jesse, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration, and accompanying us are Assistant General Counsels Richard J. Hipolit and Walter A. Hall.

I will not be able to address a few of the bills on today's agenda because we did not have sufficient time to develop and coordinate the Administration's position and cost estimates, but with your permission we will provide that information in writing for the record. Those bills are S. 3286, S. 3314, S. 3325, S. 3330, S. 3348, S. 3352, S. 3355, S. 3367, S. 3368, S. 3370, and Senator Burr's draft bill to improve VA's multifamily transitional housing program. Similarly, for most of the bills that I will address on today's agenda, we request permission to provide cost estimates for the record at a later date.

* * * * *

S. 3325

S. 3325 would authorize VA to waive the imposition or collection of copayments for telehealth and telemedicine visits of Veterans. The mission of VA's Telehealth program office is to expand access to care for Veterans through telehealth technologies. Telehealth is a new modality of care. We believe it would be inappropriate to waive copayments for Veterans who receive telehealth services at a VA facility while Veterans who see their VA provider in person in the same facility would be charged a copayment.

VA is examining the impact of copayments for care provided by video telehealth in a patient's home. A video consultation into the home is used to provide remote case management, health promotion/disease prevention, enhancement of patient self-management, and early recognition of deleterious symptoms and signs of patient deterioration from chronic disease conditions. The use of video consultation into the home is analogous to that of telephone call for which no co-payment is required, and not comparable to a clinic visit.

Recent VA experience demonstrates that co-payments for home-telehealth may have resulted in a reduced use of this intervention. To ensure convenient and cost-effective care to populations of patients who will otherwise delay care and incur larger costs from emergency room visits and hospital admissions VA will take the appropriate action to waive or modify copayments for in-home video

telehealth care for Veterans. Because VA already has the authority to waive or modify the imposition of co-payments for such care, legislation is not required.

VA estimates a revenue loss of \$2 million in the first year, \$17.7 million over 5 years and \$83.4 million over 10 years if VA stops collecting copayments for all telehealth visits.

* * * * *

S. 3314

S. 3314 would require VA and the Appalachian Regional Commission to jointly carry out a program of outreach to Veterans who reside in the Appalachian region for purposes of increasing access and use by Veterans of Federal, state, and local Veterans benefits programs and increasing awareness of, and eligibility for, such programs.

VA supports the objective of improving outreach to Veterans and other potential claimants, but does not support this bill because it would mandate outreach to only one geographic area and because it is unnecessary in light of VA's ongoing efforts to provide outreach in this area.

VA is currently making special efforts to provide medical care and access in the Appalachian region. Throughout the states and counties within this region, VA has set up an extensive and diverse array of rural initiatives, including Outreach Clinics, Community-Based Outpatient Clinics, expanded Care Coordination Home Telehealth initiatives, and the use of unscheduled Mobile Medical Units to perform assessments and physicals at events.

VA has also taken aggressive steps to ensure awareness of the facilities, initiatives, and benefits available to Veterans. Examples include partnering with states such as Maryland to use unoccupied offices in rural areas to conduct mental health assessments and provide services; collaborating with rural community health centers, such as the community health center in Harrisonburg, Virginia, to increase enrollment and improve coordination of care; and activating rural health literacy outreach, such as in the Asheville, North Carolina, area, where events were held or scheduled in an area covering the 20 counties of Western North Carolina. This is only the beginning. VA plans to continue its outreach efforts to Veterans and their families in this region. Because of VA's substantial outreach efforts to Veterans in this region, we do not believe this bill is necessary and thus do not support it. However, VA would be happy to meet with the Committee to discuss the special needs of Appalachian Veterans.

VA cannot estimate costs for this program without additional information because it is unclear to what extent VA would need to enter into contracts for the outreach that this bill would mandate.

* * * * *

S. 3330

S. 3330, the "Veterans' Health and Radiation Safety Act of 2010," would require VA to report to Congress annually on low-volume programs (defined as programs that treat 100 patients or fewer annually) at VA medical facilities. The report would have to include

the Secretary's evaluation and findings with respect to such programs. Additionally, S. 3330 would require employees working at VA hospitals where radioactive isotopes are used to receive training on recognizing and reporting medical events. Hospitals failing to provide this training would be prohibited from using radioactive isotopes for a period of time determined by the Secretary. Lastly, the bill would require VA to evaluate non-government medical services contractors through weekly independent peer reviews, written evaluations, and other evaluations VA determines are appropriate. A contracting officer would be required to review and consider the results of these evaluations before VA renews any contracts with non-government medical services contractors.

We are aware of a very unfortunate lapse that occurred at a brachytherapy program at one of our facilities. We testified about this incident before the House Committee on Veterans' Affairs on July 22, 2009. On May 3, 2010, the Office of the Inspector General (OIG) issued a report on this incident with five recommendations. Specifically, the OIG recommended that the Veterans Health Administration (VHA) standardize, to a practical extent, the privileging, delivery of care, and quality controls for the procedures required to provide this treatment. This has been accomplished. Standardized procedures have been developed, and site visits have verified that they are uniformly in place at all facilities and that steps have been taken to ensure that patients who received low radiation doses in the course of brachytherapy are evaluated to ensure that their cancer treatment plan is appropriate. We have contacted all Veterans who were potentially impacted for follow-up testing and monitoring at other VA and private facilities and are reviewing the controls that are in place to ensure that VA contracts for health care comply with applicable laws and regulations. Where necessary, we will make organizational and/or procedural changes to bring this contracting effort into compliance. A template that outlines basic requirements for all contracts is currently in development.

The OIG also recommended that senior VA leadership meet with senior Nuclear Regulatory Commission leadership to determine if there is a way forward that will ensure the goals of both organizations are achieved. VA is currently working to arrange this meeting. Finally, the OIG recommended that VHA work with the OIG to develop a list of documents that should routinely be provided to the OIG when an outside agency is notified of a possible untoward medical event. VHA will work closely with the OIG to meet this recommendation.

We appreciate the intent behind S. 3330, but for a number of reasons we do not support it. First, we note that section 2 would require the Secretary to submit annual reports to Congress on low volume programs. However, the definition of a "program" is not clear. Any treatment "program" could be defined so narrowly that no facility treats 100 patients or more per year in a particular program or so broadly that almost every program includes more than 100 patients annually. Moreover, treatment quality is not always related to patient volume or patient volume just within a given VA facility. Many VA facilities have on staff specialist providers who also work elsewhere in the community. If all care provided by a

specialist is combined, the volume can be, and many times is, significantly more than can be accounted for just within VA workload. In addition, standard credentialing, privileging, and review of quality of care are required at every facility regardless of the size of a program.

All procedures that are performed and all medical care that is provided at any VA facility involve quality assessment and oversight. The first procedure each year has precisely the same quality assessment requirements as the last, whether the annual procedure total is 5, 50, or 500. Further, each procedure is performed by a fully credentialed and privileged physician. Instead of the requirement to provide an annual report on “low volume” programs, we would like to work with Congress to identify what information would be useful for Congress to receive annually.

The mandatory training that would be required by section 3 would apply to all VHA staff and would not be limited to staff directly involved in the use of radioactive materials. Nuclear Regulatory Commission regulations already require all staff involved in the use of radioactive materials to have training and facilities to provide evidence of that training. Competency and training requirements for staff are based upon their defined duties and risks associated with those duties. In VHA, radiation safety training and education are provided annually, through the VA Learning Management System, to all staff involved in the use or handling of radioactive material. This includes all contract staff or physicians working in VA Nuclear Medicine services as a condition of their authorization to practice at a VA medical center. The definition of a medical event and reporting requirements are taught to, and reviewed annually with, all Nuclear Medicine technologists and physicians. VA’s National Health Physics Program provides a mechanism to ensure that the training provided is completed as required by VA policy. In addition, VA currently supports and trains all staff in reporting any untoward events or potential events consistent with guidance provided by the National Center for Patient Safety and the facility safety programs. As a result, many of the requirements of section 3 are duplicative of current VA policy.

The requirement in section 4 to obtain weekly independent peer reviews of all medical services provided pursuant to a contract, and written evaluations of the services carried out by the supervisor or manager of the employee providing the services, is excessive and would add unwarranted cost in staff time spent procuring and developing the reports. The requirement to undertake peer reviews each week may be ineffective if the number of procedures in a week is insufficient to carry out a statistically valid review. The requirement for additional reporting and oversight of all medical services provided by contract, most of which have not reported adverse events, would be a waste of resources. Given current VA procedures related to peer review and reporting, some of the provisions in this bill are not necessary. We are available to meet with Committee staff to discuss these issues in more detail.

While VA appreciates the Committee’s focus on this issue, we believe that these additional measures are not necessary in view of the above regulatory requirements, safeguards, and training. VA estimates that costs for this bill, if enacted, would be \$64.2 million

for the first year, \$347.5 million over 5 years, and \$770.5 million over 10 years.

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S. 3377

S. 3377 would convert VA's multifamily transitional housing loan guarantee program into one that would instead provide direct loans to qualified organizations. Under current subchapter VI of chapter 20, title 38, United States Code, the Secretary is authorized to guarantee not more than 15 loans, or an aggregate amount of \$100 million, for multifamily transitional housing projects. This bill would terminate the Secretary's authority to issue any new guarantees under section 2051, but would require the Secretary to make at least five direct loans to qualified organizations that plan to develop multifamily housing projects. The source of funds for the program would be the Multifamily Transitional Housing Loan Program Revolving Fund, established under section 1(b) of the bill.

VA does not support enactment of S. 3377. VA spent the better part of a decade testing the model and trying to make the multifamily transitional housing loan guarantee program work. During that time, the marketplace repeatedly revealed that there was a strong need for more programs that provide low-cost housing, including those offering supportive services for Veterans returning to gainful employment. There were three main reasons why organizations did not seek project financing through the VA program, which led them to try to instead find funding from other Federal, state, and local programs: (1) a lack of available operating subsidies (i.e., formerly homeless veterans cannot pay enough rent to generate sufficient project revenue to cover operating expenses and support services); (2) the debt repayment requirement (many local government entities offer either low-interest, interest-only, deferred, and/or forgivable debt products, which are more appealing to project sponsors than the VA loan guarantee program); and (3) the large project size requirement (large projects are difficult to site, and there is a growing trend towards developing mixed-tenancy projects). In addition, other sources of funding needed to create housing are almost exclusively tied to non-transitional housing. Persons living in transitional housing are normally still considered homeless.

Additionally, we have concerns how the program would be implemented, as it is not clear that the program structure would be consistent with other existing legislation, such as the Federal Credit Reform Act. Furthermore, the provision that would authorize the Secretary to delegate to a State or local government entity the authority to approve a loan might constitute an unconstitutional delegation of Federal authority. The statutory language should make clear that a delegation of approval authority to a State or local government entity remains subject to the Secretary's continuing supervision.

VA's 2011 Budget includes \$4.2 billion to prevent and reduce homelessness among Veterans—over 3.4 billion for medical services and nearly \$800 million for specific homeless programs.

VA estimates that this bill would not create any demand for multifamily transitional housing direct loans, but would result in administrative expenses of \$1.05 million in year one, and \$7.8 million over 10 years. If direct loans were made, they would likely be very expensive given the anticipated terms and conditions on the underlying loans. Therefore, it is not clear that Federal credit assistance is the most efficient or effective means of achieving the policy objective.

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S. 3035

S. 3035, the “Veterans Traumatic Brain Injury Care Improvement Act of 2010,” would require the Secretary to submit to Congress a report on the feasibility and advisability of establishing a Polytrauma Rehabilitation Center or Polytrauma Network Site for VA in the northern Rockies or the Dakotas.

VA shares the concern for providing treatment facilities for polytrauma in this region and has already completed an assessment of need. VA has determined that an enhanced Polytrauma Support Clinic Team with a strong telehealth component at the Ft. Harrison, Montana, VA facility would meet the needs and the workload volume of Veterans with mild to moderate traumatic brain injury (TBI) residing in the catchment area of the Montana Health care System. It would also facilitate access to TBI rehabilitation care for other Veterans from the northern Rockies and the Dakotas through telehealth. However, establishment of a Polytrauma Rehabilitation Center or Polytrauma Network Site, which would focus on the treatment of moderate to severe TBI, is not feasible or advisable in this area based on the needs of the population served. Because of the action already being taken by VA, this bill is not necessary, and we do not support it.

The estimated cost of staffing the Polytrauma Support Clinic Team at Ft. Harrison would be \$1 million in the first year, \$6.1 million for five years, and approximately \$13 million over 10 years.

Mr. Chairman, we would be pleased to provide the Committee with more detailed information about our findings and decisions regarding the northern Rockies and the Dakotas.

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S. 3355

S. 3355, the “Veterans One Source Act of 2010,” would require VA to establish and maintain an interactive Internet Web site that provides information on the benefits, resources, services, and opportunities provided by VA, other Federal agencies, and other sources.

VA supports the objective of S. 3355. However, VA has already collaborated with the Department of Defense (DOD) in the creation of a joint eBenefits Internet portal in response to the recommendations of the President’s Commission on Care of America’s Returning Wounded Warriors (Dole-Shalala), made in March 2007. This new Web site (www.ebenefits.va.gov) provides Servicemembers, Veterans, family members, and care providers a single transparent access point to online information about benefits, services, and

other resources. It provides a consolidated catalog of links to existing information on VA, DOD, and other Federal and state agency Web sites concerning benefits, services, and related resources. Obtaining a Defense Self-Service log-on account in order to access eBenefits has recently become mandatory for all Servicemembers and allows them to carry their eBenefits account through their life cycle and concurrently allows VA and DOD to regularly update benefit-related information. Because the eBenefits portal meets the intent and nearly all of the requirements of S. 3355, VA believes this bill is unnecessary.

Much of the information the bill would call for is available now in the eBenefits portal. Current topics include compensation, pension, health care, education benefits, home loans, financial services, employment assistance, reemployment rights, memorial benefits, Social Security benefits, DOD programs, state benefits, and Veterans Service Organizations. The eBenefits portal offers quick access to online application tools and other assistance to claimants. Secure access capabilities allow for personalization of content and services.

Self-service capabilities the eBenefits portal offers include the ability to apply for many benefits online, to check the status of compensation and pension claims, to apply for a home loan certificate of eligibility, to view VA e-health records, and to access and retrieve official military personnel records. Access to blogs and online communities is also provided.

In committing to the eBenefits portal, VA and DOD have already undertaken a multi-year project that will continue to add self-service transactional capabilities and to enlarge and refine online access to benefits, services, resources, and opportunities for Servicemembers, Veterans, family members, and caregivers. Some of these features will include the ability to: opt into the VA/DOD virtual electronic lifetime health record; transfer Chapter 33 (Post-9/11 GI Bill) benefits to dependents; change an address in both VA and DOD systems of records; communicate personally via a messaging center; receive automatic notification of benefits; view information on, and apply for, all VA benefits; and self-select to receive state benefit information. VA is confident that the capabilities of the eBenefits portal will meet the objectives of S. 3355.

Funding for the eBenefits portal in FY 2010 is approximately \$7.4 million, which includes contract support, operating costs, and FTE. VA estimates that overall operating costs, contract support, and FTE will be \$12 million in FY 2011. The estimated cost for the capabilities required by the bill that are not included in the eBenefits portal is \$1.1 million. This estimate includes costs for the following features: an animated virtual user guide; resources for caregivers (currently provided at a minimal level); information on discounts for veterans; facilitation of ride sharing for appointments; memorial notices; opportunities for volunteering; and information on community events.

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S. 2751

S. 2751 would designate the VAMC in Big Spring, Texas, as the George H. O'Brien, Jr., Department of Veterans Affairs Medical Center. Mr. O'Brien was awarded the Medal of Honor for his actions in battle in Korea and, following service, volunteered at the VAMC in Big Spring. He died in 2005. We defer to Congress in the naming of Federal property in honor of individuals.

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SUPPLEMENTAL VIEWS OF HON. RICHARD BURR,
RANKING MEMBER

I offered the text of legislation I introduced, S. 1518, the Caring for Camp LeJeune Veterans Act of 2009, as an amendment to the Committee bill at the August 5, 2010, markup. The amendment, which would give veterans and family members exposed to contaminated drinking water at Camp LeJeune VA health care eligibility for conditions related to the exposure, was, regrettably, defeated on a party-line vote. At the Committee's January 28, 2010, markup I offered the same amendment, also defeated on a party-line vote, in favor of an approach advanced by my colleagues in the majority which put the onus of providing for sick Camp LeJeune family members on the Department of Defense (DOD). I argued then that the majority's approach would not advance because of a number of problems, and that the Committee's action gave false hope to sick veterans and family members. That bill has yet to advance in the Senate, and the Senate Armed Services Committee has signaled it has no intention of moving the majority's bill.

My colleagues in the majority continue to assert that DOD must first take responsibility for the contamination at Camp LeJeune, but this view ignores the fact that DOD continues to view this issue through the prism of litigation and has no incentive to address the plight of veterans and their families exposed to environmental hazards while working and living on a DOD installation. In the absence of DOD acceptance of responsibility or formal consideration for the veterans and their families, this Committee should recognize that VA is the logical and desirable provider of health care. Furthermore, I have argued that precedent exists in VA to care for veterans and dependents suffering from the effects of harmful exposures. No such precedent exists at DOD.

I remain committed to enacting legislation providing those affected by the LeJeune water contamination with medical care for any disease associated with the water contaminants. They have waited long enough for the Congress to act. I will continue to be vocal about their plight until we finally have given them this small measure of recognition for what they have endured.

CHANGES IN EXISTING LAW

In compliance with paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman).

TITLE 38. VETERANS' BENEFITS

PART II. GENERAL BENEFITS

CHAPTER 17. HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I. GENERAL

Sec.

1701. Definitions.

1702. Presumptions: psychosis after service in World War II and following periods of war; mental illness following service in the Persian Gulf War.

1703. Contracts for hospital care and medical services in non-Department facilities.

1703A. *Oversight of medical services provided by contractors.*

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SUBCHAPTER III. MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

1721. Power to make rules and regulations.

1722. Determination of inability to defray necessary expenses; income thresholds.

1722A. Copayment for medications.

1722B. *Copayments; waiver of collection of copayments for telehealth and telemedicine visits of veterans.*

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Subchapter I. General

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SEC. 1703. CONTRACTS FOR HOSPITAL CARE AND MEDICAL SERVICES IN NON-DEPARTMENT FACILITIES

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SEC. 1703A. OVERSIGHT OF MEDICAL SERVICES PROVIDED BY CONTRACTORS

(a) *IN GENERAL.—(1) The Secretary shall ensure that the quality assessment program of the Department includes appropriate oversight of medical services provided pursuant to a contract entered into by the Secretary with a non-government entity.*

(2) Oversight of a medical service required by paragraph (1) shall include, as appropriate to the service, the following:

(A) Periodic peer reviews of such service.

(B) Periodic written evaluations of the oversight provided by the supervisor or manager of the individual providing the service.

(C) Such other evaluations as the Secretary determines are appropriate.

(3) The Secretary shall ensure that sufficient data is collected and analyzed by an employee of the Department in order to evaluate the quality of medical services provided pursuant to a contract entered into by the Secretary with a non-government entity.

(b) **REQUIREMENTS RELATING TO EXTENSION OF CERTAIN CONTRACTS.**—Before any contracting officer of the Department may extend or renew any contract entered into by the Secretary with a non-government entity for the provision of medical services, the contracting officer shall review and take into consideration the results of the evaluations carried out under subsection (a).

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Subchapter III. Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

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SEC. 1722A. COPAYMENT FOR MEDICATIONS

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SEC. 1722B. COPAYMENTS: WAIVER OF COLLECTION OF COPAYMENTS FOR TELEHEALTH AND TELEMEDICINE VISITS OF VETERANS

The Secretary may waive the imposition or collection of copayments for telehealth and telemedicine visits of veterans under the laws administered by the Secretary.

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CHAPTER 20. BENEFITS FOR HOMELESS VETERANS

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SUBCHAPTER VI. [LOAN GUARANTEE FOR] MULTIFAMILY TRANSITIONAL HOUSING

Sec.

2051. General authority

2052. Requirements

2053. Default

2054. Audit

2055. Multifamily Transitional Housing Loan Program Revolving Fund.

2056. Preferential treatment of veterans.

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Subchapter VI. [Loan Guarantee for] Multifamily Transitional Housing

SEC. 2051. GENERAL AUTHORITY

(a)(1) *The* [The] Secretary may guarantee the full or partial repayment of a loan that meets the requirements of this subchapter.

(2) *The Secretary shall, utilizing funds available in the Multifamily Transitional Housing Loan Program Revolving Fund under section 2055 of this title, issue not more than five loans that meet the requirements of this subchapter.*

(b)(1) Not more than 15 loans may be guaranteed [under subsection (a)] *under subsection (a)(1)*, of which not more than five such loans may be guaranteed during the 3-year period beginning on the date of the enactment of this subchapter.

(2) A guarantee of a loan [under subsection (a)] *under subsection (a)(1)* shall be in an amount that is not less than the amount necessary to sell the loan in a commercial market.

(3) Not more than an aggregate amount of \$100,000,000 in loans may be guaranteed *or issued* under subsection (a).

(c)(1) A loan [A loan] may not be guaranteed *or issued* under this subchapter unless, before closing such loan, the Secretary has approved the loan.

(2) *The Secretary may delegate approval under paragraph (1) to a State or local government entity.*

(3) *Approval activity of a State or local government entity under paragraph (2) shall be subject to the supervision of the Secretary.*

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(g) Notwithstanding any other provision of law, a multifamily transitional housing project that is funded by a loan guaranteed *or issued* under this subchapter may accept uncompensated voluntary services performed by any eligible entity (as that term is defined in section 2011(d) of this title) in connection with the construction, alteration, or repair of such project.

(h) *Nothing in this subchapter shall be construed to provide for a minimum or maximum size of a multifamily transitional housing project that may be financed with a loan under this subchapter.*

(i) *The Secretary may not guarantee under subsection (a)(1) any loan that is closed after the date of the enactment of this subsection. The termination by this subsection of the authority to guarantee loans under this subsection shall not affect the validity of any loan guaranteed under this subchapter before the date of the enactment of this subsection and is in force on that date.*

SEC. 2052. REQUIREMENTS

(a) * * *

(1) * * *

* * * * *

(6) The loan is subject to such terms and conditions as the Secretary determines are reasonable, *including with respect to forbearance, deferral, and loan forgiveness*, taking into account other housing projects with similarities in size, location, population, and services provided.

(b) * * *

(1) * * *

(2) provides supportive services and **【counselling】** *counseling* services (including job **【counselling】** *counseling*) at the project site with the goal of making such veterans self-sufficient;

* * * * *

(c) Such a project—

(1) may include space for neighborhood retail services, other commercial activities, **【or job training programs】** *job training programs, other types of residential units, or other uses that the Secretary considers necessary for the sustainability of the project*; and

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(d) In determining whether to guarantee *or issue* a loan under this subchapter, the Secretary shall consider—

(1) * * *

(2) the extent to which needs of homeless veterans are met in a community**【, as assessed under section 107 of Public Law 102–405】**.

SEC. 2053. DEFAULT

(a) The Secretary shall take such steps as may be necessary to obtain repayment on any loan that is in default and that is guaranteed *or issued* under this subchapter.

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(c) *The Secretary may impose such penalties or require such collateral as the Secretary considers necessary—*

(1) *to discourage default on a loan issued under this subchapter; or*

(2) *to mitigate harm to the Department from default on a loan issued under this subchapter.*

(d) *The Secretary shall administer any property coming under the jurisdiction of the Secretary by reason of default on a loan issued or guaranteed under this subchapter in accordance with regulations prescribed by the Secretary for that purpose. Such administration of property may include selling, renting, or otherwise disposing of property as the Secretary considers appropriate.*

SEC. 2054. AUDIT

(a) During each of the first 3 years of operation of a multifamily transitional housing project with respect to which a loan is guaranteed *or issued* under this subchapter, there shall be an annual, independent audit of such operation. Such audit shall include a detailed statement of the operations, activities, and accomplishments of such project during the year covered by such audit. The party responsible for obtaining such audit (and paying the costs therefor) shall be determined before the Secretary issues a guarantee *or loan* under this subchapter.

(b) * * *

SEC. 2055. MULTIFAMILY TRANSITIONAL HOUSING LOAN PROGRAM REVOLVING FUND

(a) *ESTABLISHMENT.—There is established in the Treasury of the United States a revolving fund known as the “Department of Veterans Affairs Multifamily Transitional Housing Loan Program Revolving Fund” (in this section referred to as the “Fund”).*

(b) *ELEMENTS.*—*There shall be deposited in the Fund the following, which shall constitute the assets of the Fund:*

(1) *Amounts paid into the Fund under any provision of law or regulation established by the Secretary imposing fees on persons or entities issued a loan under this subchapter.*

(2) *All other amounts received by the Secretary incident to operations relating to the issuance of loans under this subchapter, including—*

(A) *collections of principal and interest on loans issued by the Secretary under this subchapter;*

(B) *proceeds from the sale, rental, use, or other disposition of property acquired under this subchapter; and*

(C) *penalties collected pursuant to this subchapter.*

(3) *Amounts appropriated or otherwise made available before the date of the enactment of this section for purposes of activities under this subchapter, including amounts appropriated for such purposes under title I of the Department of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000 (Public Law 106-74; 113 Stat. 1049).*

(c) *USE OF FUNDS.*—*The Fund shall be available to the Secretary, without fiscal year limitation, for all operations relating to the issuance of loans under this subchapter, consistent with the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).*

SEC. 2056. PREFERENTIAL TREATMENT OF VETERANS

No provision of Federal or State law may prohibit a multifamily transitional housing project described in section 2052(b) of this title from offering preferential treatment to veterans.

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PART VI. ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81. ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

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Subchapter I. Acquisition and Operation of Medical Facilities

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SEC. 8104. CONGRESSIONAL APPROVAL OF CERTAIN MEDICAL FACILITY ACQUISITIONS

(a)(1) * * *

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(d)(1) *Except as provided in paragraph (2), in any case [In any case] in which the Secretary proposes that funds be used for a purpose other than the purpose for which such funds were appro-*

priated, the Secretary shall promptly notify each committee, in writing, of the particulars involved and the reasons why such funds were not used for the purpose for which appropriated.

(2) In any fiscal year, unobligated amounts in the Construction, Major Projects account that are a direct result of bid savings from a major medical facility project may only be obligated for other major medical facility projects authorized for that fiscal year or a previous fiscal year.

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