



National Service & Legislative Headquarters  
807 Maine Avenue, S.W.  
Washington, D.C. 20024-2410  
Phone (202) 554-3501  
Fax (202) 554-3581  
www.dav.org

***STATEMENT OF  
ADRIAN M. ATIZADO  
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
APRIL 23, 2015***

Mr. Chairman and Members of the Committee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

DAV is pleased to be here today to present our views on the bills under consideration by the Subcommittee.

**Draft – to improve the reproductive treatment provided to certain disabled veterans**

This draft measure aims to improve the reproductive treatment provided to disabled veterans, regardless of their gender, if they are enrolled in the Department of Veterans Affairs (VA) health care system and have a service-connected disability related to injury of the reproductive organs or spinal cord which directly results in being unable to procreate without assisted reproductive technology, to include the spouse of a covered veteran.

This bill would add section 1720H under Chapter 17 of title 38, United States Code, titled, "Reproductive Treatment for Certain Disabled Veterans," that would enhance VA's current reproductive technology by stipulating that the Department shall furnish assisted reproductive technology to a covered individual consisting of a maximum of three cycles of in vitro fertilization and up to six implantation attempts.

This measure would also allow for the cryogenic storage of genetic material of a covered individual for up to three years, after which the covered individual would be financially responsible for maintaining storage. The Secretary may not possess, or make any determination regarding the disposition of, genetic material of a covered individual and would be bound by the State law where the genetic material is located. Further, the Secretary may not provide any benefits relating to surrogacy or third-party genetic material donation.

For the purpose of clarity, the term “assisted reproductive technology” includes in vitro fertilization or any other accepted medical technology used to assist reproduction VA determines appropriate for purposes of this section.

While DAV has no specific resolution from our membership related to reproductive and infertility treatment, this bill is focused on improving VA’s authority to meet the long-term reproductive health care needs of veterans who have a service-connected condition that affects their ability to reproduce. For these reasons, DAV looks forward to the favorable consideration of this bill.

**Draft bill – to direct the Secretary of Veterans Affairs to submit an annual report on the Veterans Health Administration and the furnishing of hospital care, medical services, and nursing home care by the Department of Veterans Affairs.**

This bill, if enacted, requires VA submit an annual report to the House and Senate Committees on Veterans’ Affairs, and would require analyses and detail of certain access, performance, quality, workload, human resources utilization, and other activities in and of VA health care, several of which would be comparisons to the prior year’s activities.

We note the report required by this legislation focuses only on one of three pillars which enables the Veterans Health Administration (VHA) to furnish holistic health services to wounded, injured and ill veterans across all 50 states, the District of Columbia and U.S. territories. Specifically, the report would not provide an assessment or evaluation on VHA’s management of veteran-centric research and management of possibly the largest medical education training program in the world.

As the Subcommittee is aware, VHA’s research mission leads to advances in medical care on numerous topics, including post-traumatic stress disorder, traumatic brain injury, and prosthetics. Equally essential to building and maintaining proficiency of care is its training mission, where VHA annually trains, educates and provides practical experience for 62,000 medical students and residents, 23,000 nurses and 33,000 trainees in other health fields — people who go on to provide health care not just to veterans but to most Americans.

Pertaining to the language outlining the content of the report, the Subcommittee’s professional staff may wish to consult with VA staff to ensure the bill produces meaningful reports that serve Congress’ oversight responsibility. For example, adjustments may be needed to the amount of time necessary to produce an insightful evaluation of the effectiveness of a health care system to increase access to care and quality without increasing costs for more than 150 hospitals, 186 multispecialty outpatient clinics, 568 primary care outpatient clinics, 300 Vet Centers, and 135 Community Living Centers, mobile medical clinics, mobile Vet Centers and telehealth programs. The use of terms such as “the productivity of physicians and other employees,” “pharmaceutical prices,” and “the percentage of ... care provided to such veterans in Department facilities and non-Department facilities” could be subject to variable interpretations and assessments depending on the standards chosen to compare or contrast.

We note also this bill is silent on whether the VA report would be made for the Department's health care system as a whole, by Veterans Integrated Service Network (VISN), or by VA facility. Because of VHA's decentralized status, we believe Congress, DAV, other veterans service organizations, and other VA stakeholders could benefit from learning about the variability of these patient care, workload, and human resources activities at the local and/or regional level, rather than as one nationwide review without granularity. We recommend the Subcommittee considers such a change in this legislation. Finally, we recommend these reports be reviewed and certified by the Office of Inspector General before they are released.

### **H.R. 271 – The Creating Options for Veterans Expedited Recovery Act/The COVER Act**

This bill would establish a new commission, the “Veterans Expedited Recovery Commission.” The commission would be established and would function along similar lines to that of the Commission on Care mandated in Public Law 113-146, the Veterans Access, Choice and Accountability Act of 2014. Members of the commission would be selected proportionately by the President and the House and the Senate leadership.

The commission would be established to review VA's efforts on advancing wellness in veterans challenged by mental illnesses. The commission's charge would be broad-based, to investigate directly and through surveys various aspects of the use of evidence-based therapies; the prescribing of psychopharmacological agents and practices in the treatment of mental illnesses in veterans; the experience of veterans in seeking mental health services both within VA and in non-VA facilities and providers; VA's outreach efforts, and; pertinent research and present use of complementary and alternative approaches in dealing with mental illnesses of veterans.

The commission would be required to provide its final report not more than 18 months after it first meets, and the Secretary would be required to provide Congress a report on the recommendations of the commission not more than 90 days afterward.

In accordance with DAV National Resolution No. 220, approved by our membership at our most recent National Convention, assembled in Las Vegas, Nevada, August 9-12, 2014, DAV supports the intent of this bill, and we thank the sponsor for introducing it. In addition to our resolution, as a partner organization of the *Independent Budget* DAV has long supported the advent of complementary and alternative therapies in VA health care for all generations of wounded, injured and ill veterans.

The most prevalent reported health consequence in veterans of combat deployments to Iraq and Afghanistan deals with musculoskeletal injury, followed closely by mental health and post-deployment readjustment challenges. In the view of DAV, VA's Vet Center program, which employs non-drug psychological counseling (including the use of peer counselors), could be considered a model of complementary and alternative treatment; this program has been universally praised by Iraq and Afghanistan veterans. We believe more such non-drug reliant approaches should be advanced.

We call the Subcommittee's attention to language on page 4, lines 11-18 of this bill that may need clarification as to intent. Unclear to us is whether the commission would be expected to study the Veterans Benefits Administration's management of mental health disability claims as a proxy for determining the resources needed in VHA to care for the veterans associated with these claims; or, whether the term "claims" should be replaced by a different expression.

**H.R. 627 – to expand the definition of homeless veteran for purposes of benefits under the laws administered by the Secretary of Veterans Affairs.**

This measure would expand the definition of homeless veteran or veteran's family to include those fleeing domestic or dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions related to the individual's or family's current housing situation. The veteran or family must have no other residence, resources or support networks to obtain other permanent housing.

DAV Resolution No. 203 supports sufficient funding to improve services for homeless veterans in concert with VA's efforts to prevent and end homelessness among our nation's veterans. While our resolution does not include a specific provision on expanding the definition of homeless included in the bill, the provision is in line with supporting VA's efforts to assist veterans that find themselves without stable housing, resources or support networks to permanent housing despite the reason. For these reasons we have no objection to favorable consideration of this measure.

**H.R. 1369 – the Veterans Access to Extended Care Act of 2015**

Extended care services encompass the broad range of medical and personal care assistance veterans need when they have difficulty or inability with daily tasks (such as eating, bathing, getting dressed, preparing meals, and managing medication or money). Many severely wounded, injured and ill veterans receive extended care at VHA's expense through the use of provider agreements.

Congress passed the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (Public Law 108-170), giving VA the authority to use Medicare or state procedures to enter into agreements with providers to obtain extended care services for veterans. On February 13, 2013, VA issued a notice of proposed rulemaking to implement this new authority, which has been stalled with no clear sign if and when a final rule will be made. Because regulations have not been made final, no new provider agreements are being issued by VHA and existing provider agreements set to expire are not being renewed, effectively disrupting the continuity of extended care services for many service-connected disabled veterans.

DAV thanks the sponsors for introducing H.R. 1369, which would modify the treatment of VHA's authority to enable entering into provider agreements with selected extended care facilities. The intent of measure is consistent with DAV Resolution No. 209, which calls for legislation to enhance VA's extended care program for service-connected disabled veterans.

However, thousands of severely disabled veterans receive services in places other than extended care facilities, such as in their home and community or in an institutional setting at VA's expense through the use of provider agreements. For example, if the measure as currently written were enacted, it would not address concerns in VA's Veteran-Directed Home and Community Based Services (VD-HCBS) program, currently operating in 47 VA Medical Centers in 27 States and the District of Columbia. In fact, the VD-HCBS program in Arkansas serving over 30 veterans was recently terminated while the program in Hawaii remains on hold and unable to assist veterans.

We have shared legislative language with the Subcommittee pertaining to the concerns of VD-HCBS and look forward to its favorable consideration along with H.R. 1369. Without such language as part of the final legislation, this program may subsequently be terminated in other states, including Florida, Idaho, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, New York, Oregon, South Carolina, Texas, and Wisconsin. Over 400 veterans would be forced out of this program and obtain less efficient types of care at greater cost to the taxpayer—none of which reflects their personal choices and preferences. Rest assured DAV will continue working the Subcommittee and VA to advance a bill ensuring the Department has the authority it needs to enable veterans to receive extended care services.

On a broader level, this legislation and the legislative language DAV recommends is a piecemeal approach that may fall short of VA's long-term requirements to ensure a smooth delivery of services disabled veterans. In its most recent budget request, VA proposes updating its authorities, including its provider agreement authority, used for purchasing medical care. According to VA, its proposed language will streamline and speed the business process for purchasing care for an individual veteran when necessary care cannot be purchased through existing contracts or sharing agreements. We urge the Subcommittee and VA work on this proposed language to ensure veterans are not encumbered in receiving comprehensive and integrated care in their community.

**H.R. 1575 – to make permanent the pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.**

This bill would make permanent, beginning January 1, 2016, VA's pilot program on counseling retreats for newly separated women veterans. Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, authorized VA to establish a pilot program designed to evaluate the feasibility of providing reintegration and readjustment services in group retreat settings to recently separated women veterans, after a prolonged deployment.

Participation is voluntary and services provided under the pilot program include information and assistance on reintegration into family, employment, and community; financial and occupational counseling; information and counseling on stress reduction and conflict resolution; and any other counseling VA considers appropriate to assist the participants in reintegrating into their families and communities.

Also required under Public Law 111-163 is VA's report to Congress assessing this pilot counseling program in retreat settings. The report describes the program as successful at improving the ability for women veterans to reintegrate and readjust to civilian life.

We thank the Committee for its continued efforts on improving VA's women veterans' health programs and services and are pleased to support this bill in keeping with DAV Resolution No. 040, which supports enhanced medical services and benefits for women veterans. The provisions of the measure are also consistent with DAV's Report, *Women Veterans: The Long Journey Home*.

### **H.R. 1769 – The Toxic Exposure Research Act of 2015**

The 2008, 2010 and 2012 Institute of Medicine (IOM) Committees to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides concluded there is a plausible basis that male veterans exposed to the herbicides in Vietnam could result in adverse effects in are being manifested in the adult children and grandchildren as a result of epigenetic changes, and such potential would most likely be attributable to the TCDD contaminant, the most toxic form of dioxin in Agent Orange.

The 2012 Agent Orange study Committee reported it favors renewed efforts to conduct epidemiologic studies on all the developmental effects in offspring that may be associated with paternal exposure. In addition, new studies should evaluate offspring for defined clinical health conditions that develop later in life, focusing on organ systems that have shown the greatest effects after maternal exposure, including neurologic, immune, and endocrine effects. Finally, although the committee recognizes that there is evidence that environmental exposures can affect later generations, epidemiologic investigation designed to associate toxic exposures with health effects manifested in later generations will be even more challenging to conduct than research on adverse effects on the first generation.

While TCDD mostly associated with herbicide exposed Vietnam veterans, it is also one out of 56 pollutants, including several types of dioxins, of interest to the 2011 IOM Committee on the Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan.

This measure would establish in VA a national center to conduct research on the diagnosis and treatment health conditions of the descendants of veterans exposed to any toxic substances during service provided those health conditions are related to the veteran's exposure. The bill would also establish an advisory board.

Although DAV does not have a resolution from our membership to support this legislation, we encourage the Subcommittee and VA work together to ensure the legislation fulfills the IOM Committee recommendations.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.