

**LEGISLATIVE HEARING ON H.R. 1460, H.R. 3016,
H.R. 3245, H.R. 3279, H.R. 3337, H.R. 3723, AND
H.R. 4079**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
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CONTENTS

April 16, 2012

	Page
Legislative Hearing on H.R. 1460, H.R. 3016, H.R. 3245, H.R. 3279, H.R. 3337, H.R. 3723, and H.R. 4079	1
OPENING STATEMENTS	
Chairwoman Ann Marie Buerkle	1
Prepared Statement of Chairwoman Buerkle	33
Hon. Michael H. Michaud, Ranking Democratic Member	2
Prepared Statement of Hon. Michael M. Michaud	33
Hon. Russ Carnahan, prepared statement only	34
WITNESSES	
Hon. William Owens, U.S. House of Representatives, (NY-23)	3
Prepared Statement of Hon. Owens	35
Hon. John Barrow, Member, Committee on Veterans' Affairs, U.S. House of Representatives, (GA-12)	4
Prepared Statement of Hon. Barrow	35
Hon. Jeff Denham, U.S. House of Representatives, (CA-19)	5
Prepared Statement of Hon. Denham	36
Hon. Silvestre Reyes, Member, prepared statement only	37
Hon. W. Todd Akin, U.S. House of Representatives, (MO-2)	6
Prepared Statement of Hon. Akin	37
Hon. Robert T. Schilling, U.S. House of Representatives, (IL-17)	7
Prepared Statement of Hon. Schilling	38
Hon. David B. McKinley, U.S. House of Representatives, (WV-1)	9
Prepared Statement of Hon. McKinley	39
Shane Barker, Senior Legislative Associate, Veterans of Foreign Wars	13
Prepared Statement of Mr. Barker	40
Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans	15
Prepared Statement of Mr. Atizado	43
René A. Campos, Commander, U.S. Navy (Ret.), Deputy Director, Government Relations, Military Officers Association of America	16
Prepared Statement of Mrs. Campos	48
Ramsey Sulayman, Legislative Associate, Iraq and Afghanistan Veterans of America	18
Prepared Statement of Mr. Sulayman	51
Ralph Ibson, National Policy Director, Wounded Warrior Project	19
Prepared Statement of Mr. Ibson	53
Robert L. Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs	25
Prepared Statement of Dr. Jesse	57
Accompanied by:	
Susan Blauert, Deputy Assistant General Counsel, Office of General Counsel, U.S. Department of Veterans Affairs	

	Page
STATEMENTS FOR THE RECORD	
Institute of Medicine	63
Burn Pits 360	64
Humana Government	65
National Coalition of Homeless Veterans	68
Paralyzed Veterans of America	69

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MONDAY, APRIL 16, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 4:00 p.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Roe, Denham, Michaud, Reyes, and Barrow.

**OPENING STATEMENT OF HON. ANN MARIE BUERKLE,
CHAIRWOMAN**

Ms. BUERKLE. Good afternoon. This hearing will now come to order.

Thank you all for being here today as we begin to discuss seven legislative proposals concerning the care and services provided to our Nation's veterans and their families through the Department of Veterans Affairs.

The seven bills on our agenda this afternoon are: H.R. 1460, to provide for the automatic enrollment of veterans returning from combat zones into the VA medical system; H.R. 3016, to direct the Secretary of Defense and the Secretary of Veterans Affairs to jointly operate the Federal Recovery Coordination Program; H.R. 3245, the Efficient Services for Veterans Act; H.R. 3279, to clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by the VA; H.R. 3337, the Open Burn Pit Registry Act; H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011; and H.R. 4079, the Safe Housing for Homeless Veterans Act.

Together, these bills touch on a full range of issues affecting our veterans as well as their families.

The proposals we will discuss include measures to address fire and building safety code enforcement for homeless veterans participating in VA grant and per diem programs; streamline the eligibility determination for veterans seeking readjustment counseling services at Vet Centers; establish a registry for OEF/OIF veterans who may have been exposed to toxic chemicals caused by open burn pits; and allow veterans greater access to the health care they earned and deserve by reforming the VA's fee-basis care program

and by providing for the automatic enrollment of returning combat veterans into the VA health care system.

Additionally, we will discuss two bills, H.R. 3016 and H.R. 3279, that seek to improve programs that support some of our most seriously Wounded Warriors, the Federal Recovery Coordination Program and the Comprehensive Assistance for Family Caregivers Program, respectively. These programs in particular are very familiar to this Subcommittee, which has held a total of four oversight hearings last year to examine them in depth.

Our discussion today will provide us with the opportunity to thoroughly examine each of these proposals with their sponsors and the Department, as well as our partners in the veteran service organizations to find out what works, what doesn't, and what needs to be improved.

I thank my colleagues this afternoon for sponsoring the bills on our agenda and for their leadership in this very important endeavor. I also appreciate our witnesses from the veterans' service organizations as well as the VA for taking the time to join us today and for working so hard, day in and day out, in support of our Nation's heroes. I am very much looking forward to our discussion; and, at this time, I now yield to the Ranking Member, Mr. Michaud.

[THE PREPARED STATEMENT OF CHAIRWOMAN BUERKLE APPEARS IN THE APPENDIX]

**OPENING STATEMENT OF HON. MICHAEL H. MICHAUD,
RANKING DEMOCRATIC MEMBER**

Mr. MICHAUD. Thank you very much, Madam Chair.

I, too, want to thank all three groups of panelists for coming before us today. I look forward to hearing your testimony.

As you heard, the purpose of today's hearing will be to explore the policy implications of seven bills before us that cover a wide range of topics to help expand and enhance VA's health care programs and services.

Madam Chair, to allow for the maximum amount of time for our three panelists, since we are in session this afternoon, I would ask unanimous consent that the rest of my opening remarks be submitted for the record.

[THE PREPARED STATEMENT OF HON. MICHAUD, APPEARS IN THE APPENDIX]

Ms. BUERKLE. Without objection, thank you.

We will now turn to our first panel where I am very proud and pleased to welcome such a distinguished group of my colleagues and friends.

Joining us this afternoon to discuss the legislation they have introduced is: Air Force veteran and fellow New Yorker, Mr. Bill Owens; Georgian and fellow Committee Member, John Barrow.

Californian and Subcommittee Member, Jeff Denham; (Jeff Denham isn't here yet but will be here.)

Vietnam-era combat veteran, Subcommittee Member, and proud Texan, Silvestre Reyes; Show-Me State Representative Todd Akin; a small business owner all the way from the Land of Lincoln, Mr.

Bobby Shilling; and David McKinley, a civil engineer from West Virginia.

Gentlemen, thank you very much for being here with us this afternoon and for your advocacy on behalf of our Nation's veterans.

Mr. Owens, we will start with you. Thank you.

STATEMENT OF THE HON. WILLIAM OWENS

Mr. OWENS. Thank you very much, Madam Chair, Ranking Member Michaud, and Members of the Committee. I appreciate the opportunity to come before you today and testify on H.R. 1460, which is legislation I have introduced to provide for the automatic enrollment of military servicemembers in the VA health care system. As a veteran of the Air Force, I am honored to have the opportunity to help improve access to the benefits that men and women in uniform have earned in the service to their country.

The soldiers, sailors, airmen, and marines of the Armed Forces have served with great honor and distinction over a decade at war in the Middle East. PCS orders, increased op-tempo, repeat deployments, and shortened dwell times have only added to the pressures facing the military and their families to Operations Enduring Freedom, Iraqi Freedom, and New Dawn.

There is no question that we as a country have made great strides over the past 10 years to strengthen systems of care for American veterans, but obstacles remain for the men and women transitioning from service to civilian life. Representatives from various veterans' service organizations have testified on their concerns for military families being overwhelmed by the bureaucracies of both the Veterans Administration and the Department of Defense, and it should come as no surprise that VA paperwork is only one in a number of challenges facing servicemembers in their transition to civilian life.

Under my legislation, combat veterans discharging from service within 45 days must be provided enrollment in the VA, a veterans identification card demonstrating enrollment and allowing access to hospital and medical services at VA facilities, a list of VA facilities located within 100 miles of the vet's home, or the closest veterans home if there is none located near the veteran, a description of available Federal benefits, job training, placement programs, educational benefits, et cetera.

Any veteran considered under this bill will be given an option to decline enrollment beforehand and proactively given an option to disenroll from the program no more than 6 months later. The bill goes into effect 90 days after enactment.

To be clear, this legislation does not change the benefits for which a veteran is eligible or the care they are entitled to within the VA. The men and women enrolled under this legislation are already eligible for VA care. All we are doing is shifting the burden of enrollment away from those who have just returned from a theater of war to those who are deployed to serve American veterans.

In addition to reducing the government paperwork required of them, we can help ensure that overburdened servicemembers do not slip through the cracks and miss an opportunity to enjoy the benefits they have earned.

I remain particularly concerned for servicemembers afflicted with traumatic brain injury or post-traumatic stress disorder who face unique pressures in transitioning from service. This legislation will ensure that they have early access to screening for TBI and PTSD from experts at the VA who can improve the long-term prognosis for those affected and ensure proper treatment in the years ahead.

I thank you again for the opportunity to speak to you on behalf of H.R. 1460 and respectfully request that you consider lending your support to the bill. I look forward to your questions.

Thank you and I yield back.

[THE PREPARED STATEMENT OF HON. OWENS APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. Barrow.

STATEMENT OF THE HON. JOHN BARROW

Mr. BARROW. Thank you, Chairwoman Burke, Ranking Member Michaud, and Members of the Subcommittee. Thanks for giving me the opportunity to speak to you about H.R. 3016, my bill to improve the Federal Recovery Coordination Program.

Today's returning armed servicemembers face a unique combination of challenges as they reintegrate into the community. One important means for helping these folks is the Federal Recovery Coordination Program, which was originally envisioned by the Dole-Shalala Commission to help Wounded Warriors navigate the bureaucracy of the VA and the DoD health systems.

A Federal Recovery Coordinator is a nurse or a social worker with graduate-level training who helps guide Wounded Warriors to the proper treatment and benefits options. Unfortunately, administrative roadblocks have prevented the program from achieving its full potential. That is why I introduced H.R. 3016, which would correct the administrative problems that prevent the Federal Recovery Coordination Program from succeeding.

H.R. 3016 establishes joint administration of this program by placing it under the supervision of both the Secretaries of Defense and Veterans Affairs. It ensures severely injured armed servicemembers and veterans receive a Federal Recovery Coordinator, and it gives coordinators the authority to act earlier in the recovery process, and it makes certain that each branch of DoD will refer Wounded Warriors to the program.

Jim Lorraine, the Executive Director of the Augusta Wounded Warrior Project—an outstanding organization that builds collaborative relationships with local, State, and national organizations that support Wounded Warriors and their families in the Augusta area—explains how this legislation will benefit veterans:

The Federal Recovery Coordinator Program is essential to helping our most severely wounded, ill, and injured who have given so much for our Nation, help them figure out how to navigate these complex bureaucracies and improve their access to existing services. This legislation not only formally establishes the program but directs its management from the highest levels of the Department of Defense and Veterans Affairs to ensure unimpeded access to care.

I hope this Committee will join me in strengthening the Federal Recovery Coordination Program through this legislation. It is time we fulfilled the promises we made to our servicemembers by improving their care throughout the recovery process.

Madam Chair, thank you again for the opportunity to speak to this Committee. I yield back the balance of my time.

[THE PREPARED STATEMENT OF HON. BARROW APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. Denham, you may proceed.

STATEMENT OF THE HON. JEFF DENHAM

Mr. DENHAM. Thank you, Madam Chair, Ranking Member Michaud, and Members of the Subcommittee, for holding this legislation hearing today; and thank you to the Chairwoman for cosponsoring this legislation as well as Mr. Roe and Mr. Benishek for their support. Let me also thank Mr. McNerney, who joined me in a Subcommittee hearing last week on this very topic.

Vet Centers offer a wide range of readjustment counseling services to eligible veterans and their families. At our field hearing, we were able to hear firsthand how effective these centers are at delivering the care our veterans need confidentially and without any delay. This bill would provide Vet Centers with one additional tool to serve our veterans: the ability to search in the electronic database base of DD-214 records.

A DD-214 is the swiftest way to determine eligibility for the services provided by Vet Centers. A DD-214 is the capstone military service document, as it represents the complete, verified record of a servicemember's time in the military, awards, medals, and other pertinent service information such as promotions, combat, or overseas service, military occupational specialty identifiers, and the record of training and schools completed.

In the event that a veteran has lost his access to a DD-214, it can take up to 6 weeks to receive a copy; and there is no single prevailing method used by Vet Centers to request a copy of the DD-214. While during the delay, a veteran will still have access to the facility, instant verification will allow the Vet Center to immediately provide veterans the highest possible level of service and eliminate the bureaucratic hurdle for the servicemember.

There are two electronic records systems that allow users to view a DD-214 form. These systems are the Defense Personnel Records Image Retrieval System and the VA/DoD identity repository.

The latter receives nightly and near realtime transmissions from the Defense Enrollment and Eligibility Reporting System/Defense Manpower Data Center of military service information for servicemembers leaving the military.

The former provides authorized U.S. Government agencies controlled access to military personnel record images that no other sources contain. This system was initially implemented in the late 1990s, so not all personnel records are available and implementation was staggered across all branches of service. DPRIS contains narrative information in the DD-214 that no other sources contain.

The bill simply directs the Secretary of Veterans Affairs and the Secretary of Defense to jointly ensure that the Vet Centers of the Department of Veterans Affairs have access to a veteran's DD-214. As we speak, there are 7,500 current users of the system within the VBA alone and many others across the VA system. I strongly believe that the professional staff and counselors at Vet Centers should be given the same tools to serve our veterans and believe that it can be done in a way that preserves the integrity of the Vet Center system. I thank the American Legion and the VFW, Veterans of Foreign Wars, for their support of this legislation.

As a veteran myself, I know the difficulties experienced by those transitioning to civilian life and how common it is for veterans to be missing records that are important to keep. I am sure you can all agree that whenever we have the opportunity to streamline service for our veterans we should seize that chance.

Again, I thank the chairwoman, the Ranking Member, and Members of the Committee for allowing me to speak here today. I look forward to working with all of you to get this bill moving swiftly.

[THE PREPARED STATEMENT OF HON. DENHAM APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.
Mr. Akin.

STATEMENT OF THE HON. TODD AKIN

Mr. AKIN. Thank you, Chairwoman Buerkle and also Ranking Member Michaud. Thank you for the opportunity to testify before you today regarding my bill, H.R. 3337, the Open Burn Pit Registry Act.

And I am going to go on with the testimony in just a minute, but the short version is that people are exposed to the fumes that come off of burn pits, and it sometimes had delayed medical effects on people. And because it is not very easy to diagnose, it is hard for people to get connected.

And the whole point of this thing, it is not giving any money away. It is just simply saying that we are going to create a registry so that people have a chance to coordinate together, get the medical information and the symptoms and put that together. I think it is a \$2 million bill total over, I don't know how many years. So that is the quick version.

It has over 50 bipartisan co-sponsors, has been endorsed by a wide range of veterans' organizations.

The issue of burn pit exposure first came to my attention through veterans in my district who served honorably in Iraq and Afghanistan and are now suffering serious health effects apparently linked to exposure to burn pits. I will share one short story.

Tim Wymore is a Missouri Guardsman suffering from the effects of working around burn pits while deployed to Iraq in 2004 and 2005. His wife, Shanna—if his wife Shanna were here today she would tell you of the dramatic impact burn pits have had on the life of her husband and hundreds of others she has gotten to know as a result of fighting for Tim's treatment.

For nearly a year before contacting my office, as Tim's health continued to deteriorate, Shanna Wymore fought an often indif-

ferent and sometimes hostile VA medical system trying to get care of her husband's unexplained illnesses. Tim, once a strong, athletic machinist, was suffering debilitating bouts of abdominal pain, weight loss, and fatigue. Despite the adversity, Shanna persisted in her fight to get the help her husband was both entitled to and deserved. Along the way, she became an expert on burn pits and the growing number of Iraq war veterans suffering the effects of their exposure.

After more than 2 years of indecision and broken promises, with assistance from my district staff, the VA finally agreed to send Tim to the Mayo Clinic. The doctors there confirmed what the VA had long denied. Tim was suffering from the effects of what could only be attributed to the work he performed around the burn pits in Iraq.

I have had at least one other constituent, Aubrey Tapley, who has suffered the burn pit exposure and who has strongly advocated for taking proactive steps to help others who may be suffering from burn pit exposure.

Unfortunately, the health consequences of burn pit exposure are hard to understand and difficult to prove. Last fall, the Institute of Medicine released a report which concluded in part that there is insufficient data available to determine the long-term health effects of exposure to burn pits and that more study is warranted.

The intent of my bill is to establish a registry at the Department of Veterans Affairs for those individuals who have been exposed to open burn pits during their military service. This would help the Department study the issue more effectively and enable them to communicate to interested veterans as medical research on this issue develops. This registry would not affect the benefits any veteran is already entitled to receive but would help the Department take better care of our veterans.

The experience I have had with veterans in my district is enough to convince me that we need to be proactive about studying and analyzing the potential health effects of open burn pits. We have sent our best and brightest young men and women into harm's way, and it is our responsibility as a Nation to take care of them when they return. And although there is a small cost for this bill, I think it is an affordable and reasonable approach to dealing with the issue of open burn pits and ask your Subcommittee to support this bill and consider moving it forward.

Again, thank you for the opportunity to testify today. I look forward to answering any questions you may have. Thank you.

[THE PREPARED STATEMENT OF HON. AKIN APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.
Mr. Schilling, you may proceed.

STATEMENT OF THE HON. ROBERT T. SCHILLING

Mr. SCHILLING. Chairwoman Buerkle, Ranking Member Michaud, and my colleagues, thank you for this opportunity to come before the House Veterans Affairs Subcommittee on Health to speak about my bill, H.R. 3723, the Enhanced Veteran Healthcare

Experience Act of 2011. I truly believe that you can tell a lot about the country by the way they treat their veterans.

I am pursuing this legislation in part because of the many constituents who constantly share their stories of having to drive long distances while experiencing substantial wait times in an effort to make sure they get the health care they need. But I also have a personal experience from my father who passed away in 2005. He served in Korea. And as we were driving many hours to and from the veteran hospital, you know, one day I thought to myself, why is it that the veteran has to travel so far to get the care that is needed and deserved? And, hence, the reason why I came up with this bill.

We also must keep in mind the fact that we will have a new group of veterans entering into the VA system with needs that are different from the past veterans group—groups, actually. There have been many instances where the current VA fee-based system has been unable to accurately pay private providers the correct amounts, which has resulted in multiple overpayments and costs to taxpayers and their hard-earned tax dollars.

My legislation, the Enhanced Veteran Healthcare Experience Act, would merge the best parts of Project HERO with the best parts of Project ARCH and provide an alternative to the current VA-run fee-based program as the primary source of fee-based care for veterans. It would ensure that the VA contracts with qualified outside entities that meet key competency requirements such as network credentialed providers and accredited facilities, care coordination, patient advocacy, and electronic claims processing capabilities. The bill would standardize referral and authorization processes at all VA medical centers, require continuity of care for the veteran, and require key performance metrics and incentive payments.

The bill would not force veterans to stop using VA care. Veterans who prefer their current VA provider would still be able to continue receiving care from that provider. Veterans that do go outside of the system are also not prevented from returning to the VA for care in the future.

With a proven system that can properly keep track of payouts in place, the VA could save money it may have otherwise misspent, and very little additional fund would therefore be required for this more efficient program. The Congressional Budget Office has not yet officially scored this bill, but an unofficial CBO staff estimate indicated that this bill would require \$3 million total for fiscal years 2012 to 2016. However, studies and statements by the GAO, the OIG, and the VSO indicated that implementing the changes in this bill will promote savings for the VA and address medical care concerns that veterans have when working with the VA fee-based system.

The congressional process is in place, but we can perfect legislation. That is why I am working to do that on this bill. Since H.R. 3723's inception and also from its introduction, I have continued to work with the Veterans Service Organization, the VSO, to address their concerns. I hope to continue to do so with the VSO and the Committee. To that end, I have a draft legislation on the Committee that you can use to improve H.R. 3723.

Again, I would like to thank you for the opportunity to speak about ways that we can remain fiscally responsible while ensuring we keep better our promises to our veterans.

With that, I yield back.

[THE PREPARED STATEMENT OF HON. SCHILLING APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. McKinley, you may proceed.

STATEMENT OF THE HON. DAVID B. MCKINLEY

Mr. MCKINLEY. Thank you.

Chairwoman Buerkle, Ranking Member Michaud, Members of the Subcommittee. Thank you for holding this legislative hearing today on these important issues that affect our Nation's veterans. I appreciate this opportunity to give remarks about H.R. 4079, the Safe Housing for Homeless Veterans Act.

Currently, there are over 2,100 community-based homeless veteran service providers across the country and many other homeless assistance programs that have demonstrated success reaching homeless veterans. I visited some of these shelters in my home district in West Virginia but have been struck by how many are not in compliance with State, local, and fire safety and building codes.

Consequently, we began to investigate whether this is something that is isolated or other instances are occurring. It was unsettling to learn in our research about shelter fires where lives were lost. For instance, in 2009, an East Texas homeless shelter fire where five occupants were killed was found not to have a required sprinkler system. And an instance in New York City just this past year where two dozen people were injured because a sprinkler system was not working properly and the exits were blocked.

I would like to enter news articles about these fires and an additional three articles regarding other instances of code violations into the record.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Mr. MCKINLEY. Unfortunately, there is no law mandating VA homeless shelters meet code. There is only a policy in place. As a licensed professional engineer who practices both architecture and engineering, I found this to be an egregious omission in the law governing homeless program funds. H.R. 4079 would require an organization that seeks funding from VA for services to homeless veterans to provide documentation that their building meets or exceeds all Life Safety Codes.

This legislation also requires VA to give priority to shelters that need financial assistance from the VA for improvements to ensure that the facility is in compliance with all safety codes.

I am disappointed that the VA did not initially embrace H.R. 4079 in their written testimony. However, I do appreciate their willingness to work with us on this legislation so that the goal of maintaining a safe environment for homeless veterans can be achieved.

This bill simply codifies what they already have as a policy. This is common-sense legislation that would ensure the well-being of our

veterans who have fallen on hard times and are in most need of assistance; and, in extension, these same veterans are turning to society to assure them of safe, reliable housing.

As a Nation, it should be unacceptable for us to allow homeless veterans be housed in potentially unsafe conditions. In defense of our country, these men and women were put in harm's way. They should not be in doubt about their own safety now that they are home again. These homeless veterans are experiencing a difficult phase of their lives and should be able to trust that they will be safe each night as they continue their rehabilitation as members of society.

I appreciate the testimony in support of H.R. 4079 from other witnesses testifying here today, and I thank you for your concern for the safety and living environment of our veterans.

I yield back my time. Thank you.

[THE PREPARED STATEMENT OF HON. MCKINLEY APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much, and thank all of you for your testimony.

I am going to yield myself 5 minutes now for questions.

Mr. OWENS, with regards to H.R. 1460, it has been a priority of this Committee to ensure a seamless transition for our veterans coming home—and so I want to thank you for your efforts on this behalf and also thank you for your service to our country.

Mr. OWENS. Thank you.

Ms. BUERKLE. We heard from the Disabled American Veterans in written testimony, that one of their concerns is if we automatically enroll this large influx of young veterans, will it squeeze out some of the older veterans from previous wars and engagements? And if they are not in the system but then try to enter the system at a later date, is that a problem? Would you like the opportunity to address that issue?

Mr. OWENS. I would say that, from my perspective, if you think about the process that a veteran is going through when they are being—in the terms of my experience—mustered out—maybe something of an ancient phrase now—they simply are making choices at that point in time. And you walk out of the CPBO with a pack of papers about this thick. And one of the top priorities for people who are eligible for VA benefits should be they are getting those. And so, even if it does create a little bit more of an initial influx, most of those people are going to come into the system down the line anyway; and I think it is most appropriate that they have the opportunity to go in immediately.

Ms. BUERKLE. One other concern that was raised by the Paralyzed Veterans of America, was the need to ensure that veterans who decide not to enroll in the VA through that automatic enrollment process, if at a later date they needed to or chose to reenter the system, is that a problem?

Mr. OWENS. They would not be precluded. The disenrollment provisions that are in the bill simply allow people to make that choice but do not prohibit, as long as they are statutorily eligible, to reenter the system down the road.

Ms. BUERKLE. Thank you very much.

Mr. Barrow, if I could.

Mr. BARROW. Yes, ma'am.

Ms. BUERKLE. With regards to H.R. 3016, this Subcommittee has had two hearings on the Federal Recovery Coordination Program. We have grave concerns, so I am absolutely delighted that you are bringing this up and we are addressing this issue. There seems to be such an overlap between what the VA is doing and what DoD is doing, and we are really concerned about making this happen for veterans and their families.

Your testimony references administrative roadblocks that have prevented the Federal Recovery Coordination Program from achieving its full potential. Can you elaborate on that for the Committee?

Mr. BARROW. Yes, ma'am.

There is a need to get referrals from the DoD side of things, and the DoD is not as responsive in the chain of command. The recovery program has direct access to the Secretary of the VA but not the DoD, and we think it is important that that be remedied, that they have access to the highest levels of authority in both, the two main silos in which our concerns for Wounded Warriors originate, those where they began and those where they transition to.

Also, I think it is important that they be codified and established in law so that we have an ongoing commitment to the program.

Those are just a couple of ways in which I think we can overcome some of the obstacles that folks have encountered.

Ms. BUERKLE. Very good, thank you.

Mr. McKinley, if you could just elaborate a little bit further on

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Mr. MCKINLEY. I am sorry. I can't hear.

Ms. BUERKLE. If you could just elaborate a little bit further on what were the conditions that you saw and, specifically, how your bill would address those conditions.

Mr. MCKINLEY. I still didn't hear.

Mr. AKIN. What were the conditions that you saw and how would your bill affect it?

Ms. BUERKLE. I can repeat it.

Mr. MCKINLEY. What we saw were lack of sprinkler systems, fire doors that were not rated fire doors. Wall assemblies that did not meet code. Fire exit ways that did not meet code. ADA requirements of accommodations on upper floors.

These would not be acceptable in almost any other circumstance, and it is unfortunate. I think it has fallen through the cracks, that these could be addressed over a period of time and corrected, and our veterans would be housed in an equal, comparable to many other situations.

Thank you.

Ms. BUERKLE. Thank you very much.

I now yield to the Ranking Member for questions.

Mr. MICHAUD. Thank you, Madam Chair.

Once again, I would like to thank all of the panelists for coming here today and look forward to working with you as we move forward dealing with your individual pieces of legislation. So I have no questions for any of the panelists. I yield back.

Ms. BUERKLE. Thank you.

I yield to the gentleman from Tennessee, Dr. Roe.

Mr. ROE. First of all, I want to thank the panelists. Every one of you stayed within your 5 minutes. Thank you. That is amazing. I have never been to one where everybody did. So this is the first time since I have been here.

Just a couple of quick questions, one to Congressman Akin.

I want to strongly encourage us to support this piece of legislation, and I will tell you why. I served in Korea, 11 miles south of the DMZ almost 40 years ago. And sometime before that, Agent Orange was used there but there is no record of that. And now it is just a disaster trying to figure out who was there, who was not there and can you get their benefits.

You are right on by doing this. Let's just put a record down. You don't know 40 years from now what is going to come up and who is going to need that. So let's document who was there so that a congressman, much after we are all gone, can deal with this years later. I think it is a very good piece of legislation.

And just for my clarification, from Congressman Owens, if you would tell me why was the date picked in 1998 for a soldier that would be signed up, as opposed to a troop before that that may have been in a combat zone?

Mr. OWENS. I think it was simply for administrative convenience. We needed to pick a date, and we picked that. It also coincides with Gulf War 1, and we thought that those folks would be most likely in the position, whereas people who served in Vietnam were most likely, if they were going to be in the system, already in the system.

Mr. ROE. I just didn't know why that was picked. That is fine. So it is arbitrary.

And the other question I guess I had to Congressman McKinley is that, being a former mayor before I got here, how can you get a facility permitted past the building codes folks and the local fire marshal? That wouldn't happen where I live.

Mr. MCKINLEY. Some things, Congressman, occur over time. We determined up in New York, where they actually blocked fire exit ways, they may have been approved at one time. But then the way it operated, they were closed, locked. Sprinkler systems were turned off because they were not being repaired properly. So they were dripping, leaking. Instead of fixing them, they just turned them off. So you have got it initially. But there has to be and should be a follow-up. For something as serious as this, there should be ongoing investigation to see that our men and women are safe.

Mr. ROE. I guess I am more pointing at the local officials than I am the VA. Because that is a local issue at home. I don't think that could happen. They are here all the time.

Mr. MCKINLEY. I am not going to finger point as to whether it was the VA or the local fire marshal, but I think someone needs to be doing an ongoing operation. Once they get permission to do it, someone needs to follow up to make sure that both groups are complying with the requirements that were passed.

Mr. ROE. Thank you. I yield back.

Ms. BUERKLE. Thank you very much.

If there are no further questions from the Committee, I would just like to say thank you to all of you again. Thank you for your

commitment to our veterans. As a Nation, we owe them a debt of gratitude, and I appreciate your efforts on their behalf. Thank you all very much.

If our second panel would come to the table. Good afternoon, everyone.

With us on our second panel are representatives from our veteran service organizations:

We have Mr. Shane Barker, Senior Legislative Associate for the Veterans of Foreign Wars; Mr. Adrian Atizado, Assistant National Legislative Director for the Disabled American Veterans; Commander Rene Campos, the Deputy Director of Government Relations for the Military Officers Association of America; Ramsey Sulayman, Legislative Associate for the Iraq and Afghanistan Veterans of America; and Mr. Ralph Ibson, National Policy Director for the Wounded Warrior Project.

Thank you all very much for joining us this afternoon, and our sincere thanks to all of you for the good work you do for and on behalf of our veterans and their families. Thank you.

With that, Mr. Barker, if you would like to begin with your testimony.

STATEMENTS OF SHANE BARKER, SENIOR LEGISLATIVE ASSOCIATE, VETERANS OF FOREIGN WARS; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RENE A. CAMPOS, COMMANDER, U.S. NAVY (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA; RAMSEY SULAYMAN, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND RALPH IBSON, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT

STATEMENT OF SHANE BARKER

Mr. BARKER. Thank you.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee, on behalf of the 2 million members of the Veterans of Foreign Wars and our auxiliaries, it is my pleasure to be here today to share our views with you on these important pieces of legislation.

In the interest of time, I will limit my remarks to a selection of bills before the Committee.

VFW does support the intent of H.R. 1460, which would direct VA to automatically enroll servicemembers returning from Iraq and Afghanistan into the Veterans Health Administration. However, as written, we are concerned that this bill would not enroll military personnel who are medically retired as a result of a state-side injury or other extenuating circumstances.

The VFW does hope that this Committee will consider amending this legislation to provide a similar service as what you are trying to provide to people returning from Iraq and Afghanistan to all separating servicemembers and would give the VA the resources that it needs to be successful in that mission.

VFW also supports H.R. 3016, a bill that could ensure those responsible for administering the Federal Recovery Coordination Program are located in the offices of the Secretaries of DoD and VA

and not down the chain somewhere that would make them less visible to the respective Secretaries.

This program was created to ensure properly coordinated care for our Wounded Warriors without placing the administrative burden on the servicemember or their family. We have fallen short on this promise for many of our returning warriors, and we feel that we must do more to alleviate the burden caused by simply being in the program.

This legislation contains other helpful provisions, but problems within the FRC program will not be solved without taking this obvious step, and so we fully support this bill.

We also strongly support H.R. 3279, legislation that would clarify the veterans eligible for caregiver support under Public Law 111-163 as a result of serious illness are just as eligible as those veterans who qualify as a result of a combat injury. Congressional intent is clear that those who are catastrophically harmed through a debilitating disease should have equal access to the full range of benefits under the caregiver law. This is the case in the Department of Defense Caregiver Program, and we cannot accept a program that would curtail essential caregiver benefits when a military member exits DoD care and enters VA care. This is the right thing to do for our servicemembers and their families, and we offer our full support.

VFW supports H.R. 3337, the Open Burn Pit Registry Act of 2011, and thanks Congressman Akin for his introduction of this bill. It is a recognition that we have not yet reached the level of scientific knowledge to properly care for the men and women who had no choice but to inhale the toxic fumes of a burn pit in Iraq or Afghanistan.

This bill is also a recognition that our Nation wants to provide enhanced care for those exposed as new treatment options are discovered. It is important to show that those who are suffering from the effects of toxic inhalations that we care for them and want to provide the best possible treatment.

The VFW does not support H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011. We believe this bill is well intentioned and that it seeks to address a clear and significant problem within VA. Those problems are inherent in the current fee-based system. They are manifest. As an example, while the VA paid out more than \$4 billion in fee-basis health care claims in 2010 alone, they have few tools at their disposal to ensure they are getting the most for their money.

Among the serious problems that currently exist, VA has no way to ensure proper credentialing of those who bill VA for services rendered; no way to ensure bill procedures actually occurred; and no way to integrate the documentation into a veteran's electronic health record.

Nevertheless, the remedy this bill offers is, at the same time, broad in its implication and overly proscriptive in its mandates. Essentially, it would wipe away the current system of fee-basis care and would replace it with a network of providers to be administered by one or more private companies on behalf of VA.

In order for such a network to be affordable, we believe VA would have to direct a consistent number of veterans into the net-

work to keep doctors participating and to drive down unit cost. In our view, such a calculation could make the health care needs of veterans a second priority as VA seeks to manage their network.

We believe this paradigm also presupposes a robust and successful implementation of the Patient Aligned Care Teams across VHA to coordinate with the network provider to eliminate duplicative services and promote overall cost containment. The PACT model of care is not yet fully implemented, and we approach the concept of a bidirectional care coordination across VA with the private sector with a healthy amount of skepticism.

We are appreciative of the introduction of this bill, and we are pleased to be a part of this discussion. We would hope to work with the Committee in the future to continue refining this legislation.

And with that, Madam Chairwoman, this concludes my statement. I am happy to take any questions that you or Members of the Committee may have.

[THE PREPARED STATEMENT OF SHANE BARKER APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. Atizado, you may proceed.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Madam Chairman, Ranking Member Michaud, and Members of the Subcommittee, the Disabled Americans Veterans is honored to testify at this legislation hearing before the Subcommittee on Health.

Our organization has 1.2 million members, and we devote our energies to rebuilding the lives of disabled veterans and their families. For the sake of brevity, I will only speak on those bills for which DAV supports favorable consideration by this Subcommittee.

The intent of H.R. 3279 is to clarify Congress' intent in passing Public Law 111-163. That is to make family caregivers of certain veterans with serious illnesses eligible for VA's comprehensive caregiver assistance and support services. Under current law, only family caregivers of certain veterans with serious physical injuries are eligible; and we thank the sponsor for introducing this bill and strongly urge its favorable consideration.

Our national resolution passed at our most recent national convention supporting this important legislation also calls on Congress to expand the eligibility for comprehensive caregivers support services to caregivers of veterans of all eras. Those caregivers have carried a long and heavy burden for their loved ones and deserve the level of attention and support now being provided generously by VA to caregivers of the newest generation of veterans.

DAV also supports H.R. 3337, the Open Burn Pit Registry Act of 2011, because it partially fulfills propositions in our national resolution on military exposure to toxic and environmental hazards. If enacted, this bill would direct VA to establish an open burn pit registry, advise veterans in how to participate, and periodically notify registrants about significant developments in the study and treatment of conditions associated with exposure to open burn pits.

Madam Chairwoman, we note that participation in the registry is voluntary. That is the nature of the beast. And because such par-

ticipants are self-selected, they do not constitute a representative sample of all U.S. soldiers who are exposed to open burn pits.

While the limitation of a registry precludes it from being used to determine whether a particular condition is caused by a particular exposure, it does provide useful information to describe the health status of participants. That is to say, the burn pit registry could be used to determine whether to pursue research on a possible link between condition and exposure. For this importance, we support that provision of this bill.

Now, in October, 2011, the IOM, the Institute of Medicine, did issue its report on long-term consequences of burn pits in Iraq and Afghanistan. They found numerous data gaps and uncertainties in monitoring the airborne pollutants that point to the need for additional study and analysis. The IOM recommended conducting a longitudinal study to evaluate the health status of servicemembers from their time of deployment to determine their incidence of chronic disease, including cancers, some which may not appear until many months after.

Madam Chairwoman, although VA is sponsoring large-scale scientific studies that cover a wide spectrum of health effects, these studies may not meet IOM's call for a well-designed study for this particular environmental exposure. We urge your Subcommittee to consider adding to this bill a prospective research component with the identification of specified cohort groups. Cohort studies over an extended period of time have the potential to provide more meaningful insight into the long-term health consequences from combined exposures, including exposures to open burn pits.

Madam Chairwoman, this completes my testimony. I would be happy to answer any questions you or the Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.
Commander Campos.

STATEMENT OF RENÉ A. CAMPOS

Commander Campos. Madam Chair Buerkle, Ranking Member Michaud, and distinguished Members of the Subcommittee, on behalf of the 375,000 members of the Military Officers Association of America, I am grateful for the opportunity to present MOAA's views on the legislative provisions before the Subcommittee. MOAA greatly appreciates the Subcommittee's leadership in addressing the very important business of taking care of our veterans by your diligent oversight of their medical care and benefits.

We would also like to acknowledge and thank the VA for its hard work and persistence in transforming the agency's culture and systems of care.

Today, I will focus my remarks on three specific bills.

MOAA thanks Congressman Owens for his commitment to seamless transition of veterans from the military to the VA health care system with H.R. 1460. MOAA supports the concept of automatic enrollment in VA health care and recommends that H.R. 1460 be amended to authorize all Iraq and Afghanistan veterans. We be-

lieve that there should be no distinction between veterans who have served in combat theater and those who have served in other types of assignments. Automatic enrollment of only combat theater veterans will likely be perceived negatively by non-combat veterans, causing them to view it as a form of health care rationing that devalues their contributions of service to their country.

Automatic enrollment is consistent with MOAA's long-standing support for seamless transition into the VA and civilian medical systems. Ongoing work on the DoD and VA electronic medical record could be advanced by automatic VA health care enrollment, but the provision does not eliminate the requirement for the veteran to physically enroll in a VA medical center. Perhaps VA's outreach system could be strengthened by having advance information on separating servicemembers put into the VA's enrollment system.

Secondly, MOAA supports the concept of H.R. 3016, Congressman Barrow's bill, to direct the VA and DoD Secretaries to operate the joint Federal Recovery Care Coordination Program. We support, again, in concept, but we would recommend that Congress continue to provide oversight by conducting hearings and requiring reports from senior VA and DoD officials in lieu of additional legislation in order to determine the efficacy of these programs and increase accountability of the systems. The two departments have stepped up their collaborative efforts in recent months, but MOAA believes that congressional and VA-DoD leadership oversight continues to be needed until care coordination programs, policies, and systems mature and are operating efficiently and effectively.

Finally, our association supports Congressman Reyes' bill, H.R. 3279. MOAA and others here today have already recommended that there should be a change in—or have recommended in the past formal changes to the VA's interim final rules concerning the new caregiver benefits program.

Currently, VA rules define serious injury as any injury, including psychological trauma or other mental disorder incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, that renders the veteran or servicemember in need of personal care services.

It is not clear from that definition how VA will address individuals whose serious illnesses incurred during service worsened or changed to the point of needing a caregiver once they are in a veteran status.

MOAA would like to make sure that the definition is not open to interpretation. We believe the intent of Congress was to allow both active duty and veteran caregivers to qualify for the benefit for both serious illness and injury.

MOAA thanks the Subcommittee for being champions of our veterans and their families. We look forward to working with the Subcommittee and VA on ways to improve health care so that we can further enhance the quality of lives of these individuals in our veterans' community.

I look forward to answering your questions and thank you again.

[THE PREPARED STATEMENT OF RENÉ A. CAMPUS APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much, Commander.

Mr. Sulayman.

STATEMENT OF RAMSEY SULAYMAN

Mr. SULAYMAN. Madam Chairwoman, Ranking Member, distinguished Members of the Subcommittee, on behalf of more than 200,000 members and supporters of Iraq and Afghanistan Veterans of America I thank you for the opportunity to share the views of our members on these very important pieces of legislation.

My name is Ramsey Sulayman, and I am a Legislative Associate with IAVA. I am a veteran of Iraq, where I was an infantry platoon commander and company executive officer. I have spent 14 years in the Marine Corps trying to execute the Marine Corps' two missions: winning battles and making Marines.

As an IAVA staff member, I don't make soldiers, sailors, airmen, or Marines, but I do try to make their lives better. The views expressed here are not the viewpoints of the Marine Corps. They are solely mine and IAVA's analysis. Thank you for your attention to the pressing issues facing our Nation's veterans.

IAVA strongly supports H.R. 1460, ensuring that veterans are automatically enrolled in the VA health care system and required to opt out if they do not wish to be enrolled. Actually getting veterans into the VA system is the most important part of a smooth and seamless transition from the Department of Defense health care system to the Veterans Administration health care system.

Currently, only 54 percent of Iraq and Afghanistan veterans are enrolled in the VA health care system. The steep cost of quality health care to the private sector and a high rate of veteran unemployment, almost 17 percent among our membership, means many veterans do not have access to any other health care system, often for their service-related injuries. IAVA believes that H.R. 1460's solution of changing enrollment is easy and effective, both in terms of cost and efficacy. Combat veterans should not have to opt in to receive a benefit they have earned through their service.

We also support H.R. 3337, the Open Burn Pit Registry Act of 2011. Burn pits have the potential to be the insidious and long-term health issue for our generation of veterans that Agent Orange has been for our Vietnam era veterans. H.R. 3337 gets ahead of the curve in responding to potential future health concerns by establishing facts. Who is exposed, where were they exposed, and for how long? These small but crucial pieces of information will be helpful in the future in ascertaining the health impacts, facilitating subject identification for epidemiological studies, and adjudicating claims.

Burn pits were ubiquitous in Iraq and still are in Afghanistan. They are located in the midst of large numbers of troops. The twin facts that burn pits are the way waste is disposed and must be collocated with troops for logistical purposes guarantees exposure for most veterans.

While IAVA supports H.R. 3337, we do so with a caveat. Because of the ubiquity of burn pits in these conflicts, we believe that the definition of burn pit must extend beyond solely those authorized by the Secretary of Defense to include those that were established by small unit commanders to facilitate mission accomplishment. In other words, there is no garbage service for our troops to rely on

in Iraq and Afghanistan; and, by necessity, we burn all of the waste that we have.

This is a necessary addition to this important piece of legislation, and IAVA encourages inclusion of such language in the bill before passage.

We also support the goals of H.R. 3723. We believe they are laudable, and we support many of them. However, we cannot support H.R. 3723, because we believe that this legislation makes several changes that are untested and do not necessarily provide hope of significantly improved patient outcomes or access to care.

There are significant issues in the VA health care system, and my colleagues in the other VSOs have addressed them at length. I would just say that we reiterate most of those, and we think that there are many questions that need to be answered before such a drastic step is taken.

We would also point out that there are many medical options that are not cost effective in the private sector, such as prosthetics, and real questions exist regarding the fiscal benefits and patient outcomes when outsourcing these types of care.

The bill begs the question of whether another system that makes the VA a third-party payer, essentially replicating the scenario we have with fee-care, or should the VA system be strengthened, funded, and fixed if the use of third-party non-VA providers is minimized and truly used out of necessity. IAVA prefers the latter option, and therefore we cannot endorse 3723.

In the interest of time, I have submitted all of my other comments for the record, and I look forward to answering any questions that the Committee has.

Thank you very much.

[THE PREPARED STATEMENT OF RAMSEY SULAYMAN APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much.

Mr. Ibson, you may proceed.

STATEMENT OF RALPH IBSON

Mr. IBSON. Thank you, Madam Chair, Ranking Member Michaud, Members of the Subcommittee. Thank you for inviting Wounded Warrior Project to offer our views on the legislation pending before the Subcommittee.

We are particularly pleased that you are considering two bills that would close gaps in programs of real importance to Wounded Warriors. Let me first highlight our strong support for those two measures.

First, H.R. 3016 would remedy fundamental problems in the governance and operation of the Federal Recovery Coordination Program, problems that were ably documented in this Committee's hearings on the program. The bill would require the two departments both to develop a memo of understanding for joint program governance and a specific plan for program operations.

Importantly, in our view, a key provision would require the service Secretaries to refer eligible servicemembers to the program at the earliest possible time to gain the benefit of having an FRC assist all aspects of the transition process. It is clear from the experi-

ences of our warriors and their families that having the FRC early in the process can make all of the difference. But as your hearings have documented, the service departments too often elect not to refer severely injured servicemembers for an FRC until after that member has retired, often far too late in the process to be helpful.

We applaud your patient efforts to resolve these issues through hearings and discussion, but, at this point, with the risk of Wounded Warriors falling through the cracks, we believe a legislative solution is needed and strongly support the approach set out in H.R. 3016.

A second bill under review, H.R. 3279, would, as others have testified, clarify that a veteran who has a serious illness incurred in service after 9/11 can be helped through VA's Comprehensive Caregiver Assistance Program. Although VA's interim rule draws a hard line, the statute itself is not that clear. Yet there may be little distinction between the caregiving needs of a young warrior profoundly disabled by a service-connected illness and one who is injured. In each instance, a parent or spouse may have permanently left the workforce to care at home for that veteran's daily needs, leaving that veteran vulnerable to the risk of VA institutionalization if the stresses of caregiving overwhelm that family member. Surely, Congress sought to address through the caregiver law the impact of caregiving, not the underlying etiology of the veteran's condition. Clarifying the law as proposed would provide needed support. We strongly support that.

Mr. IBSON. In contrast, H.R. 3723 would change the statutory underpinnings of the VA's fee-based authority in a very fundamental but potentially problematic way, as others have suggested. Current law simply authorizes VA to provide fee-based treatment to certain veterans when it can't provide timely, geographically accessible care in its facilities. But H.R. 3723 would require contracting for care under those circumstances and require it for all enrolled veterans.

It is not clear what the impact that mandate would ultimately have. It is possible that facilities might simply be instructed to provide contract care in accordance with the law. But we question whether the change would assure the intended outcome. And by way of illustration, we note that VA policy currently says that mental health care, for example, must be made available to eligible veterans either in VA facilities or under contract arrangements. Notwithstanding that very clear policy, fee-based care is seldom an option for OEF/OIF veterans with service-connected mental health conditions, despite the fact that VA facilities frequently cannot provide that care in a timely way.

It is possible that the mandate in that bill would not have great practical effect. And yet on the other hand if the provisions were implemented literally, it could have sweeping operational and fiscal implications. In either case, we cannot support the measure.

H.R. 1640, as discussed, would require VA to enroll any veteran who served in the combat zone, subject to an option not to enroll. While the bill appears aimed at facilitating access to care, in our view enrollment itself has not been a barrier. The bigger problem that warriors have encountered, particularly with the prevalence of PTSD, is getting timely, effective mental health care. We see high

percentages of OEF/OIF veterans enrolling and being “seen for care,” but surveys indicate that VA facilities are often not adequately staffed to provide the timely care or even the right kind of care that veterans need.

So our concern is that VA has put much more emphasis on enrolling as many veterans as possible, and less emphasis on assuring that veterans are receiving the specialty care that they may need. In short, we have no objection to this bill, but we don’t believe that it solves the underlying fundamental access to treatment problems that many are facing.

Seeing that I am running out of time, Madam Chair, I will close and be available for any questions you might have.

[THE PREPARED STATEMENT OF RALPH IBSON APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much, and I thank all of the panelists for your testimony this afternoon.

I yield myself 5 minutes for questions.

Mr. Barker, regarding H.R. 1460, your concern is that it may send a message to nondeployed veterans that they may not be eligible for VA care. Is there a way that you could address that?

Mr. BARKER. Let me give it a shot. As I understand the bill, it basically facilitates enrollment but it has no bearing on whether or not a person is eligible for services. When I crafted my testimony, I wanted to try to describe the importance of allowing all veterans to have access to whatever services and benefits that they have earned. That is the important piece, and I would agree with what Mr. Ibson said. We haven’t heard anyone complain about the enrollment process, it is what happens after the enrollment process in terms of delays, et cetera.

And so in crafting an alternative to this bill, I think it would be preferable to see something that applies to everyone who is separating equally, as opposed to someone who is deployed versus non-deployed. That is the basic message I think we are trying to achieve here.

Ms. BUERKLE. Thank you.

Mr. Atizado, regarding H.R. 1460—and I asked this question of our first panel—your concern with regard to when you are enrolling and you have this influx of young enrollees that might squeeze out and preclude older veterans from enrolling. How would you address that concern?

Mr. ATIZADO. Thank you for that question, Madam Chairwoman.

The main principle behind our position is that the Secretary of Veterans Affairs’ ability to manage patient enrollment is one of a very few number of tools he or she has to control the health care system.

This authority was exercised back in 2003 when VA decided to stop enrollment for Priority Group 8 veterans, and that was at a time when resources were not keeping up with demand. So in this era, I should say in this—in the recent past, we were looking at a fiscal environment where VA will once again be subjected to fiscal constraints. So what will happen is if the VA is unable to manage its patient enrollment because they are automatically enrolling one specific category of veteran, it will undoubtedly push out oth-

ers. VA, after all, it operates in a resource-constrained environment. So that is the main thrust of our position.

I want to reiterate what my colleagues here have mentioned about enrolling. I understand, and it is in my testimony, that the services are looking at or have been mandating transition assistance for all veterans, not just those that are seriously injured, not just those who are moderately injured. Even those who are not injured. Even Guard and Reserves are now being mandated to go through TAP, and I think done so in a much more responsible manner. That is, they are given appropriate time to determine what it is that they need. Because if a servicemember, in transitioning out of service, doesn't know that they really should enroll in VA because it is such a good value, I think there is something wrong with that transition program if that is not properly conveyed.

Ms. BUERKLE. Thank you very much.

I have a few seconds left, and so I will ask Commander Campos, in your testimony you mentioned that DoD and the VA have stepped up with regards to H.R. 3016. As I mentioned in my comments to Mr. Barrow, we have had a couple of hearings on this issue. We have been really concerned with the inability to coordinate and the overlap. They have had 4 years to implement this. Do you think VA and DoD have made significant progress? Can you shed a little bit of light from your perspective?

Commander Campos. I appreciate the Subcommittee really keeping the eye on this issue because I think it is very critical to the long-term care of these wounded and disabled veterans.

We have watched this very closely. There seems to be a great deal of indication, especially after attending in early March, maybe it was late February, the recovering warrior task force where both DoD and VA recovery care coordination and the FRCP folks briefed the Committee or task force. And so it is clear that they are working together. But in our view, adding more legislation to something that is already in our minds mandated by Congress doesn't seem to be the answer. I think the only way that VA and DoD are going to continue to work close together and make this really seamless is to continue the oversight by your Subcommittee and Congress as a whole, both on the Armed Services Committee as well as the Veterans' Committee.

Ms. BUERKLE. Thank you very much.

I yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you, Madam Chair. This question is for each of the panelists, and I will start with Mr. Barker first.

Mr. Barker, under H.R. 3279, the VA estimates that 870 additional veterans and servicemembers would qualify for service and benefits, and that in fiscal year 2013 it would cost the VA \$45 million, and \$263.5 million over a 5-year period under the caregivers bill. Do you believe this number is accurate given that, to the best of my knowledge, the VA hasn't even defined under the legislation the term of serious illness?

Mr. BARKER. If I may, I would like to take that for the record to give you an accurate statement from our organization, although I would just observe there are often things that are supposed when making these estimates that we often find fault with, and I would

like to engage more in that process of articulating our view. So that would be something I would like to take for the record, if I may.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Mr. ATIZADO. Ranking Member Michaud, thank you for that question. I do not have inside knowledge on VA's estimates; but what I do know, there are a significant number of applicants, caregivers and veterans who have applied and been denied because of the lack of illness in the eligibility criteria. So I think VA knows at least those that have applied but were denied.

What they don't know and what I think they are trying to get a handle on as best they can are those caregivers and veterans who may not have applied because they realize, from hearing from the Subcommittee awhile back, that illness isn't included. So they just don't apply altogether. So I think that is the squishy part of the details.

Commander Campos. I believe—I couldn't comment, our Association couldn't comment on the specific numbers. But I know that our work with the caregiver program and the folks there have been very receptive to answering questions and responding to our questions and even engaging in individual cases. So I would have no reason to question that. However, as part of the interim rules for the caregiver, we did comment on our concerns about how those who were denied would be able to appeal as well as getting some information as to why their request was denied.

Mr. SULAYMAN. Ranking Member Michaud, thank you for the question.

I would concur with Mr. Barker, that I would like to see a little bit more analysis on what that number is. It seems a little bit high to me, especially given the rather small proportion, or the rather small population that they have cited would take advantage of it. And I would agree with both Ms. Campos and Mr. Atizado, that the real question is what other numbers are they looking at. Are they trying to access those who have been turned away in the past, or is there some other metric that they are using? That would be my sense of it.

Like Ms. Campos, we have had good relationships with those who manage the caregivers assistance program, and they have always been forthcoming, so I wouldn't doubt their answer. I would just wonder what the figure encompasses.

Mr. IBSON. At the risk of being the skeptic in the group, Mr. Michaud, I would only suggest that the history of attempting to estimate costs on legislation involving caregiver assistance has been very uneven, in my view, at the VA. And at least from the perspective of an organization working with a largely very young population, it strikes me as difficult to imagine figures that high in terms of illnesses that would require a need for caregiver assistance.

So while I certainly would be open to looking at that data and appreciate how hard the VA has worked on implementing the program, I remain skeptical of those numbers.

Mr. MICHAUD. Mr. Ibson, how would your organization define serious illness?

Mr. IBSON. Well, I think it goes to a need for caregiving, ultimately. Just as the phrase "serious injury" in the Caregiver Law itself ultimately gains meaning from the circumstances that require a need for caregiving, which is either on the basis of a need for supervision and protection, or a need for assistance based on inability to perform one or more activities of daily living. Loss of function or activities of daily living.

Mr. MICHAUD. Thank you.

Ms. BUERKLE. I yield to the gentleman from Tennessee, Dr. Roe.

Mr. ROE. I am just an old public school guy. I didn't go to private schools. But when you do the math, it is \$50 million a year and you have 800-something people; that is over \$50,000 apiece per person. I don't know how they came up with the number, but the math isn't very hard. I don't know whether that is accurate or inaccurate, but those are the numbers. It is not hard to do the math on that. I don't think anybody knows. And I agree with you, Mr. Ibson, they historically have been pretty inaccurate. That may have been how they came up with the number: How much are you spending on a caregiver today? It would be easy enough to find out. How many you have, that is not hard to find out. So we should be able to get that information pretty easily.

Just a couple of comments very quickly because I have another meeting to go to.

I think in H.R. 1460, and I share your concerns, being a Vietnam-era veteran. I served in Korea. I am a category 8 veteran, and so I can't go to the VA because of my income. I have never had a problem with that because I felt like veterans who did not have the resources I had, they should be in the front of the line and I should be in the back of the line. I think a lot of veterans feel that way. I know if the resources are limited, as you all have pointed out, we need to get those resources to the most needy veterans. To me, those are the veterans who have served in a combat zone. That may be why this is the way it is. I don't know that for a fact, but I just share that as a veteran sitting here, having gone through when the resources for veterans were very limited after the end of the Vietnam War. So perhaps in a perfect world, I agree with you, everybody should be in there.

The other thing I need a little clarification on, and help me with this because we need to make some decisions, is in H.R. 3723. I treated patients. I am an OB-GYN doctor. They didn't have a gynecologist at the local VA, and so I would see a lot of them, our group would, because they didn't provide that service. As you pointed out, that is already in the law. How would that change?

In the real world, how do you all see a change in that relationship the VA would have with me as a provider? And I agree, a veteran who has been there and has done that probably sees things a little differently than a physician who has been trained but has not been in the military. I am trying to figure out your concern because I want to make sure that I get the right vote on that proposal. Anybody who can help me.

Mr. IBSON. As I understand the bill, it aims at fostering contractual relationships with large providers. I think it would likely close the door on the individual authorization to an individual practi-

tioner, notwithstanding a finding in the bill that suggests the importance of giving veterans that kind of opportunity.

Mr. ROE. I think I need to go back and really look at that to see if—because I didn't fully understand what your all's objection was.

Lastly, I just want to thank you all for representing our veterans. Each and every one of you do a great job, and thank you for the job you do in representing the interests of veterans in this country.

I yield back.

Ms. BUERKLE. We have just been joined by Mr. Reyes, and we would like to give you the opportunity to speak about your bill if you would like to.

Mr. REYES. Thank you, Madam Chair. I apologize for being late. It is not all my fault; American Airlines has a role in that.

In the interest of time, I ask unanimous consent to include my statement for the record. I thank you and all who were here that supported my legislation, and I yield back.

[THE PREPARED STATEMENT OF MR. REYES APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you, and without objection.

Unless there are any other questions for this panel, again, let me express my gratitude to you. As was mentioned by all of the Members of the Subcommittee, thank you for what you do for our veterans and their families as well. Thanks for being here today and for your testimony. We appreciate it very much. You are excused.

Ms. BUERKLE. Representing the Department this afternoon is Dr. Robert Jesse, the Principal Deputy Under Secretary for Health. Dr. Jesse is accompanied by Ms. Susan Blauert, Deputy Assistant General Counsel for the U.S. Department of Veterans Affairs. Thank you both very much for being with us this afternoon.

Dr. Jesse, you may proceed.

STATEMENT OF ROBERT L. JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SUSAN BLAUERT, DEPUTY ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Thank you. Good afternoon, Madam Chairwoman Buerkle and Ranking Member Michaud and Members of the Subcommittee. I would like to start off by thanking you for having us here to present the administration views on several of these bills and how they might affect VA programs.

I would also like to extend my thanks to all of the veterans organizations who were here and speaking on behalf of their opinions. I think their input is very important as we make these decisions.

Five of the bills that are under consideration address aspects of the transition process from servicemembers to veterans. First, H.R. 1460 would require VA, in cooperation with DoD, to automatically enroll combat theater veterans. An important part of VA's mission is outreach on multiple fronts to let returning veterans know about the services that they have earned. We are working together in a number of areas to support this transition with information tech-

nology, an integrated disability benefits evaluation system and better information-sharing with veterans and servicemembers.

While this bill is offered in the spirit, the proposal could have complex and unintended consequences, as explained in my written statement. Thus, we have requested additional time to evaluate the proposal before submitting a position and a cost estimate for the record.

Another bill is H.R. 3016 which would require VA and DoD to jointly operate the Federal recovery coordination program. We do not believe this is necessary because a program already has the active support and engagement of the Secretaries of Veterans Affairs and of Defense, and we believe that the bill would result in duplication between the programs.

Third, H.R. 3245 would require that VA's vet centers have access to certain DoD information databases. We do not object to the bill, but vet centers are already able to verify eligibility through a number of systems. We emphasize that access granted by this bill must ensure confidentiality of veterans' records. Vet centers currently maintain a separate system of records that effectively walls off any client information which reassures veterans that their readjustment counseling remains confidential.

Fourth, H.R. 3279 would amend the eligibility criteria for the family caregiver program to include veterans with a serious illness. We agree with the intent of the legislation which would make the program more equitable in its application. It is often difficult for clinicians to distinguish between needs based on an injury rather than an illness. However, the bill would create significant additional obligations, and we caution that without additional resources, veterans' access to medical services may be negatively impacted.

Fifth, H.R. 3337 would require VA to establish and maintain a registry for veterans who may have been exposed to toxin chemicals and fumes produced by open burn pits. While we share the concerns raised by this bill and its advocates, we believe a health registry is not the appropriate tool to monitor potential adverse effects. In our written statement, we highlight the work we are doing now as well as other approaches that would yield more comprehensive and complete data. We strongly encourage any veteran who served in a combat theater to enroll with the VA to assess health care and services for conditions possibly related to their combat service for 5 years after their discharge.

For the remaining bills, H.R. 3723, the Enhanced Veteran Health Care Experience Act of 2011, would significantly alter VA's existing authority to contract for certain types of health care. Requests for non-VA care are currently evaluated based on the capacity to deliver needed services and the clinical need. We read the new bill as allowing veterans to elect to receive care from another provider separate from these limits. We believe existing authority allows VA to contract for health-care services; and under that authority, the VA continues to develop broad-based national and regional contracts. The VA has proposed legislation this year that would provide helpful clarification to VA's contracting authority.

Finally, in our written testimony, we do not support H.R. 4079, the Safe Housing for Homeless Veterans Act, which amends safety

standards for housing for homeless veterans. We express concerns about a number of issues presented, including changes that could reduce the pool of capital grantees. However, we understand that some of these consequences may have been created simply by the way the bill was drafted, and we would be glad to meet with your staff to offer technical assistance that could address those issues.

Thank you for the opportunity to testify before the Subcommittee. I would be pleased to respond to your questions.

[THE PREPARED STATEMENT OF DR. JESSE APPEARS IN THE APPENDIX]

Ms. BUERKLE. Thank you very much. I yield myself 5 minutes for questions.

I want to get right to the caregivers assistance program because that is something—as I mentioned earlier, this Committee has been very concerned about the very slow implementation of that plan. It has been 4 years now, and we still don't feel like we are where we are at. There is duplication and there are gaps. It is very frustrating.

And in your comments just now, you mentioned that wouldn't be necessary because you are afraid of duplication of processes. Can you just tell us a little bit today what specific efforts are underway to address the concerns that we had in the last couple of meetings?

Dr. JESSE. So the implementation of caregivers has been complex and has required capabilities that were not accessible out of things we had done. It is also relatively complex in the fact of training caregivers, ensuring capabilities of caregivers, and a lot of the other social service underpinnings that are required. It did take a long time to get it up and running. I am actually a little surprised at veterans' comments, because I think right now it is moving along at a pace that is reasonable. It probably could have been moving that way a little bit sooner. But again, it has been a complicated and new-to-us system.

I don't think the issue on the table here for extending it to illness has to—it is not going to be compounded in the same way. What we have learned from doing this with the injured veterans is very informing. And, in fact, as I understand it, it has been the wisdom of Congress that we had a 2-year point where we would evaluate the program, and, from that understanding, would be able to then talk about extending it to injured, is the language in the bill, of other—of the pre-9/11 veteran population. Extending it out to illness is a different issue, and it raises not a different set of processes, but I think a different set of definitions.

Ms. BUERKLE. Can you just, if you can, and if you can't we will ask you to submit it to the Committee, can you talk to us about substantive improvements and changes that have occurred since the October hearing that we had?

Dr. JESSE. I think it is probably best if I bring that back for the record.

Ms. BUERKLE. Thank you. I would appreciate that.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Ms. BUERKLE. Dr. Roe, before he left, the question came up—I'm sure you were listening—what is the cost for a caregiver. Do you have any idea what the number is?

Dr. JESSE. Our cost estimates are at this point based on a lot of suppositions. When we talk about illness, really the cost is going to be dependent on what are the brackets around the population that is included and the needs of those specific populations. So we are learning from the current injured veterans what those costs are. They will be informing as we begin to expand this out. We don't know the answer for certain, but our best guess is what we have presented.

Ms. BUERKLE. Thank you. I have a few seconds left.

In our second panel, Mr. Atizado testified that late last year, both the VA and the DoD had been coordinating a decision memorandum regarding the future direction of the FRCP. Is that true; and if so, can you tell us about the memorandum and any decisions it contains?

Dr. JESSE. There exists actually a memorandum that goes back to 2007 or 2008, back with the original legislation. What I think he is referring to is the secretaries themselves have taken a renewed interest in making this program work.

For the past, close to a year, it started about a year ago in January, February, in the very strong effort to get the integrated electronic medical record program moving forward, the secretaries have been meeting on a relatively frequent basis every couple of months and dealing with these substantive issues, and that program is squarely in their sights.

Ms. BUERKLE. Thank you. If I can ask you to provide those decisions of memorandum for the Committee, however many there might be, with regards to this issue. Thank you very much.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Ms. BUERKLE. At this time I yield the Ranking Member 5 minutes.

Mr. MICHAUD. Thank you, Madam Chair. Thank you, Doctor, for coming today as well. My questions are also regarding the caregivers legislation.

How did you come up with the number of 870 additional servicemembers when you also state that you haven't come up with a definition of serious illness? How did you come up with that number?

Dr. JESSE. I will take that for the record to give you the precise answer because I don't want to misstate it at this time.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Dr. JESSE. But I think what you said is exactly correct. We can't come up with an exact number until we define what serious illness is. That would require regulation and would have to go through a due process in order to do that. So we can only make best-guess estimates.

Mr. MICHAUD. So do you have a definition in mind of serious illness?

Dr. JESSE. Again, let me get back to you for the record.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Mr. MICHAUD. You know, it is just amazing that you are saying it is going to cost X amount when you don't even know what the definition is going to be. But you said it is going to be 870 additional servicemembers. I look forward to seeing what you come up with because I think it is very important because it gets right back to some of the issues we have had in the past about the credibility of the VA system. If you can't come up with a cost estimate, you should say you can't come up with a cost estimate. But to say that it is going to be 870 additional servicemembers and it is going to cost X amount when you don't even know what the definition is going to be, that leads the Committee, and I know myself, to question the credibility of the VA. So I will be looking forward to that answer.

And for the future, I wish the VA, whoever is drafting your testimony, would be up front and honest about it versus trying to determine whether our legislation is going to pass or fail because of a cost estimate. So I look forward to that answer.

Dr. JESSE. Yes, sir.

Mr. MICHAUD. Getting back to the burn pit issue, how does the VA train its health-care providers to address unexplained illnesses and symptoms that may be linked to open burn pits? How do you train?

Dr. JESSE. The burn pit issue is relatively new in the sense of other issues that we have dealt with in terms of servicemembers' exposures in the course of deployment or even in the course of their military careers.

The problem with training on burn pits specifically is understanding what are exactly those exposures. And one of the concerns about burn pits in particular is that everyone is different. So we know that exposure to burning things creates particulate matter, and we probably have a relatively reasonable understanding about what that can mean from other areas. But what happens to—what are the effects of the toxic, other toxic chemicals in burn pits, we don't know. I think what we train our providers is to pay attention to patients' complaints and symptoms and to bring them to resolution as absolutely best we can.

We have struggled with this in several other areas. The Gulf War illness. As you know, we have dedicated significant resources in an ongoing fashion to try and understand what are the symptoms, what are the causes and the treatment of symptoms, and in many cases unexplained symptoms, that veterans of that conflict are coming forward with. It is no simple matter.

Mr. MICHAUD. Getting accurate, up-to-date information on pre-deployment and post-deployment health records, where servicemembers were located and other pertinent information from the Department of Defense, has in the past been characterized as very difficult. What makes you believe that the exchange of information between the VA and the DoD has improved with the current deployment of Afghan and Iraqi soldiers?

Dr. JESSE. I am going to answer that cautiously because we don't know that it has improved. We are only working very diligently with them to try and improve that. We have some isolated instances, Karmanah Li, for instance, where we think that we have a very solid lockdown on who was exposed. And that is relatively

straightforward. Burn pits become another—you know, it is a whole different challenge.

The radiation exposures, potential radiation exposures from the tragedy in Japan after the tsunami, we have a very solid lockdown on who those folks were.

In the end, the VLER, the Virtual Lifetime Electronic Record, which is intended to be a consolidation of one's military service and one's health care record really should feed forward into that. And that is the intent of beginning to build that kind of a program.

But I think going back to Agent Orange was a great example of how we had very little insight into who was exposed. I know that Secretary Shinseki is passionate about trying to get a handle on this because we cannot afford to have another example like that.

Ms. BUERKLE. I now yield 5 minutes to the gentleman from Texas, Mr. Reyes.

Mr. REYES. Thank you, Madam Chair.

Thank you for being here. I am a little bit puzzled because as I understand it, the only objection to H.R. 3279 is the cost. And yet I am not sure you are prepared to give us a formula on how you arrived at the cost; is that correct, Doctor?

Dr. JESSE. I personally am not. I don't want to give you a wrong answer, which is why I best take it for the record.

Mr. REYES. But that is correct? The objection from the administration is the cost, because the cost is too high?

Dr. JESSE. No, no, no. I don't think that is the case at all. In fact, it is not an objection as much as a concern that we don't understand the true cost, and our comment on the bill is tempered by that. But in fact—

Mr. REYES. So how much time will you need to get back to us with your analysis on the cost on who is affected, on the definition of a serious illness, and all of these things that we have been talking about? How much time will it take?

Dr. JESSE. It should not take long because that should already be there. It should be done. I just don't know the precision. I don't know the answer with the level of precision that I am comfortable giving it to you today.

How long should it take us to get an answer? The data exists. We will get it to you. A couple of weeks. Is that okay?

Mr. REYES. As soon as possible, I would think. I tell you, when we take these to the floor, Members need to know exactly what the concerns are.

Dr. JESSE. I agree. We will get it to you absolutely as soon as possible.

Mr. REYES. Can you give me an example of someone who would be denied caregiver assistance for an injury but approved if illness were included? Is there a way to give me an example of that? Can you give me an example with the cost analysis?

Dr. JESSE. Someone with a serious injury should be covered under the existing caregivers. So what this is opening up to is to people who have serious illnesses as well.

Let's take an example, ALS. It is a serious illness that is service-connected, and while those people have access now to a number of services, including aide and attendants and the like, this would

markedly expand what we can provide to them. And I don't know—I am not sure that I understand, somebody who has—

Mr. REYES. Can an individual, who was denied caregiver assistance as a result of an injury, be subsequently approved because an illness was included?

Dr. JESSE. I am not sure I can answer.

Mr. REYES. Can you take that for the record and I will be happy to provide some clarification if you need it?

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Mr. REYES. My last comment, I have had a number of opportunities to discuss the difficulty that exists between giving the benefits to veterans from our perspective as a Congress to the reality at the VA hospitals and clinics around the country. And I have shared with General Shinseki, who was in Vietnam about the same time I was, the issue of Agent Orange. I think it is one of the best examples because those of us that had that experience flew in because we had to provide cover for the C-123s that were spraying the Agent Orange largely around these high artillery bases in Vietnam. And so they sprayed around the mountain where these bases were in order to get rid of the foliage because the VC and the NVA at night would come up through there. As they were spraying, they would get fired upon, so it was our job in the helicopters to go in and provide the protection. As we were providing that protection, we were flying through the mist of the Agent Orange. And I can tell you, it didn't taste anything like oranges. Many asked the question rhetorically: Is this stuff safe? Is it okay?

I grew up on a farm where we used pesticides and crop dusters and all of that, and we took great pains to not be in the way of the crop duster. But we were repeatedly reassured that the government wouldn't use that if it weren't safe. Well, now generations later, and today I am concerned about my oldest daughter because of recent research that has been done, that now apparently you can pass on the effects of Agent Orange genetically. That is what makes it so frustrating for those of us who have had those experiences, to try to get legislation through and not be taken seriously by the way definitions are made, by the way people implement the law.

I will tell you, we funded the alternative budget, the 4 years we were in charge of the House, for that reason. Let's look and see if fully funding the VA would make things get better. Well, it wasn't money. I don't know what we need to do. But something has to change to be able to get the message that these guys that are coming back from Iraq and Afghanistan and other places with TBI, PTSD and all of these other things are hurting, and we are obligated to take care of them. We do the things we do because of their willingness to be out there. And this is generation after generation.

I just get so exasperated when you can't answer our questions. I mean, if I were in charge, I would say here is what they are going to talk about. This is likely what they are going to ask. Here is the answer. It doesn't seem to be a problem to come up here and say well, "we think," "we might." And "we can get back." Madam Chair, I just get so frustrated. I know it is not—and I don't mean it at

the messenger—it is just the whole damn system that frustrates me.

Thank you.

Ms. BUERKLE. Thank you, Mr. Reyes.

I guess I will just echo my colleague's sentiments.

Dr. Jesse, with all due respect, as Mr. Reyes mentioned, you are the messenger, but when you tell me it is complex and it is complicated and it takes a long time to figure these things out, we send men and women overseas. They go over and serve our Nation. The very least we can do as a country is to make sure that they get what they need. That is all the Veterans' Affairs Committee wants, is to make sure that the men and women who serve this Nation get what they need and deserve.

What we are asking for today, and just to repeat, the cost analysis, the decision memorandums that we talked about earlier, and the definition of serious illness so we can get some clarification on those topics. Time is of the essence, as just expressed by my colleague's frustration. This isn't something arbitrary. This is something on which we have the luxury of time. The men and women care. They need access to services. Again, that is a message that needs to go back to the Department of Veterans Affairs. Time is of the essence.

I thank you both for being here today. With that, panel 3 is dismissed. Thank you so much.

If there are no further questions, I move that Members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Ms. BUERKLE. Once again, I just want to extend my gratitude to all of the witnesses, the Subcommittee Members and the audience for your participation and attendance this afternoon. We are a grateful Nation, and we must together work to make sure that the veterans, the men and women who serve, who are serving, and who have served, get what they need and what they deserve.

With that, the hearing is now adjourned. Thank you.

[Whereupon, at 5:48 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman

Good afternoon. This hearing will come to order.

Thank you all for being with us today as we meet to discuss seven legislative proposals concerning the care and services provided to our Nation's veterans and their families through the Department of Veterans Affairs (VA).

The seven bills on our agenda this afternoon are: H.R. 1460, to provide for the automatic enrollment of veterans returning from combat zones into the VA medical system; H.R. 3016, to direct the Secretary of Defense and the Secretary of Veterans Affairs to jointly operate the Federal Recovery Coordination Program; H.R. 3245, the Efficient Services for Veterans Act; H.R. 3279, to clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by VA; H.R. 3337, the Open Burn Pit Registry Act; H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011; and H.R. 4079, the Safe Housing for Homeless Veterans Act.

Together, these bills touch on a full range of issues affecting our veterans and their families. The proposals we will discuss include measures to address fire and building safety code enforcement for homeless veterans participating in VA grant and per diem programs; streamline the eligibility determination for veterans seeking readjustment counseling services at Vet Centers; establish a registry for OEF/OIF veterans who may have been exposed to toxic chemicals caused by open burn pits; and allow veterans greater access to the health care they earned and deserve by reforming VA's fee-basis care program and providing for the automatic enrollment of returning combat veterans into the VA health care system.

Additionally, we will discuss two bills—H.R. 3016 and H.R. 3279—that seek to improve programs that support to some of our most severely wounded warriors, the Federal Recovery Coordination Program and the Comprehensive Assistance for Family Caregivers Program respectively. These programs in particular are very familiar to this Subcommittee, which has held a total of four oversight hearings last year to examine them in depth.

Our discussion today will provide us the opportunity to thoroughly examine each of these proposals with their sponsors, the Department, and our partners in the veteran service organizations to find out what works, what doesn't, and what needs to be improved.

I thank my colleagues for sponsoring the bills on our agenda this morning and for their leadership. I also appreciate our witnesses from the veterans' service organizations and VA for taking the time to join us today and for working so hard day in and day out in support of our Nation's heroes. I am looking forward to a very frank and productive discussion.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member

Thank you, Madam Chairwoman.

The purpose of today's hearing will be to explore the policy implications of seven bills before us today which cover a wide range of topics that would expand and enhance VA's health care programs and services. To allow maximum time for discussion, I will limit my opening remarks primarily to H.R. 1460, H.R. 3016, and H.R. 3279.

H.R. 1460, offered by Mr. Owens of New York, instructs the Department of Defense, in conjunction with the VA, to automatically enroll veterans returning from combat zones into the VA medical system, while providing a chance to opt-out of the system both at the time of separation from the Armed Services and 6 months following.

In 2008, Public Law 110–181 was enacted, which extended the eligibility period for free VA medical care from 2 to 5 years for veterans who served in a combat theater of operations after November 11, 1998. This applies to active duty, National Guard, and Reserve servicemembers returning from recent conflicts for conditions that may be related to their combat service. Following this initial 5-year period, these veterans may continue their enrollment in the VA health care system, but they may be subject to applicable copayments for nonservice-connected conditions.

H.R. 1460 does not create new classes of veterans eligible for free VA health care, but simply changes the process by which these veterans would become part of the system upon separation from the DoD. This legislation would ensure that combat veterans are able to seamlessly receive VA health care services upon their separation from the military.

Next, H.R. 3016, introduced by Mr. Barrow of Georgia, a Member of the Full Committee, would improve reintegration efforts and require that the Federal Recovery Coordination Program (FRCP) operate jointly under both DoD and VA. This legislation follows up on two Subcommittee hearings held on this issue last year, where we discussed the continuing problems between the VA and DoD in working collaboratively. I still do not feel confident that VA and DoD can overcome existing barriers and the tangle of bureaucracy that seems to surround the implementation of this program. H.R. 3016 is intended to ensure that the FRCP moves forward in a more efficient and effective manner.

Finally, H.R. 3279, sponsored by Mr. Reyes of Texas, a Member of the Subcommittee, would clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by the VA. This legislation also follows up on two Subcommittee hearings held on this issue last year, where we examined the delays in the rollout of the implementation plan, next steps, and the narrowing of criteria for eligibility of these benefits.

When Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010, was enacted on May 5, 2010, the legislation required the VA to evaluate the program at 2 years. With this benchmark quickly approaching, I am interested in hearing more about the potential to expand this program to caregivers for veterans with serious illnesses— not just those who are seriously injured— as certain mental health conditions do require the full supervision of a family caregiver. I believe this change will expand the criteria for eligibility of these benefits to be more in line with the original intent of Congress.

I look forward to hearing the views of our witnesses on the bills before us today. Madam Chair, I yield back.

Prepared Statement of Hon. Russ Carnahan

I would like to thank the Chair and Ranking Member for holding this hearing. We must ensure that the sacrifices of our current troops, veterans, and their families do not go unnoticed and that they are given the support and resources they deserve. Our troops are committed to protecting our freedom, and our commitment to them does not end when they return home.

As veterans try to reintegrate into civilian life, many of our heroes struggle with the physical and mental effects of conflict. PTSD rates have been steadily growing since the overseas conflicts in Afghanistan and Iraq began. Diagnoses for depression are up particularly among younger active duty veterans who usually have higher combat exposure. Employment, effective health facilities, and psychological services are crucial to ensuring our veterans and their families are properly supported. Particularly in these times of tight Federal budgets and deficit reduction efforts, we must remain steadfast in our support of our veterans.

This Subcommittee has held two hearings on the Caregivers and Veterans Omnibus Health Services Act of 2010. The intent of this law is to provide comprehensive assistance and support services to family caregivers of veterans with a serious illness or injury. Unfortunately, the current interpretation of the law excludes the caregivers of seriously ill veterans. The sacrifices made by our military families begin before deployment and continue after their loved one returns home. H.R. 3279 will ensure that we fulfill our commitment to the families of seriously ill veterans, families who continue to serve our country by caring for our Nation's heroes when they are most in need of care.

I look forward to hearing from our witnesses today on ways that we can work together to guarantee our service men and women have the support they need and deserve when they return home.

Prepared Statement of Hon. William Owens

Prepared Statement of Honorable William Owens
 Chairwoman Buerkle, Ranking Member Michaud and Members of the Committee, I appreciate the opportunity to come before you today and testify on H.R. 1460, legislation I have introduced to provide for the automatic enrollment of military servicemembers in the VA health care system. As a veteran of the Air Force, I am honored to have the opportunity to help improve access to the benefits that the men and women in uniform have earned in their service to the country.

The soldiers, sailors, airmen and marines of the armed forces have served with great honor and distinction over a decade at war in the Middle East. PCS orders, increased op-tempo, repeat deployments, and shortened dwell times have only added to the pressures facing the military and their families through Operations Enduring Freedom, Iraqi Freedom, and New Dawn.

There is no question that we as a country have made great strides over the past ten years to strengthen systems of care for America's veterans, but obstacles remain for the men and women transitioning from service to civilian life. Representatives from various Veterans Service Organizations have testified on their concerns for military families being overwhelmed by the bureaucracies of both the Veterans Administration and the Department of Defense, and it should come as no surprise that VA paperwork is only one a number of challenges facing servicemembers in their transition to civilian life.

My legislation would automatically enroll veterans who are eligible for VA health care into the system, while also taking steps to better inform them of other benefits for which they are eligible. The bill also offers two proactive opportunities for veterans to opt-out of the system, both before they enter and six months after. This legislation has been endorsed by the American Legion, and I believe is a step in the right direction towards the "seamless transition" from service that has long been the goal of many in Congress and veterans advocates across the country.

To be clear, this legislation does not change the benefits for which a veteran is eligible or the care they are entitled to within the VA. The men and women enrolled under this legislation are already eligible for VA care. All we are doing is shifting the burden of enrollment away from those who have just returned from a theater of war to those who are employed to serve America's veterans.

In addition to reducing the government paperwork required of them, we can help ensure that overburdened servicemembers do not slip through the cracks and miss an opportunity to enjoy the benefits they have earned. I remain particularly concerned for servicemembers afflicted with Traumatic Brain Injury or Post-Traumatic Stress Disorder, who face unique pressures in transitioning from service. This legislation will help ensure they have early access to screening for TBI and PTSD from experts at the VA who can improve the long-term prognosis for those affected and ensure proper treatment in the years ahead.

I thank you again for the opportunity to speak before you on H.R. 1460, and respectfully ask that you consider lending your support to the bill. I look forward to your questions.

Prepared Statement of Hon. John Barrow

Chairman Buerkle, Ranking Member Michaud, and Members of the Sub-Committee:

Thank you for the opportunity to speak with you about H.R. 3016, my bill to improve the Federal Recovery Coordination Program.

Today's returning Armed Service Members face a unique combination of challenges as they reintegrate into the community. One important means for helping these folks is the Federal Recovery Coordination Program, which was originally envisioned by the Dole/Shalala Commission to help wounded warriors navigate the bureaucracy of the VA and DoD health systems. A Federal Recovery Coordinator is a nurse or a social worker with graduate level training, who helps guide wounded warriors to the proper treatment and benefits options.

Unfortunately, administrative roadblocks have prevented the Program from achieving its full potential. That's why I introduced H.R. 3016, which would correct the administrative problems that prevent the Federal Recovery Coordination Program from succeeding.

H.R. 3016 establishes joint administration of this program by placing it under the supervision of both the Secretaries of Defense and Veterans Affairs. It ensures that

severely injured Armed Service members and veterans receive a Federal Recovery Coordinator. It gives Coordinators the authority to act earlier in the recovery process, and it makes certain that each branch of DoD will refer wounded warriors to the Program.

Jim Lorraine, the Executive Director of the Augusta Warrior Project – a fantastic organization that builds collaborative relationships with local, state, and national organizations to support wounded warriors and their families in the Augusta area – explains how this legislation will benefit veterans:

The Federal Recovery Coordinator Program is essential to helping our most severely wounded, ill, and injured, who have given so much for our Nation figure out how to navigate these complex bureaucracies and improve their access to existing services. This legislation not only formally establishes the program, but directs its management from the highest levels of the departments of defense and veterans affairs to ensure unimpeded access to care.

I hope this Committee will join me in strengthening the Federal Recovery Coordination Program through this legislation. It's time we fulfill the promises we've made to our servicemembers by improving their care throughout the recovery process.

Thank you for the opportunity to speak before this Subcommittee, and I yield the balance of my time.

Prepared Statement of Hon. Jeff Denham

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee, thank you for holding this legislative hearing today. Thank you to the Chairwoman for cosponsoring this legislation as well as Mr. Roe and Mr. Benishek for their support. Let me also thank Mr. McNerney, who joined me two weeks ago for an important field hearing of this Subcommittee examining the role of Vet Centers within the VA system. Vet Centers offer a wide range of readjustment counseling services to eligible Veterans and their families. At our field hearing we were able to hear firsthand how effective these centers are at delivering the care our veterans need confidentially and without any delay. This bill would provide Vet Centers with one additional tool to serve our veterans: the ability to search an electronic database of DD-214 records.

A veteran's DD-214 is the swiftest way to determine eligibility for the services provided by Vet Centers. A DD-214 is the capstone military service document, as it represents the complete, verified record of a servicemember's time in the military, awards, medals and other pertinent service information such as promotions, combat or overseas service, Military Occupational Specialty (MOS) identifiers and their record of training and schools completed. In the event that a veteran has lost his access to a DD-214 it can take up to six weeks to receive a copy and there is no single prevailing method used by Vet Centers to request a copy of a DD-214. While during the delay a veteran will still have access to the facility, instant verification will allow the Vet Center to immediately provide veterans the highest possible level of service and eliminate the bureaucratic hurdle for the servicemember.

There are two electronic records systems that allow users to view a DD-214 form. These systems are the Defense Personnel Records Image Retrieval System and the VA/DoD Identity Repository (VADIR).

The latter receives nightly and near realtime transmissions from the Defense Enrollment and Eligibility Reporting System/Defense Manpower Data Center (DEERS/DMDC) of military service information for servicemembers leaving the military.

The former provides authorized U.S. government agencies controlled access to military personnel record images maintained by the Military Services for members of the U.S. Armed Forces. This system was initially implemented in the late 1990's, so not all personnel records are available and implementation was staggered across all branches of service. DPRIS contains narrative information in DD-214 that no other sources contain.

The bill simply directs the Secretary of Veterans Affairs and the Secretary of Defense to jointly ensure that the Vet Centers of the Department of Veterans Affairs have access to a veteran's DD-214. As we speak there are 7500 current users of the DPRIS system within the VBA alone and many others across the VA system. I strongly believe that the professional staff and counselors at Vet Centers should be given the same tools to serve our veterans and believe that it can be done in a way that preserves the integrity of the Vet Center System. I thank the American Legion and Veterans of Foreign Wars for their support of this legislation.

As a veteran myself I know the difficulties experienced by those transitioning to civilian life and how common it is for veterans to be missing records that are important to keep. I am sure you can all agree that whenever we have the opportunity to streamline service for our veterans we should seize that chance.

Again I thank the Chairman, the Ranking Member and Members of this Committee for allowing me to speak here today. I look forward to working with you all on this bill as I look for its swift passage by the Committee and this house.

Prepared Statement of Hon. Silvestre Reyes

Chairwoman Buerkle, Ranking Member Michaud, and my fellow Members of the Health Subcommittee thank you for hosting this hearing. I appreciate having the opportunity to provide additional information on a subject that is very important for our Nation's veterans.

As you know, this Committee worked to draft and pass legislation to provide needed support to caregivers for seriously injured Iraq and Afghanistan veterans. Under this initiative, the VA provides a monthly stipend, health insurance, and other support for family members who provide round the clock care for those who suffered major injuries in the line of duty.

Last year, the VA expanded the program, which helped bring the initiative closer to the intent of Congress, and I have introduced legislation, HR 3279, which would make a further needed improvement to the program.

The original caregiver legislation covered those servicemembers who incurred or aggravated a serious injury as a result of their service. The intent was to provide a much-needed benefit for those families who had suffered the most, but, by limiting the program to injuries, a category of veterans facing the same issues have been excluded by a technicality.

My legislation would expand the caregiver program to include not just serious injuries, but would also cover those who incurred or aggravated serious illnesses as well. Not every condition which would require caregiver support is related to an injury, and making this change also aligns the caregiver program with other VA programs which do not distinguish between injuries and illnesses.

I want to thank the VSO's both for expressing their support of my legislation and for their efforts on behalf of our Nation's veterans and their families. HR 3279 has garnered the endorsement of the National Military Family Association, the Retired Enlisted Association, the Association of the United States Navy, the Veterans of Foreign Wars (VFW), the Disabled American Veterans (DAV), the Military Officers Association of America (MOAA), the American Legion, the Iraq and Afghanistan Veterans Association, and the Wounded Warrior Project.

The VA has also expressed support for the intent of this legislation which will help them provide the care and support our veterans require. Expanding coverage to those veterans suffering from serious illnesses related to their service will help additional families and ensure that veterans are treated fairly, but this expansion is not without cost. Working together as a Committee, I am sure that we can find a way ensure that the caregiver program meets both the intent of Congress and the needs of veterans and their families.

The men and women who volunteer to serve our Nation put themselves at great risk, and we owe them a great debt of gratitude and honor. We also owe them and their families care and support as they deal with injuries and illnesses that resulted from their service. Making this needed change in the caregiver program is one way we to honor their sacrifice.

Prepared Statement of Hon. W. Todd Akin

Chairwoman Buerkle, Ranking Member Michaud, thank you for the opportunity to testify before you today regarding my bill, H.R. 3337, the Open Burn Pit Registry Act. As of today, this bill has over fifty bipartisan cosponsors and has been endorsed by a wide range of veterans' organizations.

The issue of burn pit exposure first came to my attention through veterans in my district who served honorably in Iraq and Afghanistan and are now suffering serious health effects apparently linked to exposure to burn pits. Let me share one short story.

Tim Wymore is a Missouri Guardsman suffering from the effects of working around burn pits while deployed to Iraq in 2004 and 2005. If his wife Shanna were here today, she would tell you of the dramatic impact burn pits have had on the

life of her husband and hundreds of others she has gotten to know as a result of fighting for Tim's treatment.

For nearly a year before contacting my office, as Tim's health continued to deteriorate, Shanna Wymore fought an often indifferent and sometimes hostile V.A. medical system trying to get care for her husband's unexplained illnesses. Tim, once a strong, athletic machinist, was suffering debilitating bouts of abdominal pain, weight loss and fatigue. Despite the adversity, Shanna persisted in her fight to get the help her husband was both entitled too and deserved. Along the way, she became an expert on burn pits and the growing number of Iraq war veterans suffering the effects of their exposure.

After more than two years of indecision and broken promises, with assistance from my District staff, the VA finally agreed to send Tim to the Mayo Clinic. The doctors there confirmed, what the VA had long denied, Tim was suffering the effects of what could only be attributed to the work he performed around the burn pits in Iraq.

I have had at least one other constituent, Aubrey Tapley, who has suffered the consequences of burn pit exposure and who has strongly advocated for taking proactive steps to help others who may be suffering from burn pit exposure.

Unfortunately, the health consequences of burn pit exposure are hard to understand and difficult to prove. Last fall the Institute of Medicine released a report which concluded in part that there is insufficient data available to determine the long-term health effects of exposure to burn pits and that more study is warranted.

The intent of my bill is to establish a registry at the Department of Veterans Affairs for those individuals who may have been exposed to open burn pits during their military service. This would help the Department study the issue more effectively and enable them to communicate to interested veterans as medical research on this issue develops. This registry would not affect the benefits any veteran is already entitled to receive, but would help the Department take better care of our veterans.

The experience I have had with veterans in my district is enough to convince me that we need to be proactive about studying and analyzing the potential health effects of open burn pits. We have sent our best and brightest young men and women into harm's way, and it is our responsibility as a Nation to take care of them when they return. Although there is a small cost for this bill, I think it is an affordable and reasonable approach to dealing with the issue of open burn pits, and I ask your Subcommittee to support this bill and consider moving it forward.

Again, thank you for the opportunity to testify today and I look forward to answering any questions you may have.

Prepared Statement of Hon. Robert T. Schilling

Chairwoman Buerkle, Ranking Member Michaud, and my colleagues, thank you for this opportunity to come before the House Veterans' Affairs Subcommittee on Health to speak about my bill, H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011.

I truly believe you can tell a lot about a country by the way it treats its veterans. I'm pursuing this legislation in large part because of the many constituents who constantly share their stories of having to drive long distances while experiencing substantial wait times in an effort to make sure they can get the health care they need. But I also experienced this in my own family when helping to take care of my father near the end of his life. We had to drive several hours to and from Iowa City for him to get the care he needed. While we appreciated the service and the care provided by the Department of Veterans Affairs (VA), I also believe that we must continue to make improvements for our veterans.

Under the current veterans' health care system, our veterans are shuttled back and forth between the VA and their local doctors' offices, bound by the red tape that exists in the fee-based care system administered by the VA. This red tape only exacerbates working with their local doctors' offices to receive the health care they need.

We also must keep in mind the fact that we will have a new group of veterans entering the VA system with needs that differ from past veteran groups. These include not only different injuries, but also women and the children of veterans. These groups of folks may require care that cannot always be addressed by the VA and allowing them a more convenient way to get their health care needs addressed is vital.

On top of that, there have been instances where the current VA fee-based system has been unable to accurately pay private providers the correct amounts, which, has

resulted in multiple overpayments and has cost taxpayers their hard earned dollars¹. It has been under close scrutiny by the Government Accountability Office and the Office of the Inspector General.² Veterans Services Organizations have also raised concerns about ensuring equal or better quality care when veterans are referred outside of the VA³. This system has also been unable to aid veterans in making and keeping their appointments.

This is unacceptable. Therefore, I am proposing we look at current systems that do work and have received a very positive response from veterans. The VA has two pilot programs, Project HERO (Health Care Effectiveness through Resource Optimization) and Project ARCH (Access Received Closer to Home), which allow veterans to use fee-based care in their hometowns with their own doctors. In addition to helping veterans cut down on commute time, these programs provide timely care to all veterans who have been placed on a long wait list. Instituting their models would revamp the VA's current fee-based care program and provide a fiscally responsible solution that results in more efficient and higher quality care for veterans seeking services outside of the VA. While these programs have not been used on a Nationwide scale, their utility cannot be ignored.

My legislation, the Enhanced Veteran Healthcare Experience Act, would merge the best parts of Project HERO with the best parts of Project ARCH, and provide an alternative to the current VA-run fee-based care program as the primary source of fee-based care for veterans. It would ensure that the VA contracts with qualified outside entities that meet key competency requirements such as network credentialed providers and accredited facilities; care coordination; patient advocacy; and electronic claims processing capabilities. The bill would standardize referral and authorization processes at all VA medical centers, require continuity of care for veterans, and require key performance metrics and incentive payments.

The bill would not force veterans to stop using VA care; veterans who prefer their current VA provider would still be able to continue receiving care from that provider. Veterans who do go outside of the system are also not prevented from returning to the VA for care in the future.

However, the bill would supplement the current VA fee-based program and utilize the funds saved within the VA's regular operating budget expenses. With a proven system in place that can properly keep track of payouts, the VA could save money it may have otherwise misspent, and very little additional funding would therefore be required for this more efficient program. The Congressional Budget Office (CBO) has not yet officially scored this bill, but because the regular VA fee-based care program is much more costly than Project HERO, the proposed blended program would likely cut overall VA costs and therefore create savings. An unofficial CBO staff estimate indicated that this bill would require \$3 million total for fiscal years 2012–2016. However, studies and statements by the GAO, OIG, and VSO's suggest that implementing the changes in this bill will create savings for the VA and address medical care concerns that veterans have when working with the VA fee-based care system.

This idea is near and dear to me, and has received a positive response from veterans I have spoken with in my district. The Congressional process is in place so that we can perfect legislation. That is what I am working to do on this bill. Since H.R. 3723's inception and also from its introduction, I have continued to work with Veteran Service Organizations (VSOs) to address their concerns. I hope to continue to do this with the VSOs and the Committee. To that end I have draft legislation that the Committee can use to improve H.R. 3723 in accordance with further input from Members of this Committee, veterans, and the VSOs.

Again, thank you for this opportunity to speak about ways that we can remain fiscally responsible, improve care, and keep our promises to our veterans.

Prepared Statement of Hon. David B. McKinley

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee, thank you for holding this legislative hearing today on important issues that affect our nation's veterans. I appreciate the opportunity to give remarks on my bill, H.R. 4079, the Safe Housing for Homeless Veterans Act.

Currently, there are over 2,100 community-based homeless veteran service providers across the country and many other homeless assistance programs that have

¹ <http://www.napawash.org/publications/veterans-health-administration-fee-care-program/>

² <http://www.va.gov/oig/pubs/VAOIG-statement-20111115-finn.pdf>

³ www.independentbudget.org/2012/5-medical-care.pdf

demonstrated impressive success reaching homeless veterans. I have visited some of the shelters in my home district in West Virginia and was struck by how many seemed to not be in compliance with state, local or federal safety codes.

After seeing these conditions with my own eyes, we began to investigate whether this is something that is isolated or more instances are occurring. It was unsettling to learn in our research about shelter fires where lives were lost. For instance, in 2009, an East Texas homeless shelter fire where five occupants were killed was found to not have a required sprinkler system and an instance in New York City just this past year where two dozen people were injured because the sprinkler system was not working properly and the exits were blocked. I would like to enter news articles about these fires and an additional three articles regarding other instances of code violations into the record.

Unfortunately there is no law mandating VA homeless shelters meet code; there is only a policy in place. As a licensed professional engineer, I found this to be an egregious omission in the law governing VA homeless program funds. H.R. 4079 would require any organization that seeks funding from VA for services to homeless veterans to have documentation that their building meets or exceeds all Life Safety Codes. This legislation also requires VA to give priority to shelters that need financial assistance from VA for improvements to ensure that the facility is in compliance with all the safety codes.

I am disappointed that VA has chosen to not support H.R. 4079, a bill that would codify what they already have as a policy. This is common sense legislation that would ensure the wellbeing of veterans who have fallen on hard times and are in the most need of assistance; and in extension these same veterans are turning to society to assure them of safe, reliable housing.

As a nation, it should be unacceptable for us to allow homeless veterans be housed in potentially unsafe conditions. In defense of our country, these men and women were put in harm's; they should not be in doubt about their own safety now that they are home again. These homeless veterans are experiencing a difficult phase of their lives and should be able to trust that they will be safe each night as they continue their return to being productive members of society.

I appreciate the testimony in support of H.R. 4079 from other witnesses testifying here today and I thank you for your concern for the safety and living environment of our veterans.

Prepared Statement of Shane Barker

Madam Chairwoman and Members of this committee, on behalf of the more than 2 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, the VFW would like to thank this committee for the opportunity to present its views on the following bills:

H.R. 1460, to provide for automatic enrollment of veterans returning from combat zones into the VA medical system:

The VFW supports the concept of H.R. 1460, legislation that would automatically enroll service members who have deployed to Iraq or Afghanistan for health services in the Department of Veterans Affairs (VA). For years now, our nation has provided 5 years of no-cost health care for separating service members through VA, but they must first go through the enrollment process. This generous provision has been critically important to many veterans, and the enrollment numbers are high. However, for a variety of reasons, many veterans have not enrolled for VA care. We believe that this automatic enrollment could positively affect those individuals, and tip the scale in favor of them receiving the VA health care they have earned.

H.R. 1460 will take the assistance we provide one step further by having VA initiate enrollment into the system on behalf of the combat veterans of our current conflicts, and taking the cumbersome work of enrolling off their shoulders while preserving their choice through a process to opt-out. Returning warriors have serious and pressing concerns they must address without delay when they return from combat – employment endeavors, rekindling relationships with family and friends, and coping with the emotional burden of their war experiences. The least we can do is remove burdens to begin receiving care from the VA so they can more quickly begin to address those important needs.

However, the VFW is concerned that it would create a paradigm in which the injuries and illnesses veterans who do not deploy incur are not given similar priority as those who deploy but do not experience any adverse health effects immediately attributable to their military service. While it does not incentivize current conflict

veterans who have deployed to hostile regions to avail themselves to VA care, it could prove to be polarizing, and send the message to non-deployed veterans that they do not qualify for VA health care.

The VFW would support this legislation if it were amended to include enrolling all separating service members into VHA. This would allow service members who were injured or became ill during service, but who did not deploy, the same accessibility as those who have deployed. Also, Congress would need to ensure VA has the resources to properly facilitate enrollment.

H.R. 3016, to direct the Secretary of Defense and the Secretary of Veterans Affairs to jointly operate the Federal Recovery Coordination Program:

The VFW supports H.R. 3016. In our view, the most important aspect of this legislation is the length it goes to keep the Federal Recovery Coordination program (FRC) a top priority of the Secretaries of Defense and Veterans' Affairs. By mandating the administration of this program must stay in the respective offices of each secretary, we can have more peace of mind that the wounded, ill and injured warriors the program was created to serve will receive the high-level attention they deserve. Administration of the FRC program has been shuffled around more than once since it was created in 2007, and we believe this legislation will end that by mandating in law that it be housed where it belongs – at the very top. This committee must also conduct continued oversight over this program as practicable to ensure that the letter and spirit of this law – and the critical importance of the FRC program – are embraced within DOD and VA. The men and women who go to war and come back with life-threatening injuries deserve no less, and we give our full support to this legislation.

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

The VFW supports H.R. 3245. This legislation requires collaboration between the DOD and VA to ensure that VA's Vet Centers have access to the two data repositories that house a service member's DD-214. Granting Vet Centers access to these databases means that they can independently verify a veteran's eligibility for services without the veteran needing to provide a paper copy of the DD-214. This instant access to service records will remove an unnecessary and often time-consuming hurdle to care for veterans needing peer support or mental health counseling from other veterans. At a time when so many of our veterans are in need of these kinds of counseling options, we should make this change without delay and continue to look for ways we can expedite and streamline services.

H.R. 3279, to amend title 38, United States Code, to clarify that caregivers for veterans with serious illnesses are eligible for assistance and support services provided by the Secretary of Veterans Affairs:

The VFW strongly supports H.R. 3279. The Caregivers and Veterans Omnibus Health Services Act of 2010, commonly known as the Caregiver Bill or P.L. 111-163, provided long-overdue financial and medical support for family members or other designated individuals who are willing to be trained to provide high-quality in-home health care for severely injured veterans of the conflicts in Iraq and Afghanistan. The Department of Defense provides similar support to family members of members of the armed forces who are catastrophically disabled, and includes disability caused by illnesses in their eligibility requirements. Because the law does not currently provide VA caregiver support to those who are seriously disabled because of an illness, the potential exists for military members and their families to lose a critical benefit as they transition out of the military into VA care.

The caregiver benefit must be seamless. It is simply too important for the physical health and general well-being of the men and women who are catastrophically disabled in service to preclude those who have suffered from a debilitating illness from receiving this benefit.

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

The VFW supports H.R. 3337. Open-air burn pits were used extensively in Iraq and Afghanistan to incinerate everything from medical supplies to automobiles, with possible hidden and grave health reactions on the military personnel exposed to them. VA, DOD, and other partners in the civilian sector are working to give us the tools necessary to properly diagnose and treat the conditions associated with open-air burn pits and other environmental exposures. However, much work remains to be done, and any delay means less than optimal treatment options now.

Both DOD and VA have areas where they could improve their support to those suffering from an environmental exposure. In addition to working to treat these conditions, the Veteran Benefits Administration must continue to improve their ability to account for their effects when evaluating claims, and DOD could make a greater

effort. Unfortunately, their lack of responsiveness to repeated requests for information from Congressman Akin in relation to this bill has made it difficult to ascertain what, if any, measures they have taken. We lament DOD's unwillingness to provide the requested information, and hope they will soon respond to that request. We would also very much like to see DOD reach out to veterans and military service organizations to forge a more productive working relationship on this important issue.

The VFW believes that this registry is essential to allow service members the peace of mind of going on record with VA at the earliest possible time to say they were exposed, and to assist VA in knowing how to best deploy advances in medicine and technology as they become available to treat the serious conditions associated with burn pit exposure. We know that the physical effects of environmental exposures can go unnoticed for decades, and it can be extraordinarily difficult to establish causation to military service that has long since passed. This legislation is a positive step forward, and we ask the committee to pass this measure without delay.

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

The VFW does not support H.R. 3723. While we do not support the legislation, we understand the impetus for it and agree that improvements to the current Fee-Basis system of referring veterans to a private-sector provider are long overdue. The program has many areas where improvements would provide more return on investment for the government and would improve the quality of care for veterans. Currently, coordination of care between VA and the private provider is virtually non-existent. As a result of limited controls and processes, VA does not have the ability to evaluate the quality of care provided, or integrate the associated private-sector medical records into existing medical history records the VA maintains for that veteran. VA also has little reach into the offices of doctors caring for veterans through the Fee-Basis paradigm to ensure the services being billed were actually performed. VA has no ability to guarantee or measure distance or timeliness standards, and veterans get no assistance from VA in finding doctors or assistance making appointments once a doctor is found. Clearly, there is much to be desired, especially when taking into account that the VA paid out more than \$4 billion in health care claims in FY 2010 alone.

Nevertheless, the VFW cannot support this legislation at the present time. The bill would mandate the Secretary to enter into contracts with network providers in order to provide a nationwide network of service providers to improve the non-VA care, thereby addressing many of the issues identified above. However, the VFW is concerned that the legislation would result in VA moving veterans outside of the VA system precipitously. Instead of working to improve processes and make the VA system more efficient and increase throughput, VA would have the obligation to move veterans into the non-VA care program when timeliness or distance standards are not met.

Complicating matters is the reality that the only way to make such a program cost-effective is to actively manage the volume of referrals into the program. Network providers would find it necessary to give care providers reasonable expectations of patient access and volume to negotiate a favorable rate for services being contracted.

The VFW would also call into question the ability for contracts entered into under this paradigm to be successful without first seeing how VA executes the implementation of the Patient Aligned Care Team (PACT) model of patient-centric care within the VA. The proponents of this legislation pre-suppose that the PACT care coordinator would act as a conduit to a care coordinator employed by the network provider. However, we see no evidence to suggest that the PACT model will routinely and successfully coordinate the care provided internally at VA without this layer of complexity added to the equation. The VFW believes that the PACT model must be a success. Therefore, we should ensure that it is refined to smooth out the rough edges before taking this step.

At the same time, VA is moving forward, if slowly, with their own efforts to implement the Patient Centered Community Care (PCCC) program that would establish contracts to provide a limited portfolio of services that would be more fully coordinated with VA. Publicly available data suggests that this portfolio is limited to medical and surgical services, but excludes dialysis, mental health, and primary care. While it is certainly true that we believe any successful program to coordinate non-VA care would include these services, we firmly believe VA must get this right. It is imperative that these issues be resolved, and we believe that VA's initiative must be given a chance to be executed and evaluated before fundamental and controversial changes, such that this bill would precipitate, are allowed to move forward.

Our veterans deserve access to timely and high quality health care that is fully integrated and responsive to their needs. To achieve this, we strongly encourage the committee to expeditiously conduct due diligence on the Fee-Basis program to have a better understanding of this and other potential options before initiating further legislative changes to this program.

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

The VFW supports H.R. 4079. We believe this legislation will ensure that homeless veterans are living in housing that is deemed safe and in compliance with codes required by county and state laws. Currently, VA is required to check housing certificates before awarding grants for housing services provided to homeless veterans. However, a thorough check of fire and safety requirements, as well as structural conditions of the building, are often overlooked.

H.R. 4079 would require certification that the building has met all necessary code specifications before a grant would be awarded. It also gives priority in awarding grants to those seeking assistance for any project that would make improvements to a building in cases where plans exist to provide housing and services for homeless veterans.

The VFW believes that there is no greater need than providing a safe and secure environment for our homeless veterans and their families. This legislation will protect the most vulnerable by making certain that the housing provided fills that need until they can return to independent community living.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or the members of the Committee may have.

Prepared Statement of Adrian Atizado

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 disenrolled 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

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 options⁴ 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 im-

¹Jim 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>

³VA Directive 0802; DOD Instruction 1300.24

⁴Beginning 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.

prove 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) 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.

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 confidentiality and a strong emphasis on informed consent.⁶

⁵P.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.

⁶<http://www.nytimes.com/2007/04/01/nyregion/01veterans.html?pagewanted=all>. Accessed March 28, 2012.

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.

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

⁷ 77 Fed. Reg. 14707–14712

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.

Prepared Statement of René A. Campos

MADAM CHAIR BUERKLE, RANKING MEMBER MICHAUD AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, on behalf of the 375,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present MOAA's views on several legislative provisions impacting veterans' health care.

MOAA does not receive any grants or contracts from the federal government.

MOAA greatly appreciates the Subcommittee's leadership in addressing the very important business of taking care of our veterans by your diligent oversight of their medical care and benefits which tangibly honors their service and sacrifice.

Our Association wants to acknowledge and thank the Department of Veterans Affairs (VA) for its hard work and persistence in transforming the agency. Clearly, VA has made significant strides in changing the culture, policies and programs and is moving towards a more veteran-centric organization.

MOAA's perspectives on the seven bills being considered by the Subcommittee today are outlined below.

- **H.R. 1460, Congressman William Owens (R-NY)**—allows veterans returning from combat zones to automatically be enrolled in the VA medical system.

MOAA thanks Representative Owens for his commitment to ensuring veterans seamlessly transfer from the Department of Defense (DoD) military health care system into VA's medical system.

While MOAA agrees with the need for seamless transition from the military to VA medical and benefits systems, we believe there should be no distinction be-

⁸Project 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).

tween veterans who have served in combat areas and those who have served in other types of assignments.

Automatic enrollment of only combat theatre veterans will likely be perceived as a negative decision by non-combat veterans, causing them to view it as a form of health care rationing and the government's attempt to diminish their contributions of service to their country.

The concept of automatic enrollment is consistent with MOAA's longstanding support for actions that lead to the 'seamless transition' of service women and men into the VA system and civilian life. Ongoing work on the bi-directional DoD – VA medical record could be advanced by automatic VA health care enrollment. But, the provision does not eliminate the requirement for the veteran to physically enroll at a VA medical center. Perhaps VA's outreach system could be strengthened by having advance information on separating service members put into VA's enrollment system.

An automatic process will, of course, simplify enrollment data tracking and would likely drive the demand and cost of VA care. For example, when Congress authorized open enrollment in the VA health system from 1999–2003 for all honorably discharged American veterans, enrollment climbed but not to unmanageable levels. With the enormous increases in health care costs since then, more separating service members might seek VA care if they were automatically enrolled and informed of the action.

MOAA supports the concept of H.R. 1460, automatic enrollment in VA health care and recommends H.R. 1460 be amended to authorize enrollment of all OIF – OEF veterans to advance seamless transition outcomes from military service to the VA.

- **H.R. 3016, Congressman John Barrow (D-GA)**—directs the Secretaries of VA and Defense to jointly operate the Federal Recovery Coordination Program (FRCP).

MOAA testified in September 2011 before this Subcommittee at a hearing on the FRCP, promoting a joint VA–DoD care coordination program oversight office and policy modeled after the FRCP.

We again testified in early March 2012, during a hearing before the House and Senate Veterans' Committees on MOAA's legislative priorities for veterans health care and benefits, stating the need for a single, joint VA–DoD office that consolidates the two agency programs. We did not recommend the program be modeled after the FRCP program because of the agencies' emphasis and desire to work more closely together to improve seamless transition of this extremely vulnerable population.

The two Departments have stepped up their collaborative efforts significantly since the DoD Recovering Warrior efforts Task Force published its 2010–2011 Annual Report last September. Both agencies acknowledge more work needs to be done in improving care coordination. We believe VA and DoD are doing their best to meet the intent of Sec. 1611 of Public Law 110–181 in the coordination of care require in the law.

MOAA does, however, believe that congressional and VA–DoD leadership oversight continues to be needed until care coordination programs, policies and systems mature and are operating efficiently and effectively. We look to Congress to determine if "a single, joint VA–DoD program and office for managing, coordinating, and assisting wounded, ill, and disabled members through recovery, rehabilitation, and retention," is still needed as required in the law.

MOAA supports the provision in concept but recommends Congress continue to provide oversight by conducting hearings and reports from senior officials in the Departments in lieu of additional legislation in order to determine the efficacy of programs and increase accountability of the systems for care coordination.

- **H.R. 3245, Congressman Jeff Denham (R-CA)**—the "Efficient Service for Veterans Act," directs the Secretaries of the VA and Defense to jointly ensure that the Vet Centers of the VA have access to the Defense Personnel Record Image Retrieval system and the VA/DoD Defense Identity Repository system. *MOAA does not have enough information on these issues to take a position on H.R. 3245.*

- **H.R. 3279, Congressman Silvestre Reyes (D-TX)**—amends and clarifies title 38, United States Code so that caregivers of veterans with serious illnesses (in addition to injuries) would be eligible for assistance and support services provided by VA.

On June 30, 2011, MOAA submitted to VA our response to the Caregiver Program's interim final regulations concerning the new benefits program directed in title 1 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111–163), signed May 5 of that year.

The letter highlighted our concerns about the “Definition of Serious Injury” in Section 71.15. In the letter we stated the VA: *defines ‘serious injury’ as “any injury, including psychological trauma, or other mental disorder, incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001, that renders the veteran or servicemember in need of personal care services.”*

It was not clear from the statement as to how VA will address those individuals whose conditions incurred during service worsen or change to the point of needing caregiver assistance once they are in a veteran status. We believe the intent of Congress was to allow both active duty and veteran caregivers to qualify for the benefit. Additionally, VA’s definition of serious injury does not specifically address illness, though it could allow for such conditions but is left open to interpretation.

In March, MOAA checked with the VA Caregiver Support Office about the status of the regulations and response to public comments. VA was quick to respond to our request for information letting us know that they were still coordinating the rules. VA’s Caregiver Support Office has also been active in its efforts to educate and inform stakeholders on the program as well as responding to wounded, injured, ill, and disabled members and families when issues surface.

MOAA supports H.R. 3279.

- **H.R. 3337, Congressman Todd Akin (R-MO)**—“*Open Burn Pit Registry Act of 2011,*” directs the Secretary of Veterans Affairs to establish an open-air burn pit registry to ensure that members of the Armed Forces who may have been exposed to toxic chemicals and fumes caused by open-air burn pits while deployed to Afghanistan or Iraq.

MOAA appreciates Congressman Atkins’ concern over the health and welfare of those men and women who have served and are currently serving in uniform near burn pit operations in Iraq and Afghanistan.

For years, the Air Force provided warnings in their pre-deployment briefings and fact sheets stating that use of open burn pits “can be harmful to human health and environment and should only be used until more suitable disposal capabilities are established.” Yet open-air burn pits continued operations in Iraq and Afghanistan.

Over the past decade, many servicemembers have complained of headaches, nausea, and irritation of the eyes after immediate exposure while several servicemembers and veterans have contracted various symptoms and life-threatening medical conditions after being exposed to burn pits used to dispose of waste in Iraq and Afghanistan.

MOAA fully supports H.R. 3337. Establishing a registry of servicemembers and veterans exposed to burn pit operations will provide a potential long-term link between exposure to harmful open-air burn pits and significant, long-term health problems.

- **H.R. 3723, Congressman Robert Schilling (R-IL)**—“*Enhanced Veteran Healthcare Experience Act of 2011,*” amends title 38, United States Code, requiring VA to enter into contracts with health care providers to improve access to health care for veterans who have difficulty receiving treatment at a health care facility of the VA.

Our Association, like Congressman Schilling, is very much concerned about the access, adequacy, and the quality of health care for our veterans. VA acknowledges a number of challenges to the existing fee-based care program and has committed significant resources and funds to look at alternative ways to deliver care while maintaining the integrity and quality of the medical system. They are also taking lessons learned from the contract pilots that have been launch in recent years, continuing to look at better and more efficient ways to deliver care and services.

MOAA agrees with the Veterans’ Independent Budget (IB) conclusion that current purchased care initiatives need time to mature. Imposing a mandate on VA could be counter-productive, disruptive, costly, and ultimately limit progress on ongoing purchased care efforts.

In addition, VA currently has no mechanism to ensure medical data from fee-based care providers are transmitted back to VA and integrated in veterans’ electronic medical records. MOAA strongly agrees with our Veterans Service Organization partners that any non-VA care must be fully integrated into the VA health care systems to protect not only the system, but also the safety of veterans.

MOAA does not support H.R. 3723 as written. Rather, we urge the Subcommittee to consider the recommendations in the FY2013 IB that address the issues in VA's purchased care system. Specifically, we strongly recommend that:

- VA should provide Congress and the veteran community a final analysis and evaluation of Project HERO.
- VA should develop an effective integrated care coordination model for all non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside the VA.
- VA should develop identifiable measures to assess its integrated care coordination model for all non-VA purchased care. The evaluation should be shared with Congress and the veteran community.
- **H.R. 4079, Congressman David McKinley (R-WV)**—“*Safe Housing for Homeless Veterans Act*,” requires homeless veteran recipients of housing grants and other assistance from the Secretary of VA to comply with codes relevant to operations and level of care provided.

MOAA does not have sufficient information on the issues to take a position on H.R. 4079.

Conclusion

MOAA thanks the Subcommittee for being champions of our veterans and their families. We appreciate the opportunity to share our views on these important provisions and we look forward to working with the Subcommittee on ways to improve VA health care so we can further enhance the quality of lives of those individuals in our veterans' community.

Prepared Statement of Ramsey Sulayman

Madam Chairwoman, Ranking Member, distinguished members of the subcommittee, on behalf of more than 200,000 members and supporters of Iraq and Afghanistan Veterans of America (IAVA), I thank you for the opportunity to share the views of our members on these very important pieces of legislation.

My name is Ramsey Sulayman and I am a Legislative Associate with IAVA. I am a veteran of Iraq where I was an infantry platoon commander and company executive officer. I have spent 14 years in the Marine Corps trying to execute the Marine Corps' two missions: winning battles and making Marines. As an IAVA staff member, I don't make soldiers, sailors, airmen or Marines but I do try to make their lives better. The views expressed in this testimony reflect the views and analysis of IAVA and not the United States Marine Corps. Thank you for your attention to the pressing issues facing our nation's veterans.

H.R. 1460 – IAVA strongly supports H.R. 1460, ensuring that combat veterans smoothly and seamlessly transition their care from the Department of Defense (DoD) healthcare system to the Veterans Administration (VA) healthcare system by automatically enrolling service members in the VA healthcare system and requiring them to opt-out if they do not wish to be enrolled. The creation of an integrated health record and the electronic transfer of medical records are steps in the right direction but the most important step is actually getting veterans into the system. Currently, veterans must independently seek out care in the VA system. That is why only 54 percent of Iraq and Afghanistan veterans are enrolled in the VA healthcare system. The steep cost of quality healthcare through the private sector and a high rate of veteran unemployment (almost 17% among our membership) means many veterans do not have access to any other healthcare system, in many cases for service-related injuries. IAVA believes that H.R. 1460's solution, changing enrollment for VA healthcare to an opt-out system, is easy and effective, both in terms of cost and efficacy. Combat veterans should not have to opt-in to receive a benefit they have earned through their service.

H.R. 3016 – IAVA supports H.R. 3016 which addresses the slow implementation of the Federal Recovery Coordination Program (FRCP) by mandating cooperation, setting deadlines and requiring oversight through reports to Congress. H.R. 3016 gets to the heart of the criticisms of the FRCP leveled by the General Accounting Office (GAO), specifically the lack of coordination between the DoD and VA. The remarkable advances in medical technology and treatment of traumatic injuries we have witnessed over the past decade have resulted in an increased survival rate for service members with formerly unrecoverable injuries. While great strides have

been made in the treatment of these injuries, the fragmentation of care across multiple systems has resulted in difficulty and frustration for many injured service members and their families. The FRCP was a common-sense response that placed an experienced health care professional at the center of the process to help guide service members and their families through the intricate, confusing and stressful process of navigating the healthcare system. IAVA believes that those who fought for their country and were injured deserve every possible bit of help to restore their lives to order.

H.R. 3279 – IAVA endorses H.R. 3279 which seeks to rectify an oversight in eligibility for family members of service members to participate in the caregivers' assistance program. Currently, service members who suffer a serious, life-altering illness as a result of service to their country are not afforded the option to participate. Only service members with physical injuries, loss of limbs for example, are eligible to apply for caregivers' assistance. A service member who contracts a debilitating disease, for example malaria, is not eligible. Many programs are hailed as "important" or "vital" but fail to live up to their billing. The VA caregivers' assistance program is vital and important, both to injured service members and their families. By promising what amounts to a very minimal safety net, caregivers' assistance allows families to make huge sacrifices in their own lives to care for severely injured service members. Families are able to make the choice to care for their loved one at home, rather than in a medical facility. Families are given the choice to stay together. The process for receiving caregivers' assistance is already robust and oversight is stringent. A relatively small number of veterans and their families receive assistance and explicitly stating that serious illness is covered as well as injury will not add significantly to the cost or numbers of veterans using caregivers' assistance but will make a significant difference in their lives.

H.R. 3337 – IAVA supports H.R. 3337, the Open Burn Pit Registry Act of 2011. Burn pits have the potential to be the insidious and long-lasting health issue for our generation of veterans that Agent Orange has been for Vietnam-era veterans. H.R. 3337 seeks to be ahead of the curve in responding to potential future health concerns by establishing facts: who was exposed, where they were exposed, and for how long. These small but crucial pieces of information will be helpful in the future in ascertaining health impacts of burn pits, facilitating subject identification for epidemiological studies, and adjudicating claims. Burn pits were ubiquitous in Iraq and still are in Afghanistan. They are located in the midst of large numbers of troops. The twin facts that burn pits are the way waste is disposed and must be co-located with troops for logistical reasons guarantees exposure for most service members. While IAVA supports H.R. 3337, we do so with a caveat. Because of the ubiquity of burn pits in these conflicts, we believe that the definition of burn pit must extend beyond solely those authorized by the Secretary of Defense. That proviso must be interpreted as broadly as possible and language should be inserted into H.R. 3337 that recognizes burn pits established by small-unit leaders to facilitate mission accomplishment. There is no garbage service for our troops to rely on in Iraq and Afghanistan and small units, by necessity, burn all the waste they have. This is a necessary addition to this important piece of legislation and IAVA urges inclusion of such language in the bill before passage.

H.R. 3723 – The goals of H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011, are laudable and IAVA supports many of them. However, IAVA cannot support H.R. 3723 because we believe that this legislation makes several changes that are untested and do not necessarily provide hope of significantly improved patient outcomes or access to care. Increased access to healthcare for rural and underserved veterans, comprehensive care coordination, and a focus on metrics of quality care and patient satisfaction are reforms which IAVA has supported and campaigned for in the past. In addition, there are significant issues present in the VA's fee-care program that need to be addressed for the sake of patient outcomes and providing the highest quality healthcare services possible.

The VA system has the capability to provide non-VA care to veterans who are either geographically constrained or who cannot be treated in a timely manner through VA providers. By removing the discretion of the VA to offer such options and mandating that services be provided on a contract basis, H.R. 3723 would effectively cripple VA healthcare. Entering into a contract for each veteran who would have previously fallen under the fee-care system would be unwieldy and cumbersome: would VA have to solicit several bids and pick the lowest bidder? Would the patient have to wait for care while the contracting process was being executed? Or would VA simply pay the fee charged by the healthcare provider without negotiation or comparison, a scenario under which upwardly spiraling healthcare costs and diminished access to services is easily envisioned? In addition, many medical options

are not cost-effective in the private sector (i.e. prosthetics) and real questions exist regarding fiscal benefits and patient outcomes when outsourcing those types of care.

As mentioned previously, there are many issues with the current fee-care system that have been raised. The National Association of Public Administrators (NAPA) issued a report which recommended that the VA cease the fee-care program because VA lacks the infrastructure and expertise to implement fee-care in the best manner possible. This begs the question: should the fee-care system be replaced by another system that makes the VA a third-party payer (essentially replicating the scenario encountered with fee-care) or should the VA system be strengthened, funded and fixed so that the use of third-party non-VA providers is minimized and truly used out of necessity? IAVA prefers the latter option. Therefore, we do not endorse H.R. 3723.

H.R. 4079 – IAVA supports H.R. 4079, the Safe Housing for Homeless Veterans Act. This bill makes explicit what we would already assume to be the case: recipients of VA funds to house homeless veterans must be in compliance with all relevant building and safety codes. This is not an onerous burden. Rather, H.R. 4079 requires meeting minimum standards of safety and construction before an entity is eligible to receive or continue to receive federal funds. “Minimum standards” are explicitly “the least we can do.” Homeless veterans are those who have fallen on hard times after honorably serving their country. Their service and sacrifice for this country should at least earn them a safe place to get back on their feet and the Safe Housing for Homeless Veterans Act accomplishes this goal.

Prepared Statement of Ralph Ibson

Chairman Buerkle, Ranking Member Michaud, and Members of the Subcommittee: Thank you for inviting Wounded Warrior Project (WWP) to offer our views on legislation pending before the Subcommittee.

WWP works to honor and empower this generation of wounded warriors – physically, psychologically and economically. Our policy objectives are targeted to filling gaps in programs or policies—and eliminating barriers—that impede warriors from thriving. Importantly, two of the bills before you this morning, H.R. 3016 and H.R. 3279, would close critical gaps facing warriors and their families and we strongly support their enactment.

H.R. 3016

Among the recommendations in WWP’s policy agenda is that Congress review the operation and effectiveness of the many programs created to improve warriors’ transition from military service to civilian status. The Federal Recovery Coordination Program (FRCP) may be among the most important of those initiatives to our warriors and their families, and we appreciate the inclusion of H.R. 3016 on your subcommittee’s agenda. H.R. 3016 would require the Secretaries of Defense and Veterans Affairs to develop a memo of understanding setting out a plan for joint Department of Defense (DoD) and Department of Veterans Affairs (VA) operation of the FRCP in accordance with the bill. As discussed below, a key provision of the bill would require the service secretaries to refer eligible servicemembers to the program at the earliest possible time, but not later than six months before expected retirement or separation from service.

By way of background, the FRCP has its roots in the President’s Commission on the Care of America’s Returning Wounded Warriors (the Dole-Shalala Commission), which found that the system of care, services, and benefits created to assist those who had been injured was too complex to navigate alone. The Commission recommended the creation of “recovery coordinators” or, in the words of the father of a severely wounded Marine, “a case manager to manage the case managers.” Ultimately, the National Defense Authorization Act of 2008 (NDAA 2008) directed DoD and VA to develop and implement a comprehensive policy to improve care, management and transition of recovering servicemembers and their families, to include the development of comprehensive recovery plans, and the assignment of a recovery care coordinator for each recovering servicemember.¹ Early on, DoD and VA entered into a memorandum of understanding establishing a joint VA–DoD Federal Recovery Coordination Program to assist those with category 3 injuries – individuals with a severe or catastrophic injury or illness who are highly unlikely to return to active duty and will most likely be medically separated. A separate DoD Recovery Coordinator

¹Public Law 110–181, sec. 1611.

Program was designed for those with category 2 injuries who might or might not return to duty.

In WWP's view, the services provided warriors and their families through the FRCP represent a too-rare instance of a holistic, integrated effort to help injured veterans successfully transition and adjust to their new normal. Federal Recovery Coordinators (FRCs) make unique contributions – both medical and non-medical—in facilitating wounded warriors' care-coordination and reintegration. Their invaluable work underscores the importance of ensuring that this program reaches all who need that help, and that it operate as effectively as possible. But while FRCs provide extraordinary assistance to warriors and their families, overarching systemic problems must be addressed to ensure that the program fully meets its objectives. We believe H.R. 3016 effectively addresses those systemic problems and we strongly support its enactment.

VA and DoD each share an obligation to severely wounded warriors and their families, but the reality is that they do not now share full responsibility for the FRC program. As this Subcommittee's hearings have ably documented, the FRC program suffers from acknowledged interdepartmental gaps.

As both your hearings and the General Accountability Office have documented, individual Service departments are not uniformly referring severely and catastrophically wounded warriors to the FRCP for assignment, or are doing so at much too late a point in the transition process. It is difficult to reconcile service-department practices that defer referral of a severely wounded warrior until that individual has retired with DoD policy or with the DoD–VA understanding under which the FRC program was established. The DoD policy makes it clear that “all category 3 service members shall be enrolled in the FRCP [Federal Recovery Coordination Program] and shall be assigned an FRC [Federal Recovery Coordinator] and an RT [recovery team].”² The policy instructs further that the FRC is to coordinate with the recovery care coordinator and recovery team to ensure the needs of the service member and his or her family are identified and addressed.

But rather than advancing seamless transition, individual Service department practices that defer referral for a possible FRC assignment until a severely wounded warrior has retired tend to frustrate realization of the goals the program was developed to achieve. By way of illustration, many severely and catastrophically wounded warriors may be eligible for assistance not only from military treatment facilities and the TRICARE program, but from the Veterans Health Administration, the Veterans Benefits Administration, the Social Security Administration, and Medicare. (As GAO recognized, “FRCs are intended to be care coordinators whose planning, coordination, monitoring and problem-resolution activities encompass both health services and benefits provided through DoD, VA, other federal agencies, states, and the private sector.”³) It is critical that a *Federal* coordinator have the depth of experience, training, and authority to navigate these multiple care/benefits systems. In contrast to those demanding requirements for an FRC, neither warrior transition unit staff nor recovery care coordinators (RCCs) – who are to assist servicemembers whose injuries are not deemed likely to result in a need for medical separation⁴—have the training, let alone the authority, to help coordinate care and other needs outside the military system. Resolving this referral problem is vitally important—failing to make a referral for an FRC until severely wounded servicemembers retire can mean delay in their recovery, rehabilitation and re-integration. These are the very kinds of problems that sparked the call for a seamless transition.

The referral issue seems a manifestation of the fact that instead of being operated as a joint, integrated VA–DoD effort, the FRC program tends to be seen—and marginalized—as a “VA program.” Given the program's importance to severely wounded warriors, it is critical that both departments fully support it. Experience under the program strongly suggests that that goal will remain elusive until there is truly shared responsibility for the program. In our view, enactment of H.R. 3016 would achieve that important objective by providing a sound framework for joint operation of the program under principles to ensure early referrals and efficient, effective recovery, transition and reintegration of severely wounded warriors. We strongly support enactment of this bill.

²Department of Defense Instruction (DODI) Number 1300.24, “Recovery Coordination Program (RCP),” Enclosure 4, sec. 2.d. (December 1, 2009).

³General Accountability Office, “DoD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges,” GAO–11–250, (Mar 23, 2011) 2. accessed at <http://www.gao.gov/products/GAO-11-250>

⁴DoDI 1300.24, Enclosure 4, sec. 2.a.

H.R. 3279

WWP is also pleased to lend our strong support to H.R. 3279. This bill would clarify that a veteran who has a serious illness incurred or aggravated in service on or after 9/11, and who is deemed to need personal care services, is an “eligible veteran” for purposes of the comprehensive caregiver-assistance program established under Public Law 111–163. The rationale for providing support services to caregivers of our wounded apply equally to family members caring for a young veteran suffering from a serious illness incurred in service. Current law governing caregiver-assistance certainly makes it clear that there is not a hard “eligibility-line” between a traumatic injury and other medical conditions. That is clear since the law states that the defining term, “serious injury,” includes a mental disorder. Yet while it would cover some veterans with mental health conditions, VA’s interim final rule otherwise reads the statute as covering only “injury” not illness. But there may be little distinction between the caregiving needs of a young warrior who is profoundly disabled as a result of serious illness in service and one who is injured. In each instance, a parent or spouse may have permanently left the workforce to care at home for the veteran’s daily needs, leaving that veteran vulnerable to the risk of VA institutionalization if the stresses of caregiving overwhelm that family member. Surely the needs Congress sought to address through the caregiver-assistance law relate to the emotional, psychological, physical, and financial impact of caregiving, not to the underlying etiology of a veteran’s condition. Clarifying the law, as proposed in H.R. 3279, would provide needed support for deserving caregivers while averting risks of unwanted institutionalization.

H.R. 3723

H.R. 3723 would change current law – which authorizes VA to provide fee-basis treatment to certain veterans for whom it cannot provide timely, geographically-accessible care in its facilities – to require it to contract for care under those circumstances for *all enrolled veterans* pursuant to a specified framework. It is helpful to review this measure in light of section 1, namely its proposed findings that (1) VA’s health care system fails to provide veterans easily accessible treatment; (2) veterans can be provided care more efficiently closer to where they live and with more flexibility in choosing their own doctors; and (3) replacing VA’s fee-basis care system with the model proposed under the bill can yield better care at little to no increased cost.

We concur that the VA health care system does not consistently provide veterans easily accessible treatment. Of course there are many factors associated with access to care, to include funding and staffing, as well as eligibility-limits on fee-basis care set in current law. Under section 1703 of title 38, U.S. Code, VA’s authority to provide care or treatment under contract is limited to specified circumstances (such as to provide ongoing needed care in follow-up to an episode of hospitalization⁵) and to specified categories of veterans (such as veterans needing treatment for a service-connected condition or veterans with service-connected disabilities rated 50% or more⁶). In short, existing law generally limits VA’s use of this tool to ensuring continuity of care and to accommodate veterans that Congress has identified as having high priority for access to care.

In this connection, our most recent experience, particularly as it relates to mental health care, is that fee-basis care is seldom an option for warriors with service-incurred mental health conditions despite VA facilities’ too-frequent inability to provide timely care or even the kind of care some need. This troubling situation exists despite very clear direction to VA facility directors regarding mental health services:

*“[These services] must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts or non-VA fee-basis care to the extent the veteran is eligible.”*⁷ (Emphasis added.)

At a time that VA facilities are ignoring or circumventing a directive that calls for utilizing fee-basis care under the limited circumstances authorized in law, it is difficult to embrace the notion implicit in H.R. 3723 that it would be timely to expand eligibility for fee-care to all enrolled veterans. But, in our view, there also is a real question as to how best to craft a legislative response to a situation where—

⁵ 38 U.S.C. sec. 1703(a)(2)(B)

⁶ 38 U.S.C. secs. 1703(a)(1)(A); (2)(A)

⁷ Department of Veterans Affairs, VHA Handbook 1160.01 (September 11, 2008), sec. 3.a.(1)

VA's own directive that action "*must*" be taken—is construed by some as simply a *guideline*. Under these circumstances, one cannot necessarily assume that amending a statutory provision governing fee-basis care to read "shall" rather than "may," as the bill proposes, would ensure the desired change. On the other hand, the establishment of such a broad mandate could certainly create serious fiscal-management challenges for VA with unintended results. We submit that these uncertainties alone raise real concerns, and suggest that the Subcommittee consider the unintended consequences of such a far-reaching bill.

Finally, we would acknowledge that H.R. 3723 raises a fair question as to whether VA's fee-basis model can be improved or even redesigned. In that regard, there is certainly merit to establishing requirements that any health care provider would have to meet in contracting with VA to treat veterans. But it is not clear that the requirements proposed in H.R. 3723 represent an optimal contracting framework. For example, the measure calls for a contractor to have "care coordinators to help veterans make, confirm and keep medical appointments." But it does not specifically require the contractor to coordinate care with VA clinicians, and as such would not necessarily assure real care-coordination or continuity of care for the veteran. In addition, the bill's requirement that a contractor have the ability to process claims from others in the provider's network suggests that such a contract would likely not, as a practical matter, be open to most individual providers or small group practices. As such, it is not clear that the bill would, in fact, "allow veterans more flexibility in choosing their own doctors", as section 1(b)(3) suggests. In sum, while H.R. 3723 raises questions that merit discussion, we cannot support its enactment.

H.R. 1460

H.R. 1460 would, in essence, direct VA to enroll any veteran who served in a combat zone in the VA health care system, subject to an option not to enroll. The bill appears aimed at facilitating a combat veteran's access to care. As discussed above, however, it has not been our experience that warriors have encountered difficulty in enrolling or are unaware of their eligibility for VA health care. Rather, we hear of warriors encountering problems *after* enrollment, particularly in getting timely, effective mental health care. VA has reported historically high percentages of OEF/OIF veterans' enrolling and being "seen" at VA health care facilities. But surveys of both warriors and VA mental health staff strongly suggest that at least some of those facilities may not be adequately staffed to provide timely care or even the right kind of care, and that in meeting VA's goal of enrolling as many veterans as possible have been less successful in providing the timely, effective care they should expect. In short, while we have no objection to H.R. 1460, we do not see this bill as solving the more serious access-to-treatment problems some returning warriors are facing.

H.R. 3337

H.R. 3337 would require VA to establish a registry for individuals who may have been exposed to toxic chemicals and fumes from "open burn pits" in Iraq or Afghanistan, and require an independent scientific organization to assess that effort, and make recommendations on (1) collection and maintenance of such information, and (2) on how best to meet the medical needs of those exposed with respect to the likely result of such exposure.

WWP shares the concern underlying this bill regarding unexplained respiratory and other illnesses among OEF/OIF veterans, and the possible role of environmental exposures in Iraq and Afghanistan. H.R. 3337 focuses specifically on the potential vulnerability of those who were based or stationed at a location where an open burn pit was used. We note, however, the recent Institute of Medicine suggestions that "service in Iraq or Afghanistan – that is, a broader consideration of air pollution than exposure only to burn pit emissions—might be associated with long-term health effects . . ." ⁸ While we have no objection to this legislation, IOM's findings and recent research ⁹ suggesting other environmental factors in southwest Asia may also be implicated in increased risk of illness raise a question whether the proposed registry would ultimately be a sufficiently helpful tracking mechanism.

Finally, WWP has no position on the two remaining bills under consideration, H.R. 4079 (addressing requirements for VA's grant program to assist homeless vet-

⁸ Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan, Institute of Medicine (Oct. 2011), 114. <http://www.iom.edu/Reports/2011/Long-Term-Health-Consequences-of-Exposure-to-Burn-Pits-in-Iraq-and-Afghanistan.aspx>

⁹ See "Harsh Environment in Southwest Asia, Not Just Burn Pits, Cause Health Problems in Troops," U.S. Medicine, vol. 48, no. 3 (March 2012), 33.

erans) and H.R. 3245 (to direct VA and DoD to provide Vet Centers with access to DoD electronic records systems in order to obtain service-discharge records (DD-214 forms). We would note, however, that warriors with whom we work have not reported any problems obtaining DD-214s or establishing eligibility for Vet Center services.

We would be pleased to answer any questions.

Prepared Statement of Robert L. Jesse

Good afternoon, Madam Chairwoman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

H.R. 1460: "Automatic Enrollment of Veterans"

H.R. 1460 would require the Secretary of VA, in cooperation with the Secretary of the Department of Defense (DoD), to automatically enroll combat-theater Veterans described in 38 U.S.C. § 1710(e)(1)(D) in VA's health care system not later than 45 days after their discharge or separation from active military, air, or naval service. The Secretary of VA would be required to provide these Veterans with a "Veteran identification" card that: 1) shows they are enrolled in VA's health care system, and 2) allows them access to VA health care facilities. The Secretary would also be required to furnish these Veterans with a list of VA medical facilities (including hospitals, outpatient centers, and mental health clinics) that are located within 100 miles of the Veterans' homes, or the closest VA facilities if none falls within that distance. It would also require that these Veterans receive at the same time a description of Federal benefits and programs, including educational benefits and job training and placement programs, for which they may be eligible.

H.R. 1460 would also permit Veterans to opt out of automatic enrollment by requiring, as part of the enrollment process described above, that they also receive the option to decline enrollment. In cases where automatic enrollment is declined, the Secretary of VA would be prohibited from automatically enrolling those individuals. A Veteran automatically enrolled in VA's health care system would have up to 6 months (from the date of enrollment) to disenroll by providing notice to the Secretary. The Secretary would be required under the bill to disenroll the Veteran within 60 days of receipt of the notice.

Finally, the provisions of H.R. 1460 would become effective 90 days after the date of enactment.

H.R. 1460 would dramatically change the process for transitioning Servicemembers, and VA is still evaluating the impact this change would have on its enrollment model, budget projections, utilization rates, and overall access to our health care system.

VA is working on many fronts to reach out to all separating Servicemembers and to ensure they know about the benefits they have earned, while making it as easy as possible to avail themselves of these benefits. Encouraging enrollment is certainly one piece of that effort.

VA and DoD are working in close partnership to ensure that every Servicemember's transition from DoD to VA is as smooth as possible. Together, the two Departments continue to progress in providing a comprehensive continuum of care to optimize the health and wellbeing of Servicemembers, Veterans, and their eligible beneficiaries. Our joint efforts to provide a "single system" experience of lifetime services encompass efficiencies in three common areas: operations; health care; and benefits. Joint planning and resource sharing have reduced duplication and increased cost savings for both Departments. Our health care goal is a patient-centered health care system that consistently delivers excellent quality, access, and value across the Departments. We also strive to anticipate and address Servicemember, Veteran, and family needs through an integrated approach to delivering comprehensive benefits and services.

VA and DoD are cooperating to improve the transition and coordination of care and benefits for Servicemembers and Veterans in four specific areas. First, in information technology, DoD and VA share a significant amount of health and benefits information today, and the Departments continue to spearhead numerous inter-agency data sharing activities and are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health and benefits information for those who have served our country. Second, in benefits de-

terminations, VA and DoD's joint efforts have created an integrated disability evaluation process for Servicemembers who are being medically retired or separated. This new, joint process was designed to eliminate the duplicative, time consuming, and often confusing elements of the separate disability processes within VA and DoD. Third, in informing Veterans and Servicemembers of the benefits they have earned, the National Resource Directory (NRD) is a comprehensive, Web-based portal that provides Servicemembers, Veterans, and their families with access to thousands of resources to support recovery, rehabilitation, and reintegration. NRD is a collaborative effort between DoD, Labor, and VA and has more than 13,000 Federal, state and local resources which are searchable by topic or location. Finally, in mental health, one of our cooperative efforts is the Integrated Mental Health Strategy (IMHS), which was developed to address the growing population of Servicemembers and Veterans with mental health needs. The IMHS centers on a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services. Recipients of these services include Active Duty Servicemembers, National Guard and Reserve Component members, Veterans, and their families.

Because of the complex issues this legislation raises and its wide-ranging impact on VA, we are still developing a position and a cost estimate for this bill. We will provide these in a letter after the hearing.

H.R. 3016 Joint Operation of Federal Recovery Coordination Program

H.R. 3016 would direct the Secretary of DoD and the Secretary of VA to jointly operate the Federal Recovery Coordination Program (FRCP). It would require the Departments to ensure that the FRCP assists members of the Armed Forces with severe or catastrophic injuries or illnesses who are unlikely to return to active duty and will most likely be medically separated, as well as Servicemembers and Veterans whose individual circumstances are determined by the Secretary concerned to cause difficulties to the Servicemember or Veteran in transitioning to civilian life. It would require the military services and the VA to make referrals to the FRCP at the earliest time feasible, including no later than 180 days prior to the last day of the month in which the Servicemember is expected to be retired or separated.

The bill would also require that the Secretaries of VA and DoD ensure that each Federal Government agency and department provides Federal Recovery Coordinators (FRC) with information, coordination, and cooperation necessary to allow FRCs to: (1) ensure the efficient recovery, transition and reintegration of eligible Servicemembers and Veterans; (2) act as liaisons between such Servicemembers and Veterans and the team of care providers and other personnel involved with a Servicemember or Veteran's recovery, transition and reintegration; and (3) work closely with case and care-management programs that assist such Servicemembers and Veterans. H.R. 3016 would require the Secretaries of VA and DoD, no later than 180 days after enactment, to develop a plan to carry out the requirements of the bill, enter into a Memorandum of Understanding (MOU) to jointly carry out the plan, and jointly submit both the plan and the MOU to designated congressional committees. No later than 180 days after the MOU becomes effective, the bill would require the Secretaries to jointly submit to designated congressional committees, a report describing and evaluating the implementation of the plan and MOU.

While VA appreciates the efforts of Congress to recognize and improve FRCP operations and provide high quality care coordination to wounded, ill, and injured Servicemembers and Veterans, VA does not support H.R. 3016. The Secretaries of VA and DoD are actively engaged on this issue and have directed that the Departments resolve the issue of coordinating efforts between and recognizing the value of each case management and care coordination program within the Departments to include, but not limited to, the VA-administered FRCP and the Service-administered Recovery Coordination Programs (RCP). Much of H.R. 3016 represents a duplication of existing requirements for VA and DoD for providing care coordination, and the requirements in the bill are already included in an existing VA-DoD MOU and in VA and DoD policy.

Because of the nature of the bill's requirements, VA cannot provide a reliable cost estimate of H.R. 3016. To provide a reliable estimate VA would need to work with DoD to develop estimates of potential clients who would be referred to FRCP under the eligibility criteria in the bill, which are significantly broader than under current policy.

We note that section 1(a)(5) of the bill would direct the Secretaries of VA and DoD to ensure that information, coordination, and cooperation are provided by each Federal Government agency and department. We believe this provision was designed, rather, to ensure that VA and DoD appropriately coordinate with other Federal agencies and departments in supporting the responsibilities of FRCs – as VA and

DoD cannot direct the actions and responsibilities of other Federal agencies and departments.

H.R. 3245 Efficient Service for Veterans Act

H.R. 3245 would require the Secretaries of VA and DoD to ensure that Vet Centers, established under 38 U.S.C. 1712A, have access to “the Defense Personnel Records Information Retrieval System” and “the Veterans Affairs/Department of Defense Identity Repository system.”

VA is authorized, under 38 U.S.C. 1712A, to establish Vet Centers that provide readjustment counseling to eligible Veterans and certain family members, upon their request. To be eligible for readjustment counseling, an individual must: have a Form DD-214 (Certificate of Release or Discharge from Active Duty); have received at least one qualifying medal; have received combat pay or combat tax exemption after November 11, 1998; or allow VA to independently verify his or her eligibility with DoD. See Vet Centers, 77 Fed. Reg. 14707-14712 (March 13, 2012) (adding 38 C.F.R. § 17.2000). H.R. 3245 would allow Vet Centers direct access to DoD’s Defense Personnel Records Information Retrieval System and the VA/DoD Identity Repository system. While the bill does not discuss the rationale for providing Vet Centers with access to these databases, we believe that the bill is designed to allow Vet Centers to utilize the databases to verify eligibility for readjustment counseling services if a Veteran does not have his or her DD-214.

VA has no objection to this bill, as it would enable Vet Centers to verify eligibility information in a timely fashion even if the Veteran or Servicemember does not have his or her DD-214. We would, however, recommend that the bill clarify the purpose for Vet Center access to the databases and the extent to which access is required. We also recommend that the bill list the information, within these databases, that should be disclosed to Vet Centers—for instance, “information relevant to Vet Center eligibility determinations.” Without these clarifications, the bill would simply ensure that Vet Centers have access to the databases, but would not specify what level of access would be granted, or the purpose for that access.

VA prides itself on maintaining Veteran and Servicemember confidentiality. To that end, Vet Centers currently maintain a separate system of records within VA, which effectively “walls off” any client’s personal identifying information from individuals who do not need access to that information. The only time that Vet Centers disclose a client’s personal identifying information is when VA has the client’s authorization or there is an immediate crisis that requires the disclosure. To protect the confidentiality of active duty Servicemembers and Veterans who request readjustment counseling, we recommend that this bill include a provision to restrict the monitoring or “logging” of Vet Center activity within the databases, other than for lawful purposes, such as law enforcement.

We would be happy to work with the Subcommittee to ensure the bill achieves its goals. Because Vet Centers already have the required technology to access these databases, we estimate that the costs for implementing this bill would be minimal. We also recommend a technical amendment to the language in H.R. 3245 to reference the “Defense Personnel Records Information Retrieval System” instead of the “Defense Personnel Record Image Retrieval System”.

H.R. 3279 Amending the Eligibility Criteria Under 38 U.S.C. § 1720G(a)(2)(B) to Include Eligible Veterans who have a Serious “Illness”

H.R. 3279 would amend the eligibility criteria for VA’s Program of Comprehensive Assistance for Family Caregivers under 38 U.S.C. § 1720G(a)(2)(B) to include Veterans or Servicemembers who have incurred or aggravated “a serious illness in the line of duty in the active military, naval, or air service on or after September 11, 2001.” Under current law, eligibility for VA’s Program of Comprehensive Assistance for Family Caregivers is limited to Veterans or Servicemembers who have incurred or aggravated “a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) . . . in the line of duty in the active military, naval, or air service on or after September 11, 2001.” See 38 U.S.C. § 1720G(a)(2)(B).

VA supports the intent of this bill. Expanding eligibility for VA’s Program of Comprehensive Assistance for Family Caregivers to include Veterans and Servicemembers with a serious illness would eliminate the need to distinguish illness from injury and establish a more equitable program. Distinguishing between a Veteran or Servicemember who incurred or aggravated a serious injury in the line of duty from one who incurred or aggravated a serious illness is often a complex process since either individual may require the assistance of a caregiver. The amendment proposed by this bill is supported by public comments received by VA in response to its interim final rule. See Caregivers Program, 76 Fed. Reg. 26148

(May 5, 2011) (adding 38 C.F.R. Part 71). These comments requested that VA consider “illness” as one of the eligibility factors for VA’s Program of Comprehensive Assistance for Family Caregivers. VA’s Office of General Counsel, however, concluded that the statutory language did not permit the addition of illness as criteria in regulations, and instead would require a statutory change.

The amendment would also align VA and the DoD Special Compensation for Assistance with Activities of Daily Living (SCAADL) program, authorized by section 603 of Public Law 111–84 (Oct. 28, 2010). Both SCAADL and VA’s Program of Comprehensive Assistance for Family Caregivers provide monetary benefits; SCAADL provides monetary compensation to eligible Servicemembers, whereas VA provides a stipend to primary Family Caregivers. SCAADL does not distinguish between illness and injury when determining eligibility compared to VA’s Program of Comprehensive Assistance for Family Caregivers, which limits eligibility to Veterans and Servicemembers who incurred or aggravated a “serious injury.” 38 U.S.C. § 1720G(a)(2)(B). This amendment would help align the two programs’ eligibility requirements, since they both aim to serve Veterans and Servicemembers who require ongoing assistance with activities of daily living or need supervision or protection.

To implement this amendment, VA would need to define the term “serious illness” and solicit public feedback on this definition. VA would also need to amend its interim final rule to include the new eligibility criteria. The amendment would expand the population eligible for benefits and services under VA’s Program of Comprehensive Assistance for Family Caregivers. An increase in the eligible population and the services and benefits that are provided to them would result in increased costs. At present, VA has approximately 3,500 Veterans and Servicemembers who have family caregivers enrolled in VA’s Program of Comprehensive Assistance for Family Caregivers. Based on this amendment, VA estimates that 870 additional Veterans and Servicemembers would qualify for services and benefits. These benefits and services include: a stipend available to primary family caregivers; VA health insurance available to eligible primary family caregivers; and respite care, mental health services, educational services, and beneficiary travel benefits available to family caregivers.

VA estimates the total cost for this bill would be \$45 million during Fiscal Year (FY) 2013, \$263.5 million over 5 years, and \$649.5 million over 10 years. VA does support the intent of this bill, because caregiver benefits indirectly support Veterans by providing assistance to their designated caregivers. However, because of the cost of the expansion proposed under this bill, there could be a negative impact on access to medical care services for Veterans unless additional funding is provided.

H.R. 3337: “Open Burn Pit Registry Act of 2011”

H.R. 3337 would require the Secretary of Veterans Affairs, not later than 180 days after enactment, to establish and maintain a registry for eligible individuals who may have been exposed to toxic chemicals and fumes caused by open burn pits. The bill would define an “open burn pit” as an area of land located in Afghanistan or Iraq that the Secretary of Defense designates for use for the disposal of solid waste by means of burning in the outdoor air without the use of a commercially manufactured incinerator or other equipment specially designed and manufactured for the burning of solid waste. It would define “eligible individual” as anyone who, on or after September 11, 2001, was deployed in support of a contingency operation while serving in the Armed Forces and who during such deployment was based or stationed at a location where an open burn pit was used.

H.R. 3337 would also require the Secretary of VA to include in the registry any information that the Secretary deems necessary to ascertain and monitor the health effects of such exposure. It also would require the Secretary to develop a public information campaign to inform eligible individuals about the registry and to periodically notify them of significant developments in the study and treatment of conditions associated with exposure to toxic chemicals and fumes from open burn pits. Additionally, the Secretary would have to enter into an agreement with an independent scientific organization to report on the effectiveness of the Department’s actions to collect and maintain information on the health effects associated with this particular type of environmental exposure. Specifically, the organization would be required to make recommendations on how the Department may improve its efforts (in collecting and maintaining registry information) and on the most effective and prudent means of addressing the medical needs of this cohort for conditions likely to result from their exposure to toxic chemicals and fumes from open burn pits.

Finally, H.R. 3337 would require the Secretary of VA to submit the scientific organization’s report to Congress not later than 18 months after establishment of the registry.

VA does not support H.R. 3337. Special authority for such a registry is not required. In carrying out the Department's medical and research missions, the Secretary may already establish under existing authority any needed health registry. Pursuant to section 703(b)(2) of Public Law 102-585 (1992), the Secretary may also provide, upon request, an examination, consultation, and counseling to any Veteran who is eligible for inclusion in any Department health registry. H.R. 3337, therefore, duplicates existing authorities.

We do not believe that a health registry is the appropriate epidemiological tool to use in identifying possible adverse health effects associated with certain environmental exposures. Health registries by their nature can only produce very limited and possibly skewed results. The major purpose of a registry is to enable medical follow-up and outreach efforts of those potentially exposed to an environmental hazard. Studies of self-selected individuals, such as those in a registry, are not representative of an entire population of potentially exposed individuals; they may therefore lead to false associations as to cause of perceived or actual illnesses. Indeed, for years, VA has maintained an Agent Orange health registry and a Gulf War health registry. While useful for outreach purposes, neither of these registries has been useful in terms of researching the types of health concerns raised by these Veterans. In addition to the issue of self-selection, there are other reasons why studies of registry populations are not useful, including exposure misclassification (self-reported but with no availability of data to support amount and time of exposure) and an inability to link to medical records to substantiate concerns about illnesses (not all registrants receive care from VA). We also note the particular timeframes under the bill are far too short to produce scientifically valid evidence.

Instead, it would be more appropriate to conduct a comprehensive prospective study of the long-term adverse health effects associated with specified environmental exposures, including exposure to toxic chemicals and fumes from open burn pits that were experienced by the OEF/OIF/OND cohort. Such a study would produce the most complete and representative information on possible adverse health effects associated with specified exposures. We are currently developing cost estimates and data requirements for a large-scale study and defining the outcomes it would provide. More importantly, VA and DoD are already engaged in several focused studies on health effects related to this cohort, including DoD's Millennium Cohort Study and VA's New Generation Study. Both Departments are also working on establishing clinical protocols for evaluating Veterans with respiratory complaints after deployment.

Finally, we note that combat-theater Veterans are eligible to enroll in VA health care up to 5 years after discharge or separation from service and receive free hospital care and medical services for conditions possibly related to their combat service. Eligible Veterans may take advantage of their VA health care benefits to obtain any desired medical advice on this topic as well as any needed medical services.

VA estimates the total cost for H.R. 3337 would be \$2.3 million during FY 2013, \$6.2 million over 5 years, and \$11.5 million over 10 years.

H.R. 3723 Enhanced Veteran Health Care Experience Act of 2011

H.R. 3723 would make various revisions to 38 U.S.C. 1703, which currently provides authority for VA to contract for certain types of health care for select Veterans when Department facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing the care or services required. Specifically, this bill would require the Secretary to provide health care through contract providers if the Secretary determines that Department facilities are not capable of economically furnishing covered health services to a Veteran because of geographic inaccessibility or because such facilities lack the required personnel, resources, or ability. This contract care would be available to all enrolled Veterans who elect to receive care under this authority.

With respect to standard acquisition practices, VA's existing authority, 38 U.S.C. 8153, to contract for health care resources from any health care provider or other entity or individual is sufficient. In fact, VA has an acquisition initiative under way to develop broad-based nationwide and regional contracts with health care providers to enhance and expand VA's ability to refer Veterans to qualified health care providers when VA is unable to furnish the required health care while helping to contain overall costs. With regard to subsection (a)(2) of section 2 of the bill, addressing qualified providers and quality of care, VA currently includes these requirements in health care contracts.

For the reasons described above, VA does not support this legislation. In addition, VA does not support H.R. 3723 because it would allow Veterans to elect to receive non-VA care under section 1703 as amended. As outlined above, section 1703 currently allows VA to purchase non-VA health care for certain eligible Veterans when

facilities are not capable of furnishing economical health care services because of geographical inaccessibility or such services are reasonably unavailable within VA. Requests for non-VA care from a VA provider must document that the local VA does not provide the requested service and that the services requested are medically necessary within generally accepted standards of medical practice. When such referral for non-VA services is received, local fee basis offices are required to verify geographic inaccessibility, availability of VA services (to include those of other VA medical centers), and eligibility for fee basis care. VA is concerned that H.R. 3723 as written would eliminate this step and marginalize the definition of what is considered geographically inaccessible as a result of the Veterans ability to elect to receive care. VA is still preparing cost estimates on this bill as written. We will provide it as soon as it is available.

VA regulations implementing the current authority in section 1703 have long provided that "individual authorizations" may be used as a method of making infrequent purchases of necessary non-VA health care for eligible Veterans. Individual authorizations provide the flexibility to purchase services necessary to a full continuum of care based on the patient's condition, frequency of need, and quality of care issues which would otherwise be unavailable from VA without negotiating the purchase under formal contracting provisions. VA, in its budget transmittal, summarized a proposal that will soon be transmitted to Congress to amend section 1703 to clarify that VA is not limited to formal contracting when purchasing health care services under this authority. We note that price reasonableness would be ensured by continuing to utilize Medicare payment rates as the payment methodology for these purchases.

VA would welcome the opportunity to work with the Subcommittee to enhance 38 U.S.C. 1703 and thereby improve VA's ability to deliver high quality health care and provide Veterans with a full continuum of health care, where standard acquisition practices are inadequate.

H.R. 4079 Safe Housing for Homeless Veterans Act

H.R.4079 would modify the Secretary's current requirements for entities seeking grants or other assistance to provide housing or services to homeless Veterans using the Life Safety Code of the National Fire Protection Agency, applicable state and local housing codes, licensing requirements, fire and safety requirements, and any other jurisdictional requirements.

The proposed amendment requires that entities providing housing or services for homeless Veterans certify compliance with "the most current Life Safety Code and all applicable State and local housing codes, licensing requirements [and], fire and safety requirements" for the buildings where services or housing is being provided. The proposed law would require that community partners are fire and safety code compliant before they are otherwise eligible to receive a grant, as well as require compliance with standards that may be above and beyond what is required by local law. This new requirement could dramatically reduce the pool of eligible capital grantees and could even preclude entities seeking capital grants intended to fix fire and safety issues. This would effectively mean severely limiting eligibility to existing providers with existing approved structures and could defeat the purpose of capital granting for new and existing community partners to make the necessary changes to provide services to Veterans.

The legislation appears to require meeting not only life safety requirements but it also outlines "any other requirements in the jurisdiction in which the project is located regarding the condition of the structure and the operation of the supportive housing or service center." This could be construed as requiring an applicant to have existing permits or licenses to provide services prior to being an eligible applicant for a capital grant.

Furthermore, by amending subchapter I of chapter 20 of title 38, this legislation would apply to every specialized homeless program operated under chapter 20 of title 38, including the Supportive Services for Homeless Vets program found in 38 U.S.C. 2044, and could require mandatory housing code upgrades in existing structures even when Veterans are not cared for in these structures. For example, under 38 U.S.C. 2044, VA provides grants to community partners to provide prevention and rapid re-housing services to homeless Veterans. In general, community partners operating under these types of grants would use existing structures for the administration of services; Veterans are not "cared for" in these structures, but services are administered and provided out of these structures. Certainly, these community partners would be expected to meet the necessary state and local housing codes, but in many cases, the Life Safety Code imposes much more rigorous requirements. This legislation would likely require costly upgrades to meet the Life Safety Code. In short, this legislation could impose onerous remodeling and upgrade costs on com-

munity partners' administrative buildings even though the services they are providing are wholly unrelated to the conditions of the building the entity occupies.

For the reasons stated above, we do not support this bill. It has the potential to be unduly burdensome and therefore would undermine the original congressional intent to encourage new partners to provide services to Veterans. The proposed law could also have a chilling effect upon the entry of new providers into the market. There are no Federal-level costs associated with this bill.

This concludes my prepared statement. Thank you for the opportunity to testify before the Subcommittee. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

Statements For The Record

PREPARED STATEMENT OF INSTITUTE OF MEDICINE

Mr. Chairwoman and members of the Subcommittee on Health, my name is Harvey V. Fineberg. I am the President of the Institute of Medicine of the National Academies. The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.

Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863. Today, the National Academy of Sciences has expanded into what is collectively known as the National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

I have been asked by your subcommittee to submit a statement for this hearing on the topic of H.R. 3337, the Open Burn Pit Registry Act of 2011. Our service men and women have long indicated concern that their health may have been adversely impacted by the burning of solid waste in open pits at US bases overseas where they were or are stationed. This concern has been echoed by Congress and the Department of Veterans Affairs. In 2009 the IOM was asked by the Department of Veterans Affairs to assess the long-term health risks from open pit burning at bases in Iraq and Afghanistan, using Joint Base Balad (JBB) near Baghdad, one of the largest military bases in Iraq, as an example.

IOM convened an expert committee to study this matter and the committee completed their report in 2011. A PDF download of this report is available to the public at no charge from the National Academy Press at the following web address: [<http://www.nap.edu/catalog.php?record-id=13209>].

I am submitting a copy of the summary of this IOM report for the record here. Briefly, the IOM collected data on environmental releases and concentrations of combustion products at JBB, considered information on possible human exposures at the base and elsewhere, and assessed the potential for long-term health effects of those exposures. The Department of Defense provided raw air-sampling data from JBB taken when the burn pit was in operation (it has since been replaced by incinerators), which were used to determine which chemicals were present at JBB. Based on these data, the committee found that levels of most pollutants at the base were not higher than levels measured at other polluted sites worldwide.

However, insufficient evidence prevented the IOM committee from developing firm conclusions about what long-term health effects might be seen in service members exposed to burn pits. Along with more efficient data-gathering methods, the report recommends that a study be conducted that would evaluate the health status of service members from their time of deployment to JBB over many years to determine the incidence of chronic diseases, including cancers, that tend to show up decades after exposure. Given the many hazards to which military personnel are exposed in the field, service in Iraq and Afghanistan in general, rather than exposure to burn pits only, might be associated with long-term adverse health effects.

In addition to instructing the Department of Veterans Affairs to establish a health registry, the proposed H.R. 3337 instructs the Secretary, Department of Veterans Affairs to enter into an agreement with an independent scientific organization to accomplish tasks outlined in Section 3 of the legislation. I will offer brief comments about those tasks. The three tasks are appropriate and feasible for an independent scientific organization to accomplish. For example, the first task is to assess of the effectiveness of actions taken by the Secretaries (Defense and Veterans Affairs) to collect and maintain information on the health effects of exposure to toxic chemicals and fumes caused by open burn pits. The independent organization could invite the Secretaries to review with the external independent organization in a public venue,

their plans and programs for carrying out the legislation's requirements. That review would include assessing the completeness of a toxic agents inventory that the Secretary, Department of Veterans Affairs, believes is associated with the open burn pits, how and where the information is being derived and maintained, and how accessible it is to veterans included in the registry. This assessment would naturally lead to a set of recommendations (the second task) to improve the collection and maintenance of such information. Finally, the third task requires an independent organization to review epidemiological studies, established and previously published, and to offer recommendations regarding the most effective and prudent means of addressing the medical needs of eligible individuals with respect to conditions that are likely to result from exposure to open burn pits. An independent scientific organization would be able to scour the world literature for relevant articles relating to this topic.

Depending on the nature of the information discovered, the independent organization could ascertain which exposures might present the most significant potential long-term health risks. That, in turn, would lead to recommendations about how best to prevent or clinically manage these potential effects. If little or no information could be obtained from a comprehensive literature review, the independent organization could suggest new research, epidemiological and otherwise, to inform the health risks.

In sum, the tasks outlined in section 3 of H.R. 3337 can be accomplished by a credible independent organization. Thank you for the opportunity to submit a statement for the record.

PREPARED STATEMENT OF BURN PITS 360

Honorable Chairman Jeff Miller and Honorable Members Of The Committee On Veterans' Affairs

It is an honor to have the opportunity to submit a statement for the record regarding Bill H.R. 3337. I am the wife of Captain Leroy Torres and founder/Executive Director of Burn Pits 360. "The War That Followed Us Home" is the slogan on t-shirts worn by many service members, veterans, and families affected. They are also the 6 words that describe the health and lives stolen from thousands of soldiers who served in the OEF/OIF war campaign where they were exposed to environmental toxins.

My husband, Captain Leroy Torres served a dual role to his community as a State Trooper in the State Of Texas and a Captain in the U.S. Army Reserves. He served a one-year tour at Camp Anaconda, a forward operating base that contained the largest burn pit. As he walked down the airport terminal with both arms and both legs, I sighed with relief thinking that we had accomplished a mission and our life would resume back to normal. It was his bulletproof vest in his civilian job that confirmed our biggest fear, returning from a war zone with life threatening injuries, everytime he put on the vest it restricted his breathing leaving him gasping for air. Since then he has been diagnosed with an irreversible lung disease, pulmonary hypertension, memory loss, parasitic infections, etc. . . . He has lost both of his careers at the age of 39 due to toxic inhalation and the effects this has had on him and on our family has been devastating. The once healthy father of 3 and husband that served on the SWAT police tactical squad and ran circles around his children is now a patient to over a dozen specialty doctors including: cardiology, neurology, pulmonary, GI, etc. . . .

Gasping for air and searching for answers we felt alone and confused. What was causing the coughing spasms, fatigue, memory loss, headaches, Gastric pains and were we the only ones out there experiencing these unexplained symptoms. Our prayers were answered the night that I googled the words, "soldiers returning sick from Iraq". It was at that moment that we discovered a community of soldiers and their families that had lost the battle to toxic exposure and many that were still fighting the battle to toxic exposure.

Like the names listed on the Vietnam Memorial Wall, we discovered name after name of individuals that were suffering from brain tumors, cancer, lung diseases, etc. . . . One of those names is SSG. Steven Ochs, 32 yrs. old, who's story of battling cancer after 3 tours in Iraq was told at the October 8, 2009 testimony before the United States Senate Committee On Veterans' Affairs. The lists of Fallen Soldiers that have lost the battle to toxic exposure include: Amanda Downing 24 yrs. old, Sgt. William Mc Kenna, Major Kevin Wilkins 51 yrs. old, SSG. Matthew Bumpus 31 yrs. old, Christopher Sachs 36 yrs. Old, Andy Rounds 22 yrs. Old, Jessica Sweet, SSGT Danielle Nienajadlo, and many more.

Since organizing Burn Pits 360, we are currently the only organization that manages a registry for those affected by toxic exposures from the Burn Pits In Iraq and Afghanistan. Our registry consists of over 600 self-reported entries. Over 90 % of the registries represent those suffering from pulmonary symptoms and others from Parkinson's, low testosterone levels, skin rashes, fatigue, joint pain, memory loss, crohn's disease, parasites, h-pylori, colon cancer, t-cell lymphoma, AML-acute myeloid leukemia, lung cancer, throat cancer, brain tumors, CML-chronic myelogenous leukemia, renal cell carcinoma, and several other illnesses.

Burn Pits 360 was developed as a pathway of advocacy by constituents and military families affected by toxic exposure. It was the only answer to avoid from becoming the next Agent Orange. This became a passion and a mission for my husband, my family, and for myself. The service members, veterans, families of the fallen, children, spouses, mothers, fathers, husbands, wives to those affected ask each and every one of you to support H.R. 3337. We have traveled to Washington at our own expense, walked the halls of Capitol Hill, visited the gravesites of those that have lost the battle, and built life long friendships with one thing in common, Burn Pits. As a military family our patriotism is shown by the American Flag that hangs over our front porch, as a caregiver to a wounded warrior, a twenty one year employee of the Department Of Veteran Affairs, and executive director to Burn Pits 360, it is my hope that each and everyone of you will show your patriotism by supporting a bill that will serve as a platform to those affected by toxic exposure.

Respectfully,
Rosie Torres

PREPARED STATEMENT OF HUMANA GOVERNMENT

Chairwoman Buerkle, Ranking Member Michaud, and members of the Subcommittee:

Introduction

Thank you for the opportunity to present Humana Veterans' views on H.R. 3723, the Enhanced Veteran Healthcare Experience Act of 2011, which would provide much needed improvements to the Department of Veterans Affairs' (VA) Fee program for Veterans who are authorized to receive medical care from non-VA providers.

Through the congressionally-directed pilot Project HERO (Healthcare Effectiveness through Resource Optimization), Humana Veterans Healthcare Services, Inc. (Humana Veterans), a Humana Government subsidiary, provides Veterans with access to non-VA healthcare when the Department determines that specific medical resources are not available within the VA healthcare system in VISNs 8, 16, 20, and 23. In these VISNs, we provide access to a competitively priced network of physicians, institutions and ancillary providers to supplement the VA healthcare system while adhering to high quality and access to care standards. With the HERO pilot scheduled to end on September 30, 2012, we would like to provide the Subcommittee our perspective on what key pilot program elements should be adopted and incorporated into a follow-on national program to replace the current VA Fee process.

Humana strongly supports H.R. 3723 because the bill addresses the fundamental flaws of the VA's non-HERO Fee program where Veterans receive fragmented care with little or no coordination between VA and non-VA healthcare systems. The bill ensures that VA would adopt the successful elements of the HERO pilot program, along with additional improvements to create a fully integrated healthcare delivery system where Veterans receive well-coordinated, patient-centric care. This bill enables VA to track and monitor all Veterans with Fee care authorizations, requires proper care coordination to positively impact Veterans' health outcomes, and will lead to cost savings by minimizing duplicative healthcare services and tests. Because of the care coordination elements in this bill, its adoption will also result in greater empowerment for VA to recapture as much of the Fee workload into the VA healthcare delivery system as they can absorb.

Challenges in VA's Fee Process

As currently implemented, the Fee process is not integrated with VA's healthcare delivery system and there is no coordination or care management of Veterans with Fee care authorizations, except in certain congressionally-directed pilot programs

such as Project HERO and Project ARCH (Access Received Closer to Home). VA's Fee process fails to ensure that Veterans are seen by credentialed and qualified non-VA providers and does not guarantee the return of pertinent clinical information to the VA primary care provider in a timely manner. With the exception of Veterans participating in Project HERO and Project ARCH, VA has no way of tracking and monitoring if and when Veterans schedule and receive care in the community. This means that VA loses track of Veterans and the care they receive once they leave the VA system for Fee care. Veterans are also left with the daunting task of navigating the very confusing VA and non-VA healthcare systems on their own without a single point of contact who will be the integrator of all care. This process is not Veteran-centered nor structured to allow VA to determine if and how a Veteran can be brought back to the VA for follow-up care and treatment, if appropriate.

In addition, the problem of erroneous Fee payments is well documented. Despite VA's best efforts to automate the Fee claims process through various pilot programs over the past 10 years, claims are still not automated today and the current manual claims process places VA at high risk for improper payments. For example, a March 2012 report by the VA Office of Inspector General identified the Fee program's improper payment rate at 12.4 percent¹, and the Government Accountability Office's February 2012 report placed the Fee program among the top 10 Federal programs with the highest reported improper payment rates². These findings are consistent in the September 2011 report by the National Academy of Public Administration (NAPA). The NAPA study also discusses the Fee program's use of "antiquated systems and technology" and points to private sector payors who provide "much more efficient and accurate claims processing"³.

To address these problems, VA and Humana Veterans worked in a close partnership to implement the HERO pilot program. The result of this experience has allowed us to capture the positive outcomes and lessons learned, and we can identify the ideal core elements that should be incorporated into the Fee program. However, instead of leveraging the lessons learned from this pilot program, VA's plan for the follow-on HERO program that they are calling Patient Centered Community Care (PCCC), would only result in the creation of a sub-specialty provider network. Care coordination is not possible under PCCC, because it excludes a number of health care services that will end up being provided in the community separately from PCCC. This will not yield meaningful improvements in the existing Fee program. Instead, PCCC will maintain the status quo of the current Fee program and the repricing contract that only gives VA a discount in price, but does not include Veteran-facing services.

In addition, under PCCC the contractor would not be able to provide the administrative services that exist in the HERO pilot and which were instrumental to the contractor's care coordination role. In its current design, PCCC would significantly limit the contractor's role to one of establishing and managing a provider network. Concurrently, VA is also creating and building new in-house capacity to handle administrative functions associated with the Fee care authorizations, visits and treatment through the Non-VA Care Coordination (NVCC) program. Instead of tapping the capacity that already exists in industry, NVCC will require significant resource investments, both in staff and the necessary tools (including IT) to properly handle the "back-office" administrative functions. It is not clear why VA would want to build internal capacity to become an insurance payor, when their expertise and experience is in delivering excellent healthcare as a provider. An unintended consequence of removing contractor-provided administrative services under the PCCC proposed model is the threat to the contractor's ability to maintain a provider network responsive to VA's changing needs. It also means that VA will not be able to get the best price, since the contractor cannot negotiate a better price with their network providers in the absence of a predictable minimum workload and without the ability to guarantee a low no-show rate, and timely, predictable payments.

The current flawed Fee program operates much like a fee-for-service program, which has perpetuated and magnified the risk for poor health outcomes, improper payments, and has resulted in unnecessary duplicative healthcare services and tests. These problems will persist if VA moves forward with PCCC in its current

¹ VA Office of Inspector General. *Department of Veterans Affairs: Review of VA's Compliance with the Improper Payments Elimination and Recovery Act*. Mar. 14, 2012. Web. 6 Apr. 2012. <<http://www.va.gov/oig/pubs/VAOIG-12-00849-120.pdf>>

² U.S. Government Accountability Office. *Improper Payments: Moving Forward with Government-Wide Reduction Strategies*. Feb. 7, 2012. Web. 6 Apr. 2012 <<http://www.gao.gov/assets/590/588228.pdf>>

³ National Academy of Public Administration. *Veterans Health Administration Fee Care Program*. Sept. 2011. Web. 6 Apr. 2012 <<http://www.napawash.org/wp-content/uploads/2011/11/White-Paper11012011webposting.pdf>>

design, and NVCC that will excise the back-office functions that contributed to the success of HERO. In today's challenging budget environment, VA cannot afford to support and expand ineffective and efficient programs. VA must make fundamental changes to the traditional Fee program to address the current program challenges. This is possible with the enactment of H.R. 3723, since this bill provides a sound foundation of core Fee program elements that can be used to guide VA as they develop the requirements for PCCC. The purpose of the congressionally directed HERO pilot program was to test ways to improve the broken Fee process. As discussed below, the HERO pilot program data point to key positive outcomes. H.R. 3723 builds on the integrity and basic successful elements of HERO to create meaningful improvements to the traditional Fee program.

H.R. 3723

H.R. 3723 ensures that Veterans with Fee authorizations receive the same high-quality care and protections that the VA healthcare system provides through the following HERO elements:

- *Fully credentialed and certified network of specialty providers:* Humana Veterans provided a network of 39,443 providers in the four HERO pilot VISNs. This network made it possible for Veterans to travel a median appointment distance of only 13 miles, even though 45 percent of the HERO appointments were in rural or highly rural areas.
- *Clinical information exchange:* Under Project HERO, Humana Veterans returned 94 percent of clinical information to the VA within 30 days with a median return of 9 days. This helped to improve clinical decision-making, and minimized duplicate care and services.
- *Care coordination:* Humana Veterans' care coordinators helped each Veteran in Project HERO navigate the care that they receive in the community. For example, Humana Veterans assisted Veterans in identifying a network community provider, scheduling the appointment, and following up to ensure that the Veteran made the doctor's visit. As a result, Humana Veterans achieved a no-show rate of 5 percent, which is significantly below the industry average that ranges between 14 percent and 24 percent. Humana Veterans also provided VA direct access to the Authorization and Consult Tracking (ACT) system, which is our proprietary IT tool for care coordination that allowed VA to track and monitor Veterans with Fee authorizations for the very first time.
- *Clinical quality management to respond to patient safety events:* Under Project HERO, Humana Veterans operated a clinical quality management program, which provided a structured way for identifying and addressing possible patient safety events. The clinical quality management program has reviewed all identified potential quality indicators and investigated 100 percent of confirmed quality issues, as well as discussed outcomes with the VA through the jointly operated Patient Safety Peer Review Committee.
- *Accurate and timely claims payment:* Project HERO required Humana Veterans to handle Fee related administrative services, including claims processing for our network providers. Using our automated claims process and contracted rates that minimize the risk for improper payments, we made 99 percent of claim payments to our providers within 30 days and maintained an extremely low payment error rate in FY 2011.

In addition, H.R. 3723 provides for stronger care coordination by requiring a VA-provided and a contractor-provided care coordinator to work together in managing the care that Veterans receive. The bill also attempts to eliminate variation by requiring VA to make consistent determination of Fee authorizations for Veterans, while leaving the Department with the flexibility to define the standards for referrals and authorizations. This means that VA retains the decision-making control of if and when they use Fee care as a tool to supplement the care that Veterans receive in the VA. In summary, H.R. 3723 provides necessary changes to the Fee program and incorporates the successful elements from HERO that will enable the VA to work in partnership with community providers to provide Veterans with not only patient-centric and coordinated care, but also ensures continuity of care across VA and non-VA provided healthcare systems.

Conclusion

In order to enhance the Veteran's healthcare experience, VA should do what they do very well (i.e., delivery of excellent healthcare) and partner with an administrative services contractor to provide services they do very well in the marketplace (e.g., care coordination, maintaining credentialed provider networks, payments, etc.).

For the reasons outlined above, Humana Veterans strongly supports H.R. 3723 and encourages its enactment. Eligible Veterans for whom VA provides Fee authorizations will benefit greatly from a fully integrated care coordinated Fee program that will also ensure VA's ability to bring these Veterans back into the VA if and when follow-up care is needed. We look forward to working with the Committee to make the necessary transformational changes to the Fee program so that Veterans receive more effective and efficient care when they must go outside of the VA system for care.

**PREPARED STATEMENT OF NATIONAL COALITION OF HOMELESS
VETERANS**

Chairwoman Ann Marie Buerkle, Ranking Member Michael Michaud, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health:

The National Coalition for Homeless Veterans (NCHV) is honored to present this Statement for the Record for the legislative hearing on April 16, 2012. On behalf of the 2,100 community- and faith-based organizations NCHV represents, we thank you for your commitment to serving our nation's most vulnerable heroes.

For the purposes of this statement, NCHV would like to formally indicate its support for the following three bills:

- H.R. 4079, Rep. David McKinley's "Safe Housing for Homeless Veterans Act."
- H.R. 3723, Rep. Bobby Schilling's "Enhanced Veteran Healthcare Experience Act of 2011."
- H.R. 1460, Rep. Bill Owens' bill to provide for automatic enrollment of veterans returning from combat zones into the VA medical system.

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

Among the homeless veteran programs that would be affected by this legislation is the Homeless Providers Grant and Per Diem Program (GPD) – which provides transitional housing with supportive services, and is a staple of the Department of Veterans Affairs' Five-Year Plan to End Veteran Homelessness.

A vast majority of homeless veterans must address mental illnesses, substance abuse disorders, physical disabilities, or co-occurring disorders. The road to recovery for GPD participants often results in triumph, but it is not without tribulation. A safe environment is critical to ensure this rehabilitation can happen.

Existing GPD capital grant regulations require compliance with the Life Safety Code of the National Fire Protection Association, as well as local and state codes and licensing requirements. The "Safe Housing for Homeless Veterans Act" would establish these policies as federal law.

Numerous homeless shelters across the country have witnessed fatal fires. We have the technology, however, to prevent these tragedies from happening. H.R. 4079 would signal to VA's community-based service provider partners the importance of meeting these safety measures.

As Congress works to protect homeless veterans and their families, it must not create undue obstacles for those who wish to serve them. The "Safe Housing for Homeless Veterans Act" offers a short-term safeguard for homeless veteran programs currently receiving federal funds – those that do not already meet the required certification would have up to two years to come into compliance.

We believe the essential components of the Five-Year Plan to End Veteran Homelessness are in place and advancing – these include access to safe housing, health services, income stability and prevention strategies. Without ensuring the safety of veterans in rehabilitative housing programs, however, our efforts to end their homelessness will be incomplete. This bill takes a sensible approach to help protect America's former service members.

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

Homeless veteran service providers have long recognized the need for an "open door" policy that ensures veterans have access to immediate primary and mental health services. This legislation would promote this policy by replacing VA's fee-based care system with the contract-based "veterans enhanced care program."

At present, it is incumbent upon the veteran – no matter his or her disability level – to travel potentially hundreds of miles to the nearest VA medical facility to apply for fee-basis care. H.R. 3723 would remove this unnecessary burden by allow-

ing qualified service providers to enter into contracts with VA to serve eligible veterans in areas that are underserved by VA facilities.

The provisions in this bill cover primary medical care, mental health services, and long-term rehabilitative care – all of which are critical to the overall health and well-being of veterans, particularly those who have served in combat and combat support operations.

For vulnerable veterans in highly rural and underserved areas, the “Enhanced Veteran Healthcare Experience Act of 2011” will provide much-needed relief, and enhance the responsiveness of the VA. NCHV supports this bill’s patient-centered approach to providing medical care.

H.R. 1460, to provide for automatic enrollment of veterans returning from combat zones into the VA medical system

Although combat exposure is not definitively linked to homelessness, it is a high predictor of later difficulties in life. The full scope of this relationship remains unclear, however. By automatically enrolling veterans returning from combat zones into the VA medical system, H.R. 1460 would enable our nation to build a comprehensive record of the health care services required by these veterans. This is critical to the VA’s full understanding of the health issues related to combat exposure, and the agency’s ability to effectively plan for the services it will have to provide to combat veterans in the long term.

This bill protects service members’ autonomy by including an option not to enroll during their discharge or separation process. Additionally, all veterans would have the option to “disenroll” for a period of up to six months after their initial enrollment.

In Summation

Thank you for the opportunity to submit this Statement for the Record. We look forward to working with this subcommittee to help advance H.R. 4079, H.R. 3723, and H.R. 1460 to the full committee and House of Representatives.

John Driscoll
President and CEO

National Coalition for Homeless Veterans
333 ½ Pennsylvania Avenue SE
Washington, DC 20003
202-546-1969

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairwoman Buerkle, Ranking Member Michaud, and members of the Subcommittee, Paralyzed Veterans of America (PVA) thanks you for the opportunity to submit a statement for the record regarding the proposed legislation being considered today. PVA appreciates the fact that you are addressing these important issues that affect the health and well-being of our nation’s veterans. We support your effort to improve the health care and benefit services that these men and women have so honorably earned and deserve.

H.R. 1460

PVA generally supports the intent of H.R.1460, a bill that would require the Department of Veterans Affairs (VA) to automatically enroll veterans returning from combat zones into the VA health care system. This bill would also provide veterans with information on job training and educational programs that may benefit veterans as they transition back into their civilian lives. PVA believes that automatic enrollment in the VA health care system immediately after veterans are discharged or separated from service will help make veterans more aware of the health care services, benefits, and veterans programs available to them through the VA. However, we recognize that as a result of automatic enrollment there will be a significant increase in utilization, which will require additional resources and funding for VA facilities. Therefore, PVA’s full support for this bill is contingent upon providing the VA with the additional resources and funding that will be necessary to meet the growth in health care demand.

PVA also has concerns that if this legislation is enacted the current generation of veterans who are discharged or separated from military service will be granted enrollment in the VA health care system when they may not otherwise be eligible. As written, this bill is unclear if the targeted population of veterans will be enrolled

in the VA health care system in accordance with current enrollment policies; or if veterans discharged or separated from military service after the bill is enacted will be eligible to enroll regardless of restrictions that may be in place for other veterans. PVA believes that veterans entering the VA health care system must meet the VA eligibility requirements that are in place during the time of automatic enrollment.

PVA would also like to ensure that a veteran's decision not to enroll does not preclude him or her from enrolling in the future. The VA must also be certain to continue its outreach to inform veterans of the many services and benefits that the VA has to offer. Educating returning service members on the many benefits of enrollment in VA's health care system is an essential element of veterans consistently seeking VA services.

Lastly, PVA believes that it is imperative that this legislation recognizes and includes our mobilized National Guard and Reservists as they are demobilized from wartime service. The period when a member of the Reserves demobilizes is an extremely hectic time and the focus of the service member is to get back home to their family. They are no less deserving of automatic enrollment and it may be even more important as they do not have the long period of preparation often afforded to those being discharged from active service.

H.R. 3016

PVA supports H.R. 3016, legislation that would mandate both the VA and the Department of Defense (DoD) to jointly operate the Federal Recovery Coordination Program (FRCP). PVA believes that the FRCP is an excellent program and has the potential to help severely injured, ill, or wounded service members and veterans navigate through the various benefits and services for which they are eligible through the VA or DoD. However, in order for the FRCP to succeed, both VA and DoD must take joint responsibility for its administration.

As identified by past hearings held by the Subcommittee, communication between the VA and DoD, as well as duplication of efforts, continues to be a problem in the administration of the program. It is for this reason that PVA believes H.R. 3016, if enacted, would not only improve communication between VA and DoD, but also encourage coordination between the two departments as veterans enter the program.

Since the VA and DoD both have responsibility for individuals enrolled in the FRCP, PVA believes that both departments should equally share responsibility for the program. If this bill is enacted, VA and DoD must work to ensure that the changes that will occur as a result of joint responsibility do not thwart the progress that has been made thus far. Administration of the program must continue to move forward in order to provide veterans with the necessary guidance and stability that is needed for them to make informed decisions in support of their full recovery and rehabilitation.

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

PVA does not have a position on H.R. 3245, legislation that ensures that VA Vet Centers have access to the Defense Personnel Record Image Retrieval System and the VA/DoD Identity Repository system.

H.R. 3279

PVA strongly supports H.R. 3279, a bill that would amend title 38, United States Code, to clarify that caregivers for veterans with either a serious illness or injury are eligible for assistance and support services provided by the VA. PVA has over 60 years of experience understanding the complex needs of spouses, family members, friends, and personal care attendants that love and care for veterans with lifelong medical conditions. PVA believes the original legislation was clearly intended to support populations of veterans that have experienced a catastrophic injury or illness.

Additionally, the Secretary of Veterans Affairs, Eric Shinseki, emphasized during the roll-out of the new caregiver program that "caregivers are critical partners with VA in the recovery and comfort of ill and injured veterans." Unfortunately, the law is being interpreted very narrowly and thus excluding caregivers who care for veterans dealing with catastrophic illnesses. PVA believes that this is simply unacceptable and urges the Committee to pass this legislation.

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

PVA supports H.R. 3337, which would require the VA to create an open burn pit registry for members of the Armed Forces who may have been exposed to toxic chemicals and fumes caused by open burn pits while deployed to Afghanistan or Iraq. This legislation would provide this population of veterans with information re-

garding burn pit exposures, and potentially assist VA with future research and health care initiatives. PVA believes that the burn pit registry is a first step towards ensuring that veterans returning from Afghanistan and Iraq receive the proper medical attention regarding exposure to toxic elements.

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

PVA does not support H.R. 3723, the “Enhanced Veteran Healthcare Experience Act of 2011.” This bill would amend title 38, United States Code to authorize the VA to enter into contracts with health care providers in an effort to increase access to health care for veterans who have difficulty receiving treatment at a health care facility of the VA. While access is indeed a serious concern for PVA, we believe VA is the best health care provider for veterans.

The veterans enhanced care program as proposed in H.R. 3723 would change the veteran eligibility requirements for VA contracted care, as well as eliminate VA’s current Fee-basis care program and replace the federal statute governing contract care within the VA. Currently, contracted care services provided through the VA are at the discretion of VA leadership; reserved for veterans who have sustained a service connected disability, or a disability for which a veteran was discharged or released from active duty; and provided when the VA is not capable of providing the needed care, or such services are geographically inaccessible. Under H.R. 3723 VA leadership will no longer have the discretion to choose when to contract with private providers for veterans’ health care, and all veterans enrolled in the VA health care system would become eligible to receive contracted care outside of the VA. This policy change has the potential to drastically increase the number of veterans seeking care outside of the VA, and PVA believes that providing quality care to meet the unique needs of veterans is an integral component of the VA fulfilling its mission.

Additionally, this legislation would also expand the criteria under which the VA must provide contracted health care to include personnel and resource shortages within VA medical facilities. PVA believes that this will only lead to the diminution of VA health care services and resources. It is PVA’s position that the quality of VA’s health care and “veteran specific” expertise cannot be adequately duplicated in the private sector. When VA is not capable of providing timely, quality services to veterans, it is the responsibility of VA leadership and Congress to work together to ensure that VA is able to meet veterans’ health care needs. PVA does not believe that contracting health care services to private facilities is an appropriate enforcement mechanism for ensuring access to care.

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

PVA supports H.R. 4079, legislation to amend title 38, United States Code, to require recipients of VA grants and other assistance for the provision of housing and other services for homeless veterans to comply with codes relevant to operations. This bill will help insure the safety of facilities that offer services to homeless veterans, as well as prevent delays in construction of such facilities by requiring that all recipients of VA grants be in compliance with safety housing codes or licensing requirements. PVA believes that H.R. 4079 is in direct alignment with Secretary Shinseki’s goal of eradicating homelessness among America’s veterans.

Chairwoman Buerkle, Paralyzed Veterans of America appreciates this opportunity to express our views on these pieces of important legislation. We look forward to working with the Subcommittee on these and other issues in the future.