

**STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 21, 2013**

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

On behalf of the DAV (Disabled American Veterans) and our 1.2 million members, all of whom are wartime wounded and injured veterans, I am pleased to present our views on legislative measures that are the focus of the Subcommittee today, and to DAV and our members.

Draft Bill, the Demanding Accountability for Veterans Act of 2013

This bill would establish a requirement in law for the Department of Veterans Affairs (VA) Inspector General (IG) to report to the Secretary and to Congress any matters of public health or safety emanating from reports of the IG that remain unresolved by VA within a specified time period after the Secretary or a subordinate VA official agrees with the IG to address such matters. In that connection, the bill would require the Secretary to reveal to the IG the personal identities of the responsible VA official(s) and manager(s) who did not resolve the issue(s) (but such identities would not be released to the public). The bill would require the Secretary to promptly notify any such individual(s) to resolve the cited issue(s); to counsel the manager(s) concerned about the failure to resolve the issue(s) brought to light; and to develop mitigation plans, presumably to the satisfaction of the IG in resolving the matters concerned.

The bill would prohibit the award of any performance award or bonus to a VA official or manager (whether in the Senior Executive Service or the competitive civil service) who had not resolved such IG recommendations under the terms of this bill, and even if they were resolved later, that the existence of previously unaddressed matters of public health and safety would be considered in future performance evaluations of any such official.

DAV has received no resolution from our membership dealing with this specific issue and takes no position on this bill. However, we urge the Subcommittee to work with VA in advancing it and to ensure those issues raised by this bill are properly addressed.

Draft Bill, the Veterans Integrated Mental Health Care Act of 2013

This draft bill proposed by the Chairman of the full Committee would establish a new authority for VA to use in contracting for VA mental health care services for eligible veterans. It would place in the hands of a veteran certain mandatory information provided by VA to guide the veteran in making a voluntary decision on whether to receive care in a VA facility, or to receive it in a non-VA facility. The bill would further require VA to contract with qualified entities that administer networks of health care providers, including those experienced in

administering the TRICARE networks, to provide coordinated mental health care. The bill would require a series of performance qualifications standards that must be met by such contractors, and would require VA to dispense or pay for prescriptions written for veterans under this program by contractor providers on the same basis as it does for other veterans receiving VA-authorized contract care under section 1703 of title 38, United States Code.

Mr. Chairman, your Subcommittee held a hearing on September 14, 2012, to discuss and consider VA's multiple approaches to providing contract health care services, including specific focus on the upcoming award of VA contracts to regionalized entities that will administer coordination of care through provider networks, including mental health care. I had the privilege of testifying on behalf of DAV at that hearing, and I would call your attention to my complete statement¹ as well as to Dr. Robert Petzel's statement, made on behalf of VA. I quote a small but crucial element of VA's statement for the benefit of the Subcommittee with respect to this bill, as follows:

PCCC [Patient Centered Community Care] will consist of a network of centrally supported standardized health care contracts, available throughout VHA's Veterans Integrated Service Networks (VISN). This initiative will focus on ensuring proper coordination between VA and non-VA providers. PCCC is not intended to increase the purchasing of non-VA care, but rather to improve management and oversight of the care that is currently purchased. This includes improvements in numerous areas such as consistent clinical quality standards across all contracts, standardized referral processes, and timeliness of receipt of clinical information from non-VA providers. The goal of this program is to ensure Veterans receive care from community providers that is timely, accessible, and courteous, that honors Veterans' preferences, enhances medical documentation sharing, and that is coordinated with VA providers when VA services are not available.

While VA intends to administer these contracts directly, it has not yet determined how they will be managed. Additionally, VA is currently researching the appropriateness of incentives tied to performance standards to help ensure the selected contractors provide excellent customer service and timely care. VA conducted a business case analysis which compared the cost of purchasing care through individual authorizations and through regional contracts. The analysis showed that regional contracts are more cost-effective, with the cost/benefit ratio improving as participation increases. The PCCC contracts will cover inpatient and outpatient specialty care *and mental health care*. [Emphasis added.]

In a precedent-setting effort to reform VA contract care, the Department is again receiving bids under PCCC from entities that are qualified and prepared to deliver not only mental health services but a wide range of other specialty health care services, one must question whether Congress, in enacting a new contracting mandate exclusively limited to mental health services would hamper VA's efforts and inject additional uncertainty to those firms that bid for PCCC contracts, and thereby cause disruption and delay in VA's plans to reform all contract and fee-basis health care. For these reasons, DAV recommends this bill be held in

¹ <http://dav.org/voters/documents/statements/Atizado20120914.pdf>

abeyance at this time. Our National Resolution No. 210 calls for program improvement and enhanced resources for VA mental health care programs, but we believe this bill, overlaid on the PCCC effort, could have the opposite effect. Therefore, we cannot support this bill in its current form.

H.R. 241, the Veterans Timely Access to Health Care Act

If enacted, this bill would establish a statutory access-to-care standard of 30 days within the VA health care system, and would define that period as the difference between the date on which a veteran contacts VA seeking a health care appointment, through the date on which a patient care visit by that veteran actually occurs with an appropriate VA health care provider. The bill would require VA to submit continuing semi-annual reports to Congress on waiting times, with specified criteria to define waiting periods, and to prescribe the content of these reports.

Our membership has approved National Resolution Nos. 211 and 225, addressing timely access to VA health care services for America's service-disabled veterans. Timely access to needed medical care is a critical domain of high quality care. Currently, VA claims to be largely meeting its stated timeliness standards, but DAV receives much anecdotal information from our members and also from VA employees that these standards are not being met in reality and suggest that "gaming the numbers" to meet standards may be in play.

DAV believes the transparency potential conveyed in this bill to document more accurate waiting times could be a worthwhile idea. However, the bill would also set a statutory limit of 30 days as a single nationwide standard within which all types of VA medical appointments for veterans must be completed. The bill would prescribe a single maximum waiting time across the universe of primary, specialty, and subspecialty care, and for routine, urgent, or emergent care appointments. DAV questions whether one performance standard of this nature would be appropriate or workable, given VA's current waiting-time standards, under which VA's performance is already reported. In some cases, a 30-day standard might in fact lengthen waiting times versus current standards; in others, it would potentially clash with the medical judgment of clinicians about when patients should make return visits for care or monitoring. Therefore, we recommend the 30-day provision be dropped from the bill.

Notably, VA spent about \$4.6 billion in fiscal year 2011 to purchase health care services from non-VA entities such as other government agencies, affiliated universities, community hospitals, nursing homes, and individual providers. Yet, performance reporting under the timeliness standard for purchased care services remains largely invisible to Congress and the public.

DAV therefore recommends this measure be amended to reflect by reference those timeliness standards adopted and reported by VA to the public, and to include such reporting the timeliness in access to care purchased by VA in the community. In addition, we recommend the required report include the performance by VA facility.

On the strength of Resolution Nos. 211 and 225, and amending this worthwhile measure to include the above mentioned recommendations to reinforce the idea of timely access as a key

element in health care delivery, health care quality and health care satisfaction, we would support the bill and urge its enactment.

H.R. 288, the CHAMPVA Children's Protection Act of 2013

This bill would amend title 38, United States Code, section 1781(c) to increase the maximum age of children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Established by law in 1973, CHAMPVA provides cost reimbursement for private health care services provided to dependents, survivors, and (via Public Law 111-163) some personal family caregivers, of certain disabled veterans. CHAMPVA enrollment has grown steadily over the years and, as of the end of fiscal year 2011, CHAMPVA covers approximately 355,000 individual beneficiaries.

A child of a veteran is eligible for CHAMPVA benefits if the veteran is rated permanently and totally disabled due to a service-connected disability; was rated permanently and totally disabled due to a service-connected condition at the time of death; died of a service-connected disability; or, died on active duty, and the dependent is ineligible for Department of Defense (DoD) TRICARE benefits. Under current law, a dependent child's eligibility, which otherwise terminates at age 18, continues to age 23 if such child is pursuing a VA-approved full-time course of education or instruction.

On the strength of DAV National Resolution No. 222, DAV supports this measure; however, we strongly urge amending it to conform to Public Laws 111-148 and 111-152. In its current form, the eligibility of a qualifying veteran's child for CHAMPVA coverage from age 18 to 26 is extended only if the child is pursuing a full-time course of instruction at an approved educational institution or is unable to continue such pursuit due to incurring a disabling illness or injury that is not the result of such child's own willful misconduct.

DAV urges the measure be amended to ensure the eligibility of a qualifying veteran's child for CHAMPVA coverage is under the same conditions of covered adult children in private health plans under the landmark Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

Under Public Laws 111-148 and 111-152, private health insurers are required to cover young adult, but still-dependent, children in covered families until these individuals attain age 26, irrespective of educational status, and regardless of financial dependency, marital status, residency or other factors. Because CHAMPVA is being governed by a different standard in law, however, children of severely disabled veterans and survivors of veterans who paid the ultimate sacrifice are being penalized by denial of these same rights and privileges as other young adults.

H.R. 984, to direct the Secretary of Defense to establish a task force on urotrauma

Mr. Chairman, DAV has not received a resolution calling for a special DoD task force on this particular combat injury. DAV understands that the small number of deserving injured veterans suffering from genitourinary trauma, life-defining injuries, currently are not afforded the same level of visibility, scrutiny or investigation as veterans with other injuries, such as traumatic brain injury or PTSD, within the DoD or VA health care systems.

However, while the proposed DoD established urotrauma task force may very well meet its charge and yield fruitful results, we believe the report of the Dismounted Complex Blast Injury Task Force,² whose membership consists of closer to the front line personnel involved with the care of severely injured service members and veterans, should also be considered by the Subcommittee.

The task force this bill would establish follows on a report issued December 27, 2011, by a private urology group, entitled “Genitourinary Trauma in the Military.”³ This report was stimulated by a previous report of the Dismounted Complex Blast Injury Task Force, issued June 18, 2011, by the U.S. Army. The Army study identified and recommended the need for new approaches for earlier treatment of combat genitourinary injuries, to intervene more aggressively to treat the acute needs of service members with severe genitourinary injuries. Also, it described the need for new injury prevention measures and recommended urologists be deployed into combat theaters, with a focus on salvage, repair, and reconstruction to promote positive long-term outcomes. Presumably, the new task force authorized by this bill would address these earlier recommendations.

H.R. 1284

This bill would amend the VA beneficiary travel statute to ensure beneficiary travel eligibility for travel expenses in connection with medical examination, treatment, or care on an inpatient basis, and while a veteran is being provided temporary lodging at VA medical centers. Veterans eligible for this benefit would be restricted to those with vision impairments, spinal cord injury or disorder, and those with double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program.

Currently, VA is authorized to pay the actual necessary expenses of travel (including lodging and subsistence), or in lieu thereof to pay an allowance based upon mileage, to eligible veterans traveling to and from a VA medical facility for examination, treatment, or care. According to title 38, United States Code, Section 111(b)(1), eligible veterans include those with service-connected ratings of 30 percent or more; those receiving treatment for service-connected conditions; veterans in receipt of VA pensions; those whose incomes do not exceed the maximum annual VA pension rate; or veterans traveling for scheduled compensation or pension examinations.

² http://www.health.mil/Libraries/110808_TCCC_Course_Materials/0766-DCBI-Task-Force-Report-Final-Redacted-110921.pdf

³ <http://tricare.mil/tma/congressionalinformation/downloads/H.Rpt.%20111-491%20Page%20316%20Genitourinary%20Trauma%20in%20the%20Military.pdf>

DAV has no resolution on this specific issue and thus takes no position on this bill. However, we would note that while the intended recipients of this expanded eligibility criteria would certainly benefit from it, we would urge the Committee to consider a more equitable approach rather than one based on the specific impairments of disabled veterans. Further, we ask that if the Committee does favorably consider this measure, it also take appropriate action to ensure that sufficient additional funding be provided to VA to cover the cost of the expanded program.

DAV appreciates the opportunity to submit our views on the several legislative measures under consideration at this hearing. Much of the proposed legislation would significantly improve VA services for our nation's disabled veterans and their families, and would make VA more accountable to ensure veterans and their families receive the benefits and services they have earned and deserve.

This concludes my testimony, Mr. Chairman. I would be pleased to answer any questions related to my statement and the views I have expressed on behalf of DAV.