STATEMENT OF
ADRIAN ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 16, 2012

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee:

Thank you for inviting me to testify on behalf of the Disabled American Veterans (DAV) at this legislative hearing of the Subcommittee on Health. DAV is an organization of 1.2 million service-disabled veterans. We devote our energies to rebuilding the lives of disabled veterans and their families.

Madam Chairwoman, the DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely. At the Subcommittee's request, the DAV is pleased to present our views on seven bills before the Subcommittee today.

H.R. 1460

This measure would require VA to automatically enroll in VA health care certain veterans who served on active duty in combat operations during a period of war after the Persian Gulf War, or veterans who served in combat against a hostile force during a period of hostilities after November 11, 1998. These veterans would also have the option to decline enrollment. If automatically enrolled, the right to be dis-enrolled as currently provided to all enrolled veterans under title 38, Code of Federal Regulations § 17.36(d)(5) would be unaffected.

While well intended, the policy this measure proposes would be inconsistent with DAV's longstanding view that *all* veterans who need VA health care should have equal access to enroll, irrespective of age, geographic barriers or of the particular health needs concerned. In the event such automatic enrollment increases utilization of VA medical care, our concern then turns to impacts on VA's resources.

A large-scale "automatic" enrollment of the youngest population cohort could serve to squeeze out older generations of veterans who have not yet enrolled but will inevitably need health care in the future. VA would not be an option for them. Moreover, once enrolled, these veterans would be subjected to existing delays in access to care that other veterans are experiencing now. While we are not aware of any service-disabled veteran experiencing difficulty enrolling (and in fact, most of them are not required to enroll to gain treatment of service-connected disabilities), we are keenly aware of delays in timely access once enrolled, generally because of insufficient VA resources, capacity, or geographic barriers.

We believe outreach and education are far more likely to improve the use of VA benefits and services, including health care services, and we believe this Subcommittee is already well aware of VA's outreach efforts to the newest generation of veterans.

The Transition Assistance Program (TAP) is one of the formal pre-discharge outreach programs in which VA is an active participant. TAP is conducted under the auspices of a Memorandum of Understanding between the Departments of Labor, Defense, Homeland Security, and VA. TAP programs are conducted nationwide and in Europe at US military installations, to prepare separating or retiring military personnel for their return to civilian life. As a partner agency, VA provides VA benefits and services briefings. At these briefings, service members are informed of the array of VA benefits and services available and instructed in completing VA applications forms. Following the general instruction segments, TAP counselors provide personal interviews for service members who desire assistance in preparing and submitting applications for VA health care, disability compensation and/or vocational rehabilitation and employment benefits.

DAV has previously testified in support of Section 202 of H.R. 2433, the Veterans Opportunity to Work Act of 2011, which would make mandatory the participation in TAP by members of the armed forces. The intent of this section was incorporated into Public Law 112-56, Title II of which is entitled "Vow to Hire Heroes." Also, we note the US Navy and Marine Corps TAP and Disabled Transition Assistance Program are already mandatory for all separating members. The US Army recently announced it is requiring transition processing to begin at least 12 months before a soldier departs active duty. According to the Army's plan, TAP participation is mandatory for all soldiers discharging from active duty, including Guard members and Reservists demobilizing after six months or more on active duty.[1]

H.R. 3016

This measure would codify the Federal Recovery Coordination Program (FRCP) and would direct DOD and VA to jointly operate it. The FRCP's mission is to assist members of the armed forces who exhibit severe or catastrophic injuries or illnesses and who are unlikely to return to active duty but will most likely be medically separated. FRCP would also aid service members and veterans whose individual circumstances related to illness, injury, mental health are likely to cause difficulties in their transitions to civilian life.

This measure requires both agencies to develop a joint plan to carry out the FRCP and submit this completed plan to committees of jurisdiction, then submit a subsequent report describing and evaluating plan implementation.

The 2011 DOD Recovering Warrior Task Force report highlights a number of issues and provides recommendations pertinent to this bill, such as standardizing and clearly defining the roles, responsibilities and criteria for assigning federal recovery coordinators (FRC), recovery care coordinators (RCC) and other case managers.[2]

[1] Jim Tice, "Transition services now mandatory for soldiers," *Army Times* (APR 3, 2012). Accessed April 04, 2012 10:52 PM
[2] http://dtf.defense.gov/rwtf/finalreport2011.pdf

The continuing challenges of the overall recovery coordination effort can be best portrayed by differences in the definition of the FRCP between VA and DOD despite the FRCP being a joint program. Another troubling characteristic is the conflicting policies governing the referral of injured service members to the FRCP. [3] The impact of these differing policies was made painfully clear during this Subcommittee's hearing on the FRCP on October 6, 2011.

Partly as a consequence of strong Congressional oversight and by this Subcommittee, VA and DOD have formulated options[4] for improving coordination between the two agencies for a relatively small population of catastrophically injured service members. By late 2011, DOD and VA had been coordinating a decision memorandum presumably based on an options matrix regarding future direction of the FRCP and RCP. The most recent information available to DAV is that the memorandum was to have been delivered to the joint Senior Oversight Committee (SOC) for consideration and a joint decision in December 2011.

Madame Chairwoman, the DAV is deeply frustrated with the slow progress for VA and DOD to implement a joint, seamless program for these severely disabled veterans – a commitment VA and DOD made over four years ago. Further, we appreciate the sponsor's desire to codify the FRCP through this bill; however, the bill would still require VA and DOD to collaborate and implement the provisions of this bill if passed into law.

We believe the proposal before the SOC has the potential to address the DOD Recovering Warrior Task Force recommendations and other known challenges, and improve the recovery coordination effort across VA and DOD programs. Therefore, we ask that the Subcommittee hold this measure in abeyance until such time as the fate of the joint decision memorandum under consideration by the SOC can be ascertained and if issued, the contents carefully examined.

H.R. 3245, the Efficient Service for Veterans Act

This measure seeks to address any delay in determining eligibility of veterans to receive Vet Center services by providing a streamlined electronic process to access military service and eligibility information. Specifically, this bill would require DOD and VA to ensure VA's Vet Centers gain access to the extant Defense Personnel Record Image Retrieval System (DPRIS) and VA/DOD Information Repository (VADIR).

The DPRIS is a secure electronic gateway that enables veterans to access to their Official Military Personnel File (OMPF) information. OMPF is primarily an administrative record, containing information about the subject's service history, such as date and type of enlistment/appointment; duty stations and assignments; decorations and awards; date and type of separation/discharge/retirement (including DD Form 214, Report of Separation, or equivalent); and, other personnel actions. The Personnel and Readiness Information Management (P&RIM)

[3] VA Directive 0802; DOD Instruction 1300.24

[4] Beginning in December 2010, the Senior Oversight Committee directed its care management work group, which includes officials from the FRCP and DOD's Recovery Coordination Program (RCP) to conduct an inventory of DOD and VA case managers and perform a feasibility study of recommendations on the governance, roles, and mission of DOD and VA care coordination.

office, in the office of the Under Secretary of Defense (Personnel and Readiness) is the office of primary responsibility for DPRIS.

VADIR is intended by VA as its "golden source" for military service information. It is a database populated daily and electronically with military service data provided from DOD's Defense Manpower Data Center (DMDC). DMDC receives information from Defense Enrollment Eligibility Reporting System (DEERS) and the military service branches. Once received, DMDC synchronizes its data with VADIR.

Information from VADIR is disseminated in three ways: 1) approved VA systems electronically request and receive data from VADIR over the internal VA network, 2) data are provided over the dedicated circuit between VADIR and DMDC for reconciliation of records or to identify military retirees and dependents with entitlement to DOD benefits but who are not identified in DEERS, and 3) periodic electronic data extracts of subsets of information contained in VADIR are provided to approved VA offices over the internal VA network.

Madam Chairwoman, DAV has a special connection to the VA Vet Center program and the counseling services it provides. In 1976, the DAV funded the groundbreaking Forgotten Warrior Project, which first defined the issue of post-traumatic stress disorder (PTSD) among Vietnam war veterans. Vietnam veterans were experiencing serious post-war problems at that time, and DAV hoped our new study would make it impossible for Congress, the VA, and the American public to continue ignoring the lingering dilemma that prevented many of these veterans from returning to normal lives after serving in a very unpopular and difficult war.

Congress and the VA failed to act on the findings from our project; therefore, DAV initiated our own Vietnam Veterans Outreach Program in 1978. This DAV-sponsored study and the DAV's clinical outreach work spurred new, broad realization and additional research by others that forced the federal government to confront the psychological impact of war on veterans of Vietnam, and subsequently of all wars. When that movement finally occurred, the DAV Vietnam Veterans Outreach Program was already there to serve as an effective treatment model to be adopted by the VA's Vet Center program as we know it today.

Since the Readjustment Counseling Service program was established by Congress in 1979, eligibility for Vet Center readjustment counseling services has expanded from Vietnam-era veterans to include all combat veterans, to veterans who experienced military sexual trauma, to certain family members, and to survivors of veterans who die in combat or on active duty.[5] Vet Centers also offer a list of vital services, including counseling for post-traumatic stress disorder (PTSD) and other readjustment challenges; marriage and family counseling; and, bereavement counseling. One key policy of Vet Centers is to ensure veterans seeking help are not required to wait to receive it.

[5] P.L. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, and P.L. 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008.

Vet Centers are known for minimal barriers and almost no bureaucracy. The Vet Center is a non-medical setting in a safe environment with high confidentially and a strong emphasis on informed consent.[6]

Although providing the 300-plus Vet Centers direct access to DPRIS may improve speed in eligibility determinations, it may also compromise the confidential nature of services Vet Centers provide. We contacted the DOD office with primary responsibility for DPRIS. This office indicated that identifying who accesses DPRIS information and what DPRIS information is being retrieved is easily accomplished and is reportable information. Further, any personnel in DOD and in each military service branch that has designated "manager" status for the system has the capability to discover who is using that system for data retrieval. We urge the Subcommittee to consider removing the provision allowing Vet Center access to DPRIS.

In light of VA's recent proposed rule to implement an important provision in section 401 of Public Law 111-163, to expand eligibility for Vet Center services to current members of the armed forces, including members of the National Guard and Reserve who serve on active duty in Operations Enduring Freedom, Iraqi Freedom and New Dawn (OEF/OIF/OND),[7] DAV believes protecting Vet Center confidentiality is critical to its effectiveness, outreach and success. Therefore, DAV opposes this measure as currently written.

H.R. 3279

The intent of this bill is to make family caregivers of certain veterans with serious illnesses eligible for a VA program of comprehensive assistance and support services. Under current law, only family caregivers of certain veterans with serious physical injuries are eligible.

DAV testified before this subcommittee on July 11, 2011, recommending VA's adding the term "seriously ill" as we believe was intended by Congress under title 38 United States Code, section 1720G (a)(2)(B), and accordingly that VA revise its proposed eligibility criteria. To date, the final rule implementing Title I of the Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, has yet to be published.

DAV supports this measure based on our national Resolution No. 195, to support legislation that would expand eligibility for comprehensive caregiver support services. We thank the sponsor for introducing this bill and strongly urge the subcommittee to give it favorable consideration.

We also note the same resolution supporting this important legislation also calls on Congress to expand the eligibility for comprehensive caregiver support services to caregivers of veterans from all eras of military service. Those caregivers have carried a long and heavy burden for their loved ones, and deserve the level of attention and support services now being provided generously by VA to caregivers of wounded and ill OEF/OIF/OND veterans.

[6] http://www.nytimes.com/2007/04/01/nyregion/01veterans.html?pagewanted=all. Accessed March 28, 2012.
[7] 77 Fed. Reg. 14707-14712

H.R. 3337, the Open Burn Pit Registry Act of 2011

If enacted, this bill would direct VA to establish an open burn pit registry and ensure military personnel deployed to Afghanistan or Iraq who are exposed to toxic chemicals and fumes from open burn pits are advised about the existence of the registry and how to participate. Under the bill, eligible individuals would be periodically notified about significant developments in the study and treatment of conditions associated with exposure to toxic chemicals.

This legislation would direct VA to enter into an agreement with an independent scientific organization to develop a report that evaluates the effectiveness of the VA in collecting and maintaining such information on the health effects of exposure to toxic chemicals from open burn pits. In addition, the selected independent consultant would evaluate other published epidemiological studies, and recommendations regarding the most effective means of addressing medical needs of individuals that are likely to be occasioned by exposure to open burn pits.

DAV supports this bill because it partially fulfills the premises of DAV National Resolution No. 183, by providing improved surveillance of environmental hazards from military toxic and environmental hazards exposure. Hundreds of current and former service members have reported to DAV that they were exposed to heavy fumes from numerous burn pits throughout Iraq and Afghanistan, often becoming ill during such exposures, and that their illnesses from such exposures have continued to worsen thereafter.

The October 2011 Institute of Medicine (IOM) report, "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan," found numerous data gaps and uncertainties in the monitoring of airborne pollutants that point to the need for additional studies and analysis. The IOM recommended a longitudinal study be conducted that would evaluate the health status of service members from their time of deployment to Joint Base Balad, Iraq to determine their incidence of chronic diseases, including cancers, some of which may not manifest for decades following exposure.

Although VA is sponsoring scientific studies that cover a wide spectrum of health effects, these studies may not meet the IOM's call for a well-designed epidemiologic study of this particular environmental exposure in Iraq and Afghanistan. We urge this Subcommittee to consider adding to this bill a research component with the identification of cohort groups, one of which was deployed to the countries in question and one that was not. This comparative data would provide VA the opportunity to contrast the two cohorts' health concerns over an extended period, with the potential to provide more meaningful insight into the long-term health consequences of toxic exposures.

H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011

This bill would require VA to provide all enrolled veterans with health services to be provided by a contracted non-VA provider, if the Secretary determined that VA facilities were incapable of furnishing such services because of geographical inaccessibility or a lack of required personnel, resources, or ability at VA facilities.

Under the bill, in entering such contracts with non-VA providers, VA may consider only those contractors that demonstrate the ability to meet certain quality and safety standards and business processes on par with VA's. The measure also sets forth requirements concerning VA's eligibility determinations, coordination with non-VA providers, health information exchanges, and performance metrics for the purpose of incentives or bonus payments to the contractor(s). VA would also be required to submit a report to Congress based on implementation of the new authority.

DAV National Resolution 182 calls for a non-VA purchased care coordination program that complements the capabilities and capacities of each VA medical facility and includes care and case management, non-VA quality of care and patient safety standards equal to or better than VA's, timely claims processing, adequate reimbursement rates, health records management and centralized appointment scheduling. We are therefore pleased with some provisions in this bill that promote the coordination of cost effective non-VA health care; however, DAV is unable to support this measure since it proposes to significantly change current law that would adversely affect veteran patients and the VA system quite dramatically.

Title 38, United States Code, section 1703 authorizes VA to contract for inpatient care and limited outpatient care for specified categories of veterans, when VA facilities are unable to provide the care, or when these VA facilities are geographically inaccessible. This contracting authority is not limited to contracts which contain negotiated prices. Title 38, Code of Federal Regulations, section 17.52, which implements the statutory authority granted by section 1703, allows for individual authorizations when demand is only for infrequent use. This is the foundational authority for VA fee-basis care, where individual authorizations are essentially a price offer to the non-VA provider, who then accepts that offer by performing services for the authorized veteran patient.

This measure proposes to change VA's authority under title 38, United States Code, section 1703 from discretionary to mandatory such that if a VA facility is not capable of furnishing care to an eligible veteran, the Department must purchase the care by contract. We are concerned the mandatory language operates without exception, including clinical determinations or when the care needed is not available under existing negotiated contracts. Further, since the bill is intended to replace VA fee-basis care up to and including its entirety, this mandatory requirement may serve to obstruct a VA facility or a VA provider from acquiring non-VA medical care for eligible veterans. We therefore urge the Subcommittee to consider substituting a discretionary authority for the mandatory form in the current proposal.

This measure would also expand currently specified categories of eligible veterans to all enrolled veterans. We note under current law, VA already possesses three major approaches to provide non-VA care – through contracts to purchase care; fee-for-service arrangements; and via sharing agreements with DOD and academic affiliates. Under title 38, United States Code, section 8153, the VA possesses discretionary authority to use contracts with non-VA providers as a vehicle to provide hospital care and medical services (as those terms are defined in title 38, United States Code, section 1701) to all enrolled veterans.

This authority will be employed in the near future to create centrally supported health care contracts available throughout the VA health care system. This effort is a soft approach toward applying lessons learned from a demonstration project,[8] now in its fifth and final year, toward a new contract care initiative called Patient Centered Community Care (PCCC). According to VA, the goal of PCCC is to provide eligible veterans coordinated, timely access to high quality care from a comprehensive network of VA and non-VA providers.

Unlike H.R. 3723, the stated purpose of VA's contracting authority under title 38, United States Code, section 8153 is, "[t]o strengthen the medical programs at Department facilities and improve the quality of health care provided veterans under this title by authorizing the Secretary to enter into agreements with health-care providers in order to share health care resources with, and receive health-care resources from, such providers while ensuring no diminution of services to veterans." On the other hand, exercising §§ 8151-8154 only partially meets DAV Resolution 182 lacking certain quality of care and care coordination provisions that are contained in H.R. 3723.

Finally, DAV is unable at this time to delineate what impact the enactment of this bill would have on title 38, United States Code, sections 8151-8154 and on numerous VA health services that are dependent on non-VA purchased care. We believe a more detailed and comprehensive discussion is needed with VA on these matters.

With all these thoughts in mind, DAV is unable to support H.R. 3723 in its current form.

H.R. 4079, the Safe Housing for Homeless Veterans Act

This bill would require those organizations receiving VA grants that provide assistance to homeless veterans through the Homeless Providers Grant and Per Diem Program (GPD) to certify their facilities meet current Life Safety Codes as well as state and local housing codes, licensing and safety requirements. This legislation would also require VA to give priority to those organizations that include making improvements to their housing or service facilities to meet these requirements. Those providers that do not currently meet the certification requirements would have up to two years to bring their facilities into compliance.

While DAV has not received a National Resolution from our membership on this particular matter, we would not be opposed to favorable consideration of this legislation.

Madam Chairwoman, this completes my testimony. Thank you again for inviting Disabled American Veterans to present this testimony today. I would be pleased to address questions from you or other Members of the Subcommittee.

[8] Project on Healthcare Effectiveness through Resource Optimization (See H. Rept. 109-305 for the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (P.L. 109-114).