LEGISLATIVE HEARING ON DRAFT LEGISLATION, 'THE VETERANS INTEGRATED MENTAL HEALTH CARE ACT OF 2013;' DRAFT LEGISLATION, 'THE DEMANDING ACCOUNTABILITY FOR VETERANS ACT OF 2013;' H.R. 241; H.R. 288; H.R. 984; AND H.R. 1284

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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Tuesday, May 21, 2013

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

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Wenstrup, Brownley, Ruiz, Negrete McLeod, Kuster.

Also Present: Representative Miller.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Good morning. The Subcommittee will come to order.

Thank you all for joining us today as we begin to discuss six legislative proposals aimed at strengthening the health care and services we provide to our honored veterans through the Department of Veterans Affairs.

The six bills on our agenda this morning are draft legislation, The Veterans Integrated Mental Health Care Act of 2013; draft legislation, The Demanding Accountability for Veterans Act of 2013; H.R. 241, The Veterans Timely Access to Health Care Act; H.R. 288, The CHAMPVA Children's Protection Act of 2013; H.R. 984, to direct the Department of Defense to establish a task force on urotrauma; and H.R. 1284, to provide for coverage under VA's Beneficiary Travel Program for certain disabled veterans for travel for certain special disabilities rehab.

These bills seek to address a number of important issues facing our veterans. I expect today's hearing to encompass a highly detailed and thorough discussion of the potential merits, challenges, and implications of each proposal before us.

I look forward to working with the Ranking Member, the bill sponsors, and my Subcommittee colleagues to fully evaluate these proposals and ensure that we advance meaningful and appropriate legislation to fulfill the promise we made to our veterans.

My bill, the Demanding Accountability for Veterans Act, is intended to address the pervasive lack of action taken by VA based

on their own agreed upon timelines for remediation of issues and recommendations included in VA inspector general reports.

Currently, the IG tracks open recommendations on their Web site and in their semi-annual report to Congress, the latest of which show that there were 177 total open reports and 1,140 total open recommendations. Of those, 33 reports and 93 recommendations had remained open for more than one year.

My bill would require the IG to make a determination on whether VA is making significant progress on implementing VA's own agreed upon action plan and timeline to implement the recommendations made by the IG in a report concerning public health or patient safety.

Under the bill, if the IG determines that significant progress has not been made, the IG would be required to notify the committees and the secretary of the department's failure to respond appropriately.

Following notification, the secretary will be given 15 days to submit the names of each VA manager responsible for taking action to the IG. In turn, the secretary would be required to properly notify each responsible manager of the issue requiring action, direct that manager to resolve the issue, and provide him or her with appropriate counseling and a mitigation plan.

The secretary would also be required to include in the responsible manager's performance review an evaluation of actions in response to a relevant IG report and prohibit the individual from receiving a bonus or other performance award for failure to take action.

The goal of this legislation is simple; to create a culture within VA where problems that go unresolved are unacceptable.

Far too often, I have seen serious issues that the IG has identified go unaddressed by the department. Such inaction is intolerable where the care and services provided to our veterans is concerned. And it is well past time for those at VA who are responsible for implementing needed changes to be held accountable for their work.

I am hopeful that The Demanding Accountability for Veterans Act is the first step in ensuring that they are.

I would be happy to answer questions my colleagues may have on the bill and listen to the views of all of our witnesses.

To that end, I would like to thank all the sponsors for taking the time to speak with us about their proposals today. I am grateful for each for their leadership and advocacy efforts on behalf of our veterans and their families.

I would also like to thank our veteran service organization partners and other stakeholders, both those who will testify here this morning and those who submitted statements for the record for their valuable input.

I am also grateful to the VA for being here to provide the department's views on these important proposals.

With that, I now yield to Ranking Member Brownley for any opening statement she may have.

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

OPENING STATEMENT OF HON. JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for providing the full schedule today that includes six bills before us that address some of the unique needs of our Nation's honored veterans' population.

The bills pertain to a variety of areas that affect the lives of veterans every day and this Subcommittee has conducted many oversight hearings to understand the problems and then fix them.

The first two bills on today's agenda including one of your proposals, Mr. Chairman, are pieces of draft legislation to address mental health concerns and increasing accountability at the VA.

The next bill, H.R. 241, The Veterans Timely Access to Health Care Act, was introduced by Mr. Ross of Florida and pertains to timely, organized, and scheduled visits to VA medical facilities.

H.R. 288, The CHAMPVA Children's Protection Act of 2013, sponsored by Mr. Michaud, Ranking Member of the Full Committee, would amend the maximum age for children to obtain medical care under CHAMPVA from 23 to 26 and effectively reflect The Patient Protection and Affordable Care Act enacted in 2010.

I will speak further on this bill during the first panel.

Next, H.R. 984 introduced by Mr. Guthrie of Kentucky would direct the Secretary of Defense to establish a national task force on urotrauma.

And, finally, my bill, H.R. 1284, The Veterans Medical Access Act, would provide better access for blind and severely disabled veterans who need to travel long distances to obtain care at a special rehabilitation center.

Oftentimes, blind and catastrophically-disabled veterans choose not to travel to VA medical centers for care because they cannot afford the cost associated with that travel.

Currently, the VA is required to cover the cost of transportation for veterans requiring medical care for service-connected injuries.

H.R. 1284 would extend those travel benefits to a veteran with vision impairment, a veteran with spinal cord injury or disorder, or a veteran with double or multiple amputations whose travel is in connection with care provided through a special disabilities rehabilitation program of the VA.

Our disabled veterans have already made the greatest of sacrifices and I firmly believe, as I am sure everyone here in this Committee hearing today believes, that no veteran should be denied needed medical care.

I thank all of the Members for their thoughtful legislation and I want to thank you, Mr. Chairman, for including my bill here today.

Thank you, and I yield back my time.

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

Mr. BENISHEK. Thank you, Ms. Brownley.

I would now like to welcome our first panel to the witness table. At the dais we have our Chairman, a well-respected and well-established leader for our veterans, to discuss his draft legislation, The Veterans Integrated Mental Health Care Act of 2013.

We also have my friends and colleagues, Dennis Ross, Representative of Florida's 15th congressional district; and Brett Guthrie, Representative of Kentucky's 2nd congressional district. Brett is also a West Point grad and a veteran of the army's 101st airborne division. I would like to thank him for his service in uniform.

Thank you all for being here this morning. It is a pleasure having you and I will yield this time for the Chairman for his testimony.

STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman.

It is great to be here today, with you the Members of the Subcommittee on Health, Representatives from the VSOs that have joined us and other interested stakeholders and audience members. I appreciate the opportunity to discuss my draft bill, The Veterans Integrated Mental Health Care Act of 2013.

Two weeks ago yesterday, I spent the day in Atlanta with many members of the Georgia delegation to discuss inpatient and contract mental health program mismanagement issues at the Atlanta Department of Veterans Affairs Medical Center.

This visit occurred after the VA inspector general issued two reports which found that failures in management, leadership, oversight, and care coordination at the Atlanta VAMC contributed to the suicide deaths of two veteran patients and the overdose deaths of two others.

Now, alarmingly, the IG found that approximately four to five thousand veteran patients fell through the cracks and were lost in the system after the Atlanta VAMC failed to adequately coordinate or monitor the care they received under VA's contracts with community mental health providers.

I wish that I could say that the issues in Atlanta are an isolated aberration. Unfortunately, that would be far from the truth. Rather, the Atlanta story is just the latest in a tragic series of incidents highlighting serious and systematic deficiencies plaguing the provision of mental health care to at-risk veterans through the VA health care system.

Since 2007, VA's mental health care programs, budget, and staff have increased significantly, yet the numbers of veterans taking their own lives has remained stagnant for the past 12 years, with 18 to 22 veteran suicide deaths per day since 1999 according to VA's own records.

I could go on, but the bottom line of this is that the one size fits all path to mental health care that the department is on is failing the veterans most in need of its services. And the time to act is now.

I have been and will certainly continue to be a strong and supportive advocate of VA taking action to hire staff and address the continued failures of mental health care provided within its own walls.

However, it has become abundantly clear through the data that I have discussed this morning, through committee oversight in this room, through numerous IG and Government Accountability Office reports, and through the personal accounts of the veteran constituents that call my office and the offices of my colleagues on a daily

basis, to ask for help that VA cannot cope with the magnitude of mental health needs our veterans experience in a bureaucratic vacuum with the normal VA business as usual approach.

In order to truly maximize mental health care access for today's veterans, VA has got to embrace an approach to care delivery that treats veterans where and how they want to be treated, not just where and how VA wants to do the treatment.

Some have said this could undermine VA health care as we know it, but nothing could be further from the truth. This is not about supplanting the VA health care system. It is about supporting that very system.

To truly address and resolve the breakdown in the provision of mental health care services to veteran patients, VA has got to adopt an integrated, coordinated care delivery model for mental health care.

Most importantly, VA has got to adopt a mental health care delivery model that is truly veteran-centric, one that meets and cares for veteran patients where they are, treats the entirety of their concerns with supportive and timely wrap-around services, and recognizes and respects their unique circumstances, goals, and health care needs throughout their lives as a veteran.

That is why I have proposed the draft Veterans Integrated Mental Health Care bill that is before us this morning. It would take the first important step to help veterans in need, whether those services are provided in or outside of VA facilities.

Specifically, the draft would require VA to provide mental health care to an eligible veteran who elects to receive such care at a non-VA facility through a care coordination contract and with a qualified entity and require such entity to meet specific performance metrics regarding the quality and timeliness of care and exchange relevant clinical information with the VA.

It would ensure that existing mental health care resources, both those found within the VA facilities and those provided to veterans through fee-basis care, are managed effectively.

It would also ensure that the care provided to veteran patients in need of mental health services is timely and that it is convenient and coordinated from the initial point of contact throughout the recovery process.

I understand that some veteran service organizations have expressed concern about waiting until VA rolls out its own new contract care initiatives. And while I appreciate and I understand and respect those views, I look forward to working closely with them to address those concerns, but the time for waiting is over.

Last year, the IG found that more than half of the veterans who go to VA seeking mental health care services wait 50 days on average to receive an initial evaluation.

This year, the IG found that thousands of Georgia veterans had fallen through giant cracks in the system and may or may not have received the care that they so desperately needed. We cannot wait to see what next year brings.

When a veteran is in need of mental health care services, the difference of a day or a week or a month can be the difference between life or death, contentment or continued struggle. The time to act is now.

I look forward to working hand in hand with Committee Members, our VSO partners, and other stakeholders to strengthen the language in this draft bill and address any issues that may be raised during the Subcommittee's discussion this morning.

I appreciate you holding this hearing, Mr. Chairman, and for your hard work and steadfast leadership of the Subcommittee on Health. I yield back.

[THE PREPARED STATEMENT OF HON. JEFF MILLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Chairman.

I look forward to hearing from the VSOs about your legislation and it certainly is timely.

With that, I will yield to Mr. Ross, my colleague. Thank you.

STATEMENTS OF HON. DENNIS ROSS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

STATEMENT OF HON. DENNIS ROSS

Mr. ROSS. Thank you, Mr. Chairman, and thank you, Ranking Member Brownley and the Committee, for allowing me to testify on behalf of legislation I have introduced entitled The Veterans Timely Access to Health Care Act.

America's veterans are the backbone of the freedom and prosperity that this country has enjoyed for over 200 years. We owe them a debt that we can never truly repay.

Unfortunately, across the country and across Florida's 15th congressional district, veterans continue to encounter unacceptable problems and delays receiving appointments from the Veterans Administration for essential medical and specialty health care needs.

For instance, the VA has set a goal to provide an initial medical health examination within 14 days from the time a veteran contacts a VA medical provider to schedule a consultation. They claim, the VA claims to have met this goal with a 95 percent success rate.

However, an inspector general report in 2012 published, greatly contradicts these claims. In fact, the IG report determined that the VA met its goal only 49 percent of its time.

As Chairman Miller pointed out, for example, more than 184,000 veterans waited approximately 50 days to receive critical mental health evaluations, not treatment, just the formal evaluation. This is a disgrace to our veterans and something that should not be tolerated.

Additionally, Chairman Mike Coffman of the Subcommittee on Oversight and Investigations held a hearing on March 14th, 2013 to examine patient wait times at VA medical facilities. Sadly, the Chairman revealed that according to VA documents, at least two veterans died last year from diseases while waiting for a medical consultation at the VA.

That is why I am proud to have introduced H.R. 241, The Veterans Timely Access to Health Care Act. This legislation supported by the Military Officers Association of America and the Retired Enlisted Association will ensure that veterans seeking primary and

specialty care from a VA medical facility receive an appointment within 30 days period.

This legislation also contains a number of detailed reporting requirements so that Congress may better track the VA's progress. And if the VA discovers they are not meeting their goals and the mandated 30-day access to care, it is my hope that they will reach out to Congress before the reports are filed so that we can work together to meet the needs of our Nation's brave and courageous veterans.

We are all on the same team here with the same goal of providing timely, high-quality health care to our veterans. However, this legislation will go a long way in ensuring veterans' critical needs like those needs of the more 184,000 veterans who waited over 50 days for initial mental health screening. We want to make sure they no longer slip through the cracks.

It will also prevent the unnecessary loss of life of those veterans in need of medical care and consultation.

Moving forward, I would like to work with this Subcommittee to strengthen this legislation potentially including additional access to care standards. Today, this legislation is a first step to hold the VA accountable.

Thank you, Mr. Chairman, and I yield back the balance of my time.

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

Mr. BENISHEK. Thank you Representative Ross. I appreciate your words.

Brett, why don't you just go ahead with your testimony as well?

STATEMENT OF HON. BRETT GUTHRIE

Mr. GUTHRIE. Thank you, Mr. Chairman.

And good morning, Ranking Member Brownley and colleagues.

I come before you today as both a Member of Congress and a former army officer to thank you for your past support of this issue and continued work that we need to move forward.

As you may know, genitourinary trauma or simply urotrauma is a class of wounds that literally hits below the belt. Urotrauma accounts for wounds to the kidneys, reproductive organs, and urinary tract organs. These injuries are some of the most common and debilitating suffered by our veterans from IED detonations and have long-lasting physical and psychological impacts.

Urotrauma is one of the signature wounds of the IED and now accounts for one-eighth of all injuries suffered by our troops in Afghanistan. Unfortunately, the most recent data available suggests that this figure is still rising even after nearly doubling in incidence between 2009 and 2010.

I know we are in the veterans committee today, but by way of background, let me paraphrase Department of Defense report to Congress titled Genital Urinary Trauma In The Military and the army's surgeon general's report entitled Dismounted Complex Blast Injury.

According to these papers, urotrauma on today's battlefield exceeds incident rates of all prior conflicts by at least 350 percent

and, yet, the DoD under secretary for Personnel and Readiness concedes that urotrauma injury is not part of the standards of predeployment training for U.S. military surgeons and nurses and that existing infrastructure for tracking these casualties is not sufficient to assess the long-term prognosis of GU trauma injuries.

This lack of adequate infrastructure is exacerbated by the inherent complications of transitional care from DoD to VA where most victims will receive treatment for the remainder of their lives.

Let me say that this is not my view that the VA or DoD are ignoring urotrauma. To the contrary. I believe that many skilled professionals are hard at work on the issue, but, as is often the case in government, their efforts are divided, un-integrated, and because of this less effective.

By my tally, there are six government agencies currently working on urotrauma and while I am heartened that this research is occurring, I am discouraged that there seems to be little dialogue or centralization of information.

Put simply, we are not learning from experience and if we are, we are learning too slowly. And that is why I introduced H.R. 984, a bill that I have authored with the help of practicing urologists who have cared for wounded warriors in Iraq and Afghanistan.

This bill would unite public and private resources to address the growing problem that is urotrauma. I would like to highlight two specific opportunities for improved care that are within the Committee's jurisdiction.

First, the existing infrastructure to track urotrauma patients is not sufficient. We need the research infrastructure to facilitate urotrauma outcomes research and corresponding follow-up with DoD and most critically after transition to the VA.

Unfortunately, one thing I have heard time and again is that the joint theater trauma registry, which tracks approximately 16,000 trauma victims, lacks the specificity of detail needed to accomplish this end. VA, DoD, and health care providers need a better platform to coordinate care across a lifetime for our wounded warriors.

Related to this is a second issue I would like to focus on, transition of care. Rather than mincing words, I will quote the American Urologists Association Urotrauma Task Force directly.

It is clear to those urologists in DoD who care for our soldiers with complex urotrauma that the transition to the VA is currently fraught with barriers. These barriers include deficits of communication of the detailed medical and surgical history of injured servicemembers from DoD physicians to VA physicians.

Another problem continues to be GU injured soldiers within the VA system being cared for in locations where access to expertise in GU trauma is lacking.

One solution to this problem would be designated care coordinators to urotrauma victims. These coordinators would need access to DoD and VA health information and guide our wounded warriors toward existing centers of excellence and polytrauma care.

However, as a Member of Congress, I am not wedded to a single solution to this or any other improvement to urotrauma care. That is why 984 allows for a big tent solution. As DoD has said in writing, we need inter-service and interagency relationships to facili-

tate aggressive, innovative, and relevant translational and outcomes-based clinical research.

And that is what this does. It brings together VA, DoD, HHS, surgeon generals of all of our Armed Services and civilian expertise to create a plan to care for our wounded warriors from the point of injury to their final resting place decades from now.

I urge this Committee to continue the work it has already done to further our care for these wounded warriors in suffering these effects, and I yield back my time.

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

Mr. BENISHEK. Thank you very much, Representative Guthrie.

I will now yield again to the Ranking Member, Ms. Brownley, to speak on H.R. 288.

Ms. BROWNLEY. Thank you, Mr. Chairman.

H.R. 288, The CHAMPVA Children's Protection Act of 2013, was introduced by Mr. Michaud, Ranking Member of the Full Committee. Thank you for including it in today's agenda.

Dating back to 1973, the CHAMPVA program was established to provide health care services to dependents and survivors of certain veterans. It is designed to provide care in a manner similar to that of DoD's TRICARE program in that it is a fee-for-service program that provides reimbursement for medical care provided by the private sector.

Individuals who are eligible for CHAMPVA are the dependents of certain living and deceased veterans who were rated permanently and totally disabled for a service-connected disability, died from a service-connected disability, or died while on active duty which was not due to personal misconduct.

As we are all aware, The Patient Protection and Affordable Care Act requires health plans and health insurance issuers that offer dependent coverage to extend this coverage until the adult child turns 26 years of age.

The fiscal year 2011 National Defense Authorization Act provided DoD with the authority to extend TRICARE coverage to age 26 as well. However, this provision has yet to apply to CHAMPVA.

H.R. 288 would extend that same coverage to CHAMPVA beneficiaries. It is a simple fix that would ensure that our veterans' families are able to receive health care commensurate with the rest of the Nation.

And I thank you, Mr. Chair, and I yield back the balance of my time.

Mr. BENISHEK. Thank you, Ms. Brownley.

I am going to yield myself five minutes for a few questions concerning the legislation and maybe you all can answer a couple of points that I have.

Mr. Ross, thanks for your interest in ensuring that our veterans have timely access to care. As you know, care delayed is care denied.

Some concerns have been raised about H.R. 241 that would establish in law a single measure of timeliness. I am looking forward to the opportunity to work with you on this legislation to achieve your goal, which I think is to ensure that veterans have a clear ex-

pectation that they will receive timely care and that the VA will be held accountable.

But there is some concern I have about one standard. There are different types of issues that come up. For example, the mental health timeliness issue may be different than a routine appointment.

Can you respond to these questions that I came up with——

Mr. ROSS. Yes, sir.

Mr. BENISHEK. —when I read your legislation?

Mr. ROSS. Thank you, Chairman.

And I agree with you. I think, you know, we are trying to impose one standard of 30 days. When the VA says that they now do it within 14 days, we know they do not meet that standard.

What we are trying to do is assess the situation. We know we have a problem. We are trying to get to the solution by putting in initially a 30-day maximum period of time by which the appointment must be given and then having the assessment thereafter of a report from the secretary that is due to Congress that would show how many appointments were really made within 30 days, how many in excess of 30, how many in excess of six months.

From that data, we should be able to then decide what is the appropriate standard for appointments. But I use this legislation as a step, the first step in trying to recognize that we have a problem in providing adequate and necessary health care in an expeditious fashion.

And so while I am not seeking that 30 days should be the standard, it is a starting point to assess where the problems are and then hopefully take corrective action based on the information we get back from the secretary.

Mr. BENISHEK. All right. Okay. Is there any enforcement mechanism about this or is this the beginning?

Mr. ROSS. Mr. Chairman, sadly there is not any enforcement. I say sadly because in most of these regulatory issues we have little enforcement ability with the agencies that we deal with. And I think that one of the things, I would really enjoy working with this Committee, is trying to find an enforcement mechanism.

I think once we identify what the solution should be in terms of the appropriate access to care standard depending on the diagnosis or for that matter just the initial evaluation, then I think we can look at what the enforcement should be for their failure to do so.

I mean, for something that would be, you know, like a physical soft tissue injury, there may not be as great of enforcement penalties, if it was something more of a severe mental health condition or something that requires exigent medical care and treatment at the time.

Mr. BENISHEK. Thank you.

Mr. ROSS. Thank you.

Mr. BENISHEK. Mr. Guthrie, you know, I am excited that you brought this up here because I am a trauma surgeon myself and I got to meet with some of the great urologists that provide urotrauma care. And I just want to commend your efforts to get this thing going here.

I know that this bill would unite public and private resources to address the growing problem in urotrauma.

What is being done in that area to currently make the private and public sector work together?

Mr. GUTHRIE. Well, one of the great examples of that is that one of the people that brought this to my attention is a physician, who you are going to hear from in the second panel, who is in private practice, but was deployed forward with the national guard, so experienced it firsthand and sees it back now, back home in country.

And so what we are hoping to do there, what I am not seeing is the DoD and VA are dealing with this. As I mentioned in my testimony, they are dealing with it through several different categories. And what we are trying to do is unite it. So we do have private research with public research.

I think one example that sort of fits, I mean, in Boston in the marathon blast, I think the trauma surgeons there had been trained with some Israeli surgeons and it just happened that they had that special training at that time and undoubtedly saved lives.

And so what can happen through the military and bringing private sources together can be replicated to help people, not just military folks, but that is what the focus is, try to bring everybody together from both sides, whether you are DoD employed or you are in private practice or private research.

Mr. BENISHEK. Well, I know that it is going to be a challenge for our veterans who want to go home and, yet, in their hometown or their local VA may not have an expert urologist trained in urotrauma and that a task force to address that issue, I think, is a great idea and coordinating care nationally to get the best taking care of this.

Mr. GUTHRIE. The biggest thing I think can come out of this is actually that because our guys have gotten really good unfortunately at training because they see it in Landstuhl and here.

But when our soldiers go home to live out the rest of their lives, I think that is what is so important for this Committee to focus on. They are not going to be in Walter Reed or in Landstuhl for the rest of their lives. They are going to be home and that is what we need to focus on.

Mr. BENISHEK. Thank you.

Mr. GUTHRIE. Thanks for that comment.

Mr. BENISHEK. I will yield now to the Ranking Member, Ms. Brownley, if she has any questions.

Ms. BROWNLEY. I do not have any questions at this time. Thank you.

Mr. BENISHEK. Mr. Wenstrup.

Mr. WENSTRUP. No questions.

Mr. BENISHEK. Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chairman, and thank you for convening this hearing.

I think these are critical issues for us to be dealing with. And I commend you and Ms. Brownley for your leadership on this.

And thank you to our colleagues.

Both of these issues, I think, are critical and I just want to lend my support. I do not have any particular questions. You have been very informative and the testimony is very helpful.

But I just want to say that we appreciate you coming forward. Thank you for service. And please know that on both sides of the

aisle here on the Veterans Committee, these are bipartisan, nonpartisan issues that we want to work with you on and work with the VA and the VSOs and make sure that our troops get the care that they need.

And I am particularly reading the testimony. The confluence of the mental health issues with the complex trauma issues, I think, is the lesson, sadly, that we will all learn from the last 12 years is that from what I hear back in my district in New Hampshire, the impact, the cumulative impact on the family structure.

And I think about the urotrauma issues and I think about more women getting into the military and seeing combat and what the long-term implication is for that for our society.

So I just commend you and I would like to work with you and work with the chair and the Ranking Member on this Committee and just say that I think it is really significant work that we are doing.

Thank you. I yield back the balance of my time.

Mr. BENISHEK. Thank you, Ms. Kuster.

Mr. Huelskamp, do you have any questions for the panel?

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate my colleagues for bringing these proposed bills before the Committee.

I had a couple questions and wanted to see what your thoughts were, particularly first for Congressman Ross.

Recently, the Committee reviewed a report from the OIG about, I think it was entitled Reported Outpatient Wait Times, and what was disturbing to me was some evidence that certain facilities either had an unusual definition of what the wait time was or actually potentially falsified the data.

And I found that very concerning, especially when we talk about the need, and I agree with you, to set a standard by which they will reach. But when we found cases or the OIG found cases where they went in on the day they actually had their appointment, went in, says, okay, that was the wait time, the day they came in rather than the time they applied.

Any thoughts on that and response from, you think, from the Department of Veterans Affairs when we have these kind of things occurring?

Mr. ROSS. Thank you, Mr. Huelskamp.

You know, every specialty, medical specialty has practice protocols by which there is a recommended course of treatment and rehabilitation depending on the diagnosis.

And while not having a single standard is going to work in terms of getting in to see the health care provider that they see, I think what is important is that we make sure that we collect the data appropriately as to when the first request is made until their first evaluation and then subsequent follow-ups can be offered.

But I think that what we are trying to do is recognize that we have a problem here and I think that a lot of it has been covered up and the issue is a lot worse than what we know it to be.

So, again, I would ask to work with this Committee so that we can have some enforcement mechanisms in there to not only hold the Veterans Administration accountable, but also to make sure that those that are collecting the data are doing it appropriately and accurately.

Mr. HUELSKAMP. I appreciate that. I think that is absolutely essential and to create legislation or ways to hold the VA accountable, particularly for those that it aims to serve.

And, Brett, comment for you or question. I serve a very rural district. I am sure you understand that. I was actually visiting with a veteran who was in Syracuse, Kansas and this was about a year ago. And he had noted where he was instructed by the VA to make, I think it was a 260-mile, 261-mile one-way trip.

And he made the round trip three times in ten days and he said, you know, Congressman, the care they wanted me to get, and it was not urology, it was another type of care, I could have got that in my local hospital and the VA would not allow that to happen.

And, by the way, just five days ago, the local hospital announced they could be shutting their doors.

And one issue I have had is, well, how can we make certain that whether on the care that you mention and the care Congressman Ross mentions, they can get that close to home, not only to, you know, help assist the VA, but also to protect our local hospitals.

Any comments you might have for someone like me that serves in a rural area?

Mr. GUTHRIE. Oh, absolutely. I think of it, sir, not just with my bill, but any time a service person wants or serviceman or woman wants service and they can get it locally and they can get what they need locally, you know, if they live next door to the VA hospital. If they live in Nashville, instead of going to Vanderbilt, you go to the VA hospital. I might get that because I live just as close to Nashville.

But if they are, you know, out where you are, they should go get the service where they can get it. And I have people in my district like that, that are not as close to Nashville as I am. I know I am in Kentucky, but we are on the border.

And so I agree with you. I think we ought to find a way to deliver services the best that we can to people in the way that they can receive it.

Mr. HUELSKAMP. Yeah. I appreciate that.

And the VA had an initiative a few years ago. They are proceeding with that, Project Arch, and one of the pilot spots was formerly in my district, but in the first year they had not found a single person that had received mental health services through that pilot project.

And so we have a long ways to go. I appreciate your gentlemen's proposals and I look forward to working with those in the Committee.

And, Mr. Chairman, I yield back.

Mr. BENISHEK. Thank you.

I will now yield to my colleague, Dr. Ruiz.

Mr. RUIZ. Thank you very much, Mr. Chairman.

Thank you both, Dennis and Brett, for your work in introducing these bills.

I applaud and encourage highly the gathering of accurate data. I believe very much in evidence-based medicine, and I believe very much in evidence-based policy. And it is the best way that we can find the bottlenecks that is justified through the information that

we get on performance measurements in order to make the best decisions and the best policy that we can for our veterans.

Brett, I am a strong supporter of our urotrauma surgeons and making sure that we provide the best treatment. This is something that we need to follow through all the way to the outcomes and measuring what those outcomes are.

I know that Dr. Anine has been the champion and going around meeting a lot of us on the Committee. And I applaud his work and I encourage more urologists to do the same.

In terms of the task force, oftentimes, there is concerns that the task force or advisory committee recommendations are ignored and are not very effective. And this is something that we cannot let happen.

So what can we do to ensure that any recommendation is actionable and we can carry through to have some actual outcomes?

Mr. GUTHRIE. Yeah, that is frustrating. Now I say sometimes task forces or good ideas go to die sometimes. And we just have to do the oversight. They have to report two years after the task force is implemented. They have two years, one year for a report, the second year the final report.

And I think it is our job as Members of Congress as people have brought this issue to us, is that to make sure these are implemented and have oversight of the implementation of the task force because it will go as far as we reflect. And hopefully it will go without us, oversight, but certainly our oversight will help it move forward. And I think that is what we have to do is be dedicated to this issue.

Mr. RUIZ. Well, I look forward to working with you on this and after the recommendations are given.

Mr. GUTHRIE. I appreciate that very much.

Mr. RUIZ. I yield back my time.

Mr. GUTHRIE. Really look forward to it.

Mr. BENISHEK. Well, does anyone else have any questions of the panel?

[No response.]

Mr. BENISHEK. Well, I certainly appreciate your time this morning, gentlemen. I am looking forward to working with you on this legislation moving forward. Thanks.

I would like to welcome the second panel to the witness table, please.

Joining us on the second panel will be Dr. Mark Edney, a Member of the Legislative Affairs Committee and the Urotrauma Task Force for the American Urological Association; Mr. Michael O'Rourke who is the Assistant Director of Government Relations for the Blinded Veterans Association; Mr. Adrian Atizado, the Assistant National Legislative Director for the Disabled American Veterans; and Mr. Alex Nicholson, Legislative Director for the Iraq and Afghan Veterans of America; and Ms. Alethea Predeoux, Associate Director for Health Analysis for the Paralyzed Veterans of America.

I hope I got your name right.

Thank you for all your service to our Nation in uniform and through your advocacy work. I appreciate you all being here today and look forward to hearing your views.

And let's begin the panel with Dr. Edney. Please go ahead. You have five minutes.

STATEMENTS OF MARK EDNEY, MEMBER, LEGISLATIVE AFFAIRS COMMITTEE AND UROTRAUMA TASK FORCE, AMERICAN UROLOGICAL ASSOCIATION; MICHAEL O'ROURKE, ASSISTANT DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; ALEX NICHOLSON, LEGISLATIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; ALETHEA PREDEOUX, ASSOCIATE DIRECTOR, HEALTH ANALYSIS, PARALYZED VETERANS OF AMERICA

STATEMENT OF MARK EDNEY

Dr. EDNEY. Chairman Benishek, Ranking Member Brownley, Members of the Committee, honored guests, fellow servicemembers, I thank the Committee on Veterans Affairs' Subcommittee on Health for inviting me to testify regarding H.R. 984, a bipartisan bill introduced by Representative Guthrie, to direct the secretary of Defense to establish a task force on urotrauma.

I am a urologist, a surgical specialist who treats genitourinary disease and injury. I am also an army reservist of 11 years. My active duty tours include service with the 399th combat support hospital in Mosul, Iraq in 2006.

I have treated genitourinary trauma in the theater of operations and I have also participated in its chronic management at our largest military medical center stateside.

It is an honor to represent the American Urological Association, the world's premier professional association of urologists and our Urotrauma Coalition in support of H.R. 984 on behalf of this unique class of injured servicemembers.

Our Urotrauma Coalition includes distinguished medical societies including the American College of Surgeons, the American Congress of Obstetrics and Gynecology, the Society of Women's Health Research, and a diverse group of veteran service organizations and industry partners who all support urotrauma policy initiatives contained in H.R. 984.

Fifty thousand American servicemen and women have been injured in Iraq and Afghanistan. A recent study indicates that about a thousand soldiers have sustained injury to the urogenital organs.

Approximately 60 percent of these injuries involve the external organs including penoscrotal, testicular and urethral injury with another 40 percent involving kidney, ureter and bladder, and in women, the uterus, vagina, fallopian tubes, and ovaries.

Dismounted complex blast injury is the constellation of lower extremity loss, often bilateral, occasionally with upper extremity loss, and often with genitourinary injury.

Urotrauma is up 350 percent in Afghanistan compared to Iraq because of the increased necessity of soldiers to patrol on foot rather than in fortified vehicles.

Although veterans suffering genitourinary injury may exhibit no outward evidence, they suffer the life-changing loss of proper urinary, bowel, and sexual function and fertility. These deficits have

significant effects on marriages, other social relationships, and enormous effects on overall quality of life.

The cumulative physical and psychological impact of urotrauma on these soldiers is no less profound than those recovering from extremity loss and neurocognitive injury.

As a complex injury pattern, urotrauma has not received the same policy attention and care coordination that has been afforded the more common injury patterns such as extremity loss, traumatic brain injury, and eye injury, each with its own center of excellence.

Genitourinary injury is increasingly a critical military women's health issue. With women now able to serve in direct combat roles, we must do better with the care and coordination of urotrauma.

An AUA urotrauma work group was convened in 2009 to define areas of opportunity for improvement in urotrauma care. To broaden the discussion and establish the framework for accomplishing these policy objectives, the AUA with Congressman Guthrie has crafted H.R. 984.

This establishes an interagency task force to study a broad range of opportunities for enhancing the prevention, management, and study of urotrauma. The task force will evaluate and define improvement opportunities in a variety of areas including an assessment of the true scope and impact of the injury pattern, the status of prevention, and assessment of current facilities and programs within the DoD and VA engaged in the prevention, management, and study of urotrauma with a special focus on the status of research, expertise, and health care infrastructure for female victims of urotrauma and then analysis of the reproductive services available to servicemembers who have been rendered infertile as a result of urotrauma.

The care of these complicated injuries requires a tremendous amount of expertise in care coordination. It is clear that the transition of soldiers with urotrauma from the DoD to the VA represents an area of opportunity not only with respect to DoD physician to VA physician communication, but also with the geographic placement of soldiers with these unique needs in proximity to the available expertise, technology, and programs in the VA to provide for their needs.

Finally, although each of the functional challenges that result from damage to the genitourinary organs is life altering, perhaps one of the most profound is the loss of fertility. The brave young Americans who are voluntarily putting themselves in harm's way in defense of our country are often doing so prior to their reproductive years. Some are suffering injuries that severely impair or eliminate their natural reproductive capability, shattering the dream of many to begin a family of their own.

H.R. 984 seeks an analysis of the technical, administrative, and budgetary mechanisms to allow for enhanced reproductive services for members who have been affected by urotrauma or who are at high risk of urotrauma.

The AUA recognizes that there is much to be done in this area from pre-deployment sperm banking to prior preservation of sperm at the initial point of care when testicular loss is inevitable, to providing advanced reproductive services to all military victims of

urotrauma who are infertile and receiving care in the DoD and the VA.

We are currently short of that goal and the AUA working group also supports legislation to enhance these policies.

In summary, the rate of genitourinary injury suffered by American soldiers is up 350 percent in Afghanistan compared to Iraq as a result of the increased necessity of dismounted patrol.

Genitourinary injuries are increasingly common, complex constellation of wounds with devastating long-term implications for urinary, bowel, and sexual function and fertility. These sequelae in turn have profound impacts on soldiers' mental health, marriages, and other social relationships and overall quality of life.

H.R. 984 prescribes the comprehensive study required to address the variety of opportunities for improving the prevention, initial management, care coordination, and research of this devastating and increasingly prevalent pattern of injury. We owe these finest Americans no less for the sacrifices they have made for our great Nation.

On behalf of the American Urological Association and the Urotrauma Coalition partners, I urge you to support H.R. 984 and favorably report it out of the Committee.

Again, I want to thank the Veterans' Affairs Committee for their invitation to testify before you, and I am available to answer any questions.

[THE PREPARED STATEMENT OF MARK EDNEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. Edney. Appreciate your testimony.

Mr. O'Rourke, please proceed.

STATEMENT OF MICHAEL O'ROURKE

Mr. O'ROURKE. Thank you, Mr. Chairman.

On behalf of the Blinded Veterans of America, we thank you for this opportunity to provide testimony on current legislation before the Subcommittee on Health.

Chairman Benishek, Ranking Member Brownley, and Members of the House Committee, we are very interested and look at beneficial travel for blinded veterans, H.R. 1284. We appreciate the Ranking Member Brownley for introducing the bill.

We would like to point out that last week in the Senate, the VA Committee held a hearing on a companion bill, S.633, introduced by Senator Tester that was broadly supported by the witnesses.

The legislation, H.R. 1284, would assist disabled spinal cord injury and blinded or visually impaired veterans who are currently ineligible for beneficial travel benefits. This bill would assist mostly low-income and catastrophically-disabled veterans by removing the travel financial burden to access vital care that will improve independence and quality of life.

We look at the blind rehabilitation centers that the VA provides and the spinal cord injury centers which are probably two of the most renowned facilities the VA has that they utilize. It makes no sense to have developed over the past decades outstanding blind rehabilitation programs known for their very high quality and pa-

tient care, only to tell low-income veterans that they are unable and, therefore, cannot attend these centers.

To put this dilemma in perspective, a large number of our constituents are living at or below the poverty line while the VA means test threshold for travel is $14,340. This bill here would assist individuals to partake at a blind rehabilitation center.

To elaborate on the challenges of the travel for a blinded person, we look at current facts. In a study of new applications for recent vision loss rehabilitative services, seven percent had current major depression and 26.9 percent met the criteria for sub-threshold depression.

Vision loss is a leading cause of falls in the elderly. One study found that visual field loss was associated with a six-fold risk. While only 4.3 percent of those 65 and older in that population live in nursing homes, the number rises to about six percent for those who are visually impaired and 40 percent for those who are blind. Medicare direct cost of this is $11 billion per year.

If blinded or spinal cord injury veterans are not able to obtain the rehabilitative center training to learn to function at home independently because of travel cost barriers, the alternate charges for nursing home care or assisted home care are far larger than they can afford. Thus, the Federal Government usually subsidizes in the form of Medicare.

We caution that private agencies for the blind are located in large urban cities; New York City, Chicago, Seattle, Orlando, or Boston. So travel barriers would preclude utilization of many of these sites for some of our veterans.

VA centers often use specialized nursing, physical therapy, audiology, pharmacy, radiology, and laboratory support services that are necessary for clinical care and blinded veterans.

Again, we stress one of the big challenges is that in the civilian medical world, there is not a high incident of these kinds of facilities that are available to veterans.

That concludes my testimony. I will be able to stand by and answer any questions you might so have.

[THE PREPARED STATEMENT OF MICHAEL O'ROURKE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. O'Rourke. I really appreciate your time.

Mr. Atizado, you can go ahead for five minutes. Thank you.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Thank you, Chairman Benishek, Ranking Member Brownley, Members of the Subcommittee.

On behalf of DAV's 1.2 million wartime wounded and injured veterans, I am pleased to present our views on the legislative measures subject to today's hearing.

Requesting my written testimony be made part of the record, I will only address those bills on today's agenda for which DAV has a mandate from our membership.

The Veterans Integrated Mental Health Care Act of 2013 would establish a new authority for VA to use in contracting for mental health services for eligible veterans.

DAV national resolutions were passed at our most recent national convention which calls for program improvement and enhanced resources for VA mental health programs as well as care coordination when VA purchases care in the community.

However, in light of this Subcommittee's hearing on September 14, 2012, and as Chairman Miller had mentioned in his opening statement, where we had discussed the VA's patient centered community care and non-VA care coordination initiatives. These initiatives are to promote coordinated contract health care services including mental health care.

DAV believes this bill overlaid on these initiatives which are ongoing would hamper VA's efforts and thereby cause disruption and delay to reform all contract and fee-based health care.

Mr. Chairman, I would like to note at this point that it has been years since we have been asking for care coordination in contract care, which is why I believe enactment of this bill should be done prudently.

For these reasons, DAV recommends that this bill be held in abeyance at this time until we realize or at least find out in concrete manner how this bill if enacted would impact the current initiatives.

H.R. 241, The Veterans Timely Access to Health Care Act, would establish a statutory access to care standard of 30 days within the VA health care system. The bill would also require VA to submit to Congress continuing semi-annual performance reports on waiting times.

Timely access to needed medical care is a critical domain of high-quality care. Our membership approved national resolutions addressing timely access to VA health care services for service-disabled veterans.

However, we urge the Committee against prescribing a single standard of waiting times across the universe of appointment types as was mentioned earlier with the first panel. A 30-day standard may lengthen waiting times considering VA's current access standards.

DAV believes the transparency potential conveyed in this bill to document more accurate waiting times is a worthwhile concept. We ask for consideration and adding to the reports greater granularity such as including waiting times for purchased care, care purchased in the community whether it is mental health or inpatient or rehab services.

We also ask for greater specificity in reporting such as performance reporting by each VA facility.

H.R. 288, The CHAMPVA Children's Protection Act of 2013, would extend the maximum age eligibility of a qualifying veteran's child to CHAMPVA coverage from age 23 to 26 only if the child is pursuing a full-time course of instruction at an approved educational institution or is unable to continue to do so because of a disability not resulting from a child's willful misconduct.

Now, DAV supports this measure based on resolution number 222. However, we strongly urge amending it to conform to Public Laws 111–148 and 111–152. These two public laws require private health insurance to cover adult dependent children in covered families until these individuals attain the age of 26 irrespective of mar-

ital status, financial dependency, or other factors, and including in this instance educational status.

DAV urges the measure to be amended to ensure children of severely-disabled veterans and survivors of veterans who have paid the ultimate sacrifice enjoy the same rights and privileges as other young adults of our country.

This concludes my testimony, Mr. Chairman. Thank you for allowing DAV to testify, and I would be pleased to answer any questions you or the Members of the Subcommittee may have.

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

Mr. BENISHEK. Thank you very much for your input, sir. I really appreciate it.

Mr. Nicholson, please proceed with your testimony for five minutes.

STATEMENT OF ALEX NICHOLSON

Mr. NICHOLSON. Thank you, Mr. Chairman, Ranking Member Brownley, and distinguished Members of the Subcommittee.

On behalf of Iraq and Afghanistan Veterans of America or IAVA, we thoroughly appreciate the opportunity to share our views regarding these important pieces of legislation pending before you today.

As many of you know, IAVA is the Nation's first and largest nonprofit, nonpartisan organization for the veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is important but simple, to improve the lives of Iraq and Afghanistan veterans and their families.

With a steadily growing base of over 200,000 members and supporters, we strive to create a society that honors and supports veterans of all generations. IAVA believes that all veterans must have access to quality health care and related services. IAVA is therefore supportive of each of the bills that are the subject of this hearing here today.

With regard to H.R. 241, IAVA supports The Veterans Timely Access to Health Care Act because it will help hold the VA accountable for meeting maximum allowable wait times. A veteran's ability to access timely care plays a vital role in sustaining his or her quality of life post service. But from a mental health point of view in particular, the importance of providing timely care becomes even more critical.

Timely mental health care can sometimes mean the difference between life and death for veterans in crisis. And IAVA believes that every VA medical center and health care provider should be able to provide reasonable standards of timeliness when providing care for veterans.

IAVA also supports H.R. 288, The CHAMPVA Children's Protection Act of 2013. With the enactment of The Affordable Care Act, children up to age 26 can now be covered by their parents' health insurance plans.

While legislation was subsequently enacted to extend this coverage to eligible children of TRICARE recipients, this legislation is still needed so that benefits can also continue to be similarly pro-

vided to children of our Nation's wounded warriors under CHAMPVA.

IAVA also supports H.R. 984 which would establish a task force on urotrauma in order to expand research on and develop new care recommendations for these injuries. Urotrauma, which is often seen in servicemembers and veterans who have sustained blast injuries, has unfortunately become more prevalent among those who have served in Iraq and Afghanistan.

Because of advances in modern treatment practices within the military medical community, servicemembers and veterans are surviving these types of injuries with greater frequency than in past conflicts which means that VA now finds itself treating more injuries such as genitourinary injuries for which there may not be a wide range of experience or vast body of knowledge extant within the system.

IAVA sees H.R. 984 as an important step in providing the necessary research and treatment options to address these serious wounds of war.

IAVA supports H.R. 1284, which would authorize the VA to reimburse the travel costs associated with seeking approved inpatient care at a VA special disabilities rehabilitation program for additional categories of catastrophically-disabled veterans.

We believe this legislation will provide critical assistance for more disabled veterans to allow them to receive the specialized inpatient treatment that they need.

IAVA also supports Chairman Miller's draft bill, The Veterans Integrated Mental Health Care Act. IAVA's 2013 member survey revealed that 80 percent of respondents do not think servicemembers and veterans are getting the mental health care they need.

IAVA believes that one way to help address the mental health care needs of veterans is through building the type of community partnerships that are advocated for and facilitated by this bill, and we believe this bill was a step in the right direction toward building such positive and beneficial community partnerships.

And finally, IAVA supports The Demanding Accountability for Veterans Act, which would formalize the system of accountability within VA, give the VA inspector generals' report recommendations more authority, and institute consequences for failing to fix problems clearly identified by the VA's IG.

IAVA believes this bill will strengthen current systems of accountability by narrowing the focus of scrutiny as to who is responsible for producing and correcting IG identified public safety issues.

Mr. Chairman, we at IAVA again appreciate the opportunity to provide our views on these important pieces of legislation and we look forward to continuing to work with each of you, your staff, and the Subcommittee to improve the lives of veterans and their families.

Thank you for your time and attention.

[THE PREPARED STATEMENT OF ALEX NICHOLSON APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Nicholson. I appreciate your comments.

Ms. Predeoux, five minutes.

STATEMENT OF ALETHEA PREDEOUX

Ms. PREDEOUX. Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, Paralyzed Veterans of America would like to thank you for the opportunity to present our views on health care legislation being considered by this Subcommittee.

These important bills will help ensure that veterans receive the best health care services available. We are particularly pleased that two bills, H.R. 288 and H.R. 1284, that are very high priorities for PVA are being considered today.

My remarks will focus only on a few bills as PVA's full statement has been submitted to the Subcommittee.

At this time, PVA does not support The Veterans Integrated Mental Health Care Act of 2013, a bill that would require the VA to provide veterans with an integrated delivery model for mental health care through care coordination contracts.

The VA is currently working on multiple initiatives to improve care coordination with private providers and increase timely access to mental health services. More specifically, the VA is in the process of transforming its national non-VA care program in an effort to improve coordination services with non-VA providers which includes mental health services.

PVA believes that the current VA initiative should be further developed before additional resources are put into another program for non-VA care coordination.

PVA generally supports the intend of The Veterans Timely Access to Health Care Act which proposes to direct the VA secretary to establish standards of access to care for veterans seeking services from VA medical facilities.

If enacted, this bill would establish a standard for access to care that requires the date on which a veteran contacts the VA seeking an appointment and the date on which a visit with an appropriate health care provider is completed to be 30 days.

While this legislation may potentially improve the delivery of VA services, the language does not take into account the fact that the standard for access to care may vary depending on the type of care needed.

As such, PVA has concerns regarding the use of a 30-day standard for access to care without specifying the type of care that is being provided.

While PVA believes that timely access to quality care is vital to VA's core mission of providing primary care and specialized services to veterans, it is also important that factors such as the nature of the services provided and efficient use of VA staff and resources be considered when developing standards for access to care.

PVA supports H.R. 288, legislation to increase the maximum age for children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans, CHAMPVA.

CHAMPVA is a comprehensive health care program in which the VA shares the cost of covered health care services for eligible beneficiaries including children up to age 23.

As part of health reform, all commercial health insurance coverage increased the age for covered dependents to receive health in-

surance on their parents' plan from 23 years of age to 26 years of age in accordance with the provisions of Public Law 111–148, The Patient Protection and Affordable Care Act.

This change also included health care coverage provided to servicemembers and their families through TRICARE.

Today, the only qualified dependents that are not covered under a parent's health insurance policy up to age 26 are those of 100-percent service-connected disabled veterans covered under CHAMPVA.

This unfortunate oversight has placed a financial burden on these disabled veterans whose children are still dependent upon their parents for medical coverage, particularly if the child has a preexisting medical condition.

PVA believes that this legislation will make the necessary adjustment to help veterans and their families in this position.

Lastly, PVA strongly supports H.R. 1284, a bill that if enacted would provide coverage under the Beneficiary Travel Program to non-service-connected veterans with a spinal cord injury or disorder, double or multiple amputations, or vision impairment.

Too often, catastrophically-disabled veterans, particularly non-service-connected veterans who do not have the benefit of travel reimbursement, choose not to go to VA medical centers for care due to significant costs associated with their travel.

When these veterans do not receive the necessary care, the result is often the development of far worse health conditions and higher medical costs for the VA. For veterans who have sustained a catastrophic injury like a spinal cord injury or disorder, timely and appropriate medical care is vital to their overall health and well-being.

PVA believes that expanding VA's beneficiary travel benefit to this population of severely-disabled veterans will lead to an increasing number of catastrophically-disabled veterans receiving quality, timely comprehensive care and result in long-term cost savings for the VA.

Again, thank you for the opportunity to submit PVA's views on the legislation being considered today, and I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF ALETHEA PREDEOUX APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Ms. Predeoux.

I am going to yield myself a few minutes to ask a few questions about some of the legislation.

I want to thank you all for your candid comments because I think your input is very valuable. I had some of the same thoughts and questions about some of the legislation myself.

I am so happy to hear your opinion. And I hope that you all will be willing to work with the Committee to try to improve some of this legislation.

I know that many of you had concerns about the Chairman's Veterans Integrated Mental Health Care Act. I am concerned about addressing the concerns that you brought up, so hopefully you will be able to work with the Committee and the Chairman to address that.

I have a question concerning my legislation, The Demanding Accountability for Veterans Act. I sponsored this after the Subcommittee had a hearing where they had this IG report where VA has not had a plan for physician staffing the last 30 years. The IG had reported like eight times that we should do something and then the VA reported back, oh, we are going to have something in three years.

I cannot imagine how we could get people to do what they are supposed to do at the VA. With the amount of open IG recommendations, do any of you have any ideas as to how we can make these particular managers more responsible?

I understand that Congress has oversight responsibility, but, we come upon an incident somewhere in the VA and we highlight it here it in Committee and it is talked about everywhere, but there are things going on. There are a thousand open IG recommendations. We cannot get to every one of them in these committees for oversight. The IG is their own oversight.

So shouldn't we have those IG reports have some teeth to them? And I would like to ask any of you if you have any opinion as to what my legislation does or if you have a better idea as to how to hold the VA accountable for getting things done.

Mr. O'Rourke, do you have anything?

Mr. O'ROURKE. No, sir, not at the present time.

Mr. BENISHEK. Mr. Atizado?

Mr. ATIZADO. Thank you for the question, Chairman Benishek.

I can tell you that it is an appropriate question to ask about IGs' recommendations. I actually had the opportunity, probably about a year and a half ago, to try and follow-up on these recommended actions and I could not follow it.

I called between the IG and the program office at VA to see what the status was on the recommendations and for the most part, the actions that were recommended were actually negotiated, which means the recommended actions that were written on the report were not actually the recommended actions that VA was working on as agreed upon by OIG.

Meaning to say, Mr. Benishek, that while this bill intends to put some greater enforcement and accountability on the part of the IG, we have to be a little bit more thoughtful on how this is done.

For example, better definition of what covered reports are. Anything that VA does which is a public health institution deals with public health and safety. Does it include all the reports that the IG provides? What does significant progress mean?

Just some thoughts, Mr. Benishek. That is all I have.

Mr. BENISHEK. I understand what you are thinking, but I am trying to find the best way to do this too. How do we hold the VA accountable? How do we get people to actually produce?

Mr. Nicholson, do you have any other ideas there?

Mr. NICHOLSON. I would just add, Mr. Chairman, that I think we are on the same page in terms of solutions that would actually have teeth to them. You know, I think whether it is public safety issues, IG recommendations, following through on reducing the backlog, it does not sort of matter, you know, what issue you look at, you know, the VA, I think, keeps promising us progress year after year and, you know, we see backlogs and not only disability

claims, you know, issues, but, you know, like you mentioned earlier in following through on all these outstanding IG recommendations.

You know, so something, I think, that would add some teeth to, you know, the accountability factor, I think, would be certainly welcomed by us.

You know, we hear from our members consistently year after year. You know, we do an annual survey of our membership which is one of the largest that is done independently of Iraq and Afghanistan era veterans. And we consistently hear that while veterans are satisfied with the care they receive, they continue to be dissatisfied overall with the VA itself. You know, there is sort of a disconnect between, you know, sort of the tactical level and the strategic level here.

And so, you know, I would say from our perspective solutions like you mentioned with teeth, would certainly be welcome and I think it is, you know, high time that we start adding teeth into these types of bills.

Thank you.

Mr. BENISHEK. I want to talk a bit more about this, but I want to give Ms. Brownley an opportunity to ask some questions.

Ms. BROWNLEY. Thank you, Mr. Chair.

Again, I also want to thank everybody here who has testified and appreciate your comments and recommendations. And I want to particularly thank Mr. O'Rourke for a detailed perspective on H.R. 1284 and the benefits for veterans.

I would like to hear from the Blinded Veterans Association and the DAV and the PVA if they have any comments relative to some of the VA testimony that this particular bill as written might provide some disparate travel eligibility to a limited group of veterans and they would favor opening up the travel benefits to a wider group of veterans, of course contingent upon funding, but would like to hear your response to that suggestion.

Ms. PREDEOUX. I can begin. PVA certainly would not be opposed to expanding that benefit. However, we believe that the three populations that are targeted is a good start simply because these groups have systems or centers of care within the VA that are not always geographically accessible for this population of veterans, these populations of veterans.

When you consider that they may have clinics or other access to VA facilities, comprehensive care that is needed at least at a minimum, oftentimes more, once a year getting to those facilities oftentimes could be three to four hours. And so to ensure that they are receiving the care at least once a year, we wanted to make sure that cost did not prevent them from doing that.

So it is those centers of care oftentimes, we cannot have one everywhere, and particularly in the rural areas, so I think this is a good first step and we would definitely support the expansion of the benefit to other veteran populations.

Ms. BROWNLEY. Thank you.

Mr. Atizado.

Mr. ATIZADO. Ranking Member Brownley, thank you for that question.

So in our testimony, we talk about possibly expanding beyond the current statutory requirement as well as what this bill pro-

poses to do. Simply because there is a provision, actually it is paragraph two below the one that this bill wants to amend, that gives the secretary discretionary authority to provide these benefits to any other veteran that the secretary deems fit or appropriate to which we do not believe it has actually been exercised but for very anecdotal, very specific instances.

For example, facility transfers from SCI to SCI, air travel, things of that nature. So the need is there and there is a wide gap between those anecdotal incidences as well as these three populations. We think it should be a little bit more broader with a sense that there should be more parity.

Yes, the three populations that this bill considers is certainly deserving, but there are others as well, whether it be those who are frail elderly who just cannot drive and need somebody to help them drive to a facility, things of that nature. That is where we would like to see this provision go. We agree with PVA that it is a good first step and would not oppose its enactment.

Ms. BROWNLEY. Thank you for that.

Mr. O'Rourke, do you have any additional comments?

Mr. O'ROURKE. Yes, ma'am. I think the VA has some outstanding facilities and I think that at times they go under-utilized. So my point being here is, we would like to expand into the inpatient treatment facilities more patient care from eligible veterans. And this would be the first step for those that are non-service that come down with age-related disease entities.

As we progress in age, some things just happen to us. We do not want them to happen, but they do. Glaucoma becomes more constant, diabetic neuropathy with the diabetic population.

In our veterans, we look at macular degeneration. We look at the many different types of wounded that are coming back from OIF/OEF that that IED, that blast does not just stop at the TBI or the traumatic brain injury. It affects the eyes. It affects audiology. It affects the lower abdomen.

I wish we had Kevlar to take care of that, but we do have fine upstanding VA facilities that I think are going under-utilized, if that is appropriate terminology. And I think we have the veterans that need and deserve the care at these facilities.

And this travel bill will assist them. And they do such good work there that I would think that it would be advantageous for the VA to do it in many other arenas, but I understand finances. And today's society, I think it is the next right move.

Ms. BROWNLEY. Thank you very much.

And I will yield back to the Chairman.

Mr. BENISHEK. Thank you, Ms. Brownley.

We have a few more questions, but I think maybe I will submit some of the questions that I have to you in writing and hopefully get a response from you there because I know as far as my legislation is concerned, I do not want to have any, you know, let me put it that way, that I want to have some strict definitions of what is going on there so that we can actually hold people accountable and not slip out, if you understand what I mean.

So I truly appreciate all your comments here today and look forward to speaking to you further about these issues and these pieces

of legislation. I truly appreciate your time and you being here today.

So unless you have any other questions, you can expect a few written questions from us, and the panel is now excused. Thank you very much for being here.

And at that point then, we are going to welcome our third and final panel to the witness table. And that will be from the Department of Veterans Affairs Dr. Robert Jesse, the Principal Deputy Under Secretary for Health. Dr. Jesse is accompanied by Susan Blauert, Deputy Assistant General Counsel.

So, Dr. Jesse, thanks for joining us today. I appreciate your presence and I look forward to your comments about the proposed legislation before us. And you can proceed when you are ready.

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

Dr. JESSE. Well, thank you, sir.

And good morning, Chairman Benishek and Ranking Member Brownley and Members of the Subcommittee. And thanks for the opportunity to address the bills on today's agenda and the impact that these are going to have on the VA.

And as you mentioned, I am accompanied by Susan Blauert, VA's Deputy Assistant General Counsel.

Sir, we very much appreciate your continued efforts and those of the Subcommittee to support and improve veterans' health care.

Because of the short time for preparation views, we do not have formal testimony on two of the draft bills, H.R. 241, The Veterans Integrated Mental Health Care Act of 2013, and H.R. 984, Demanding Accountability for Veterans Act of 2013.

Despite not having formal prepared views on these bills, we do recognize the importance of addressing these underlying issues and that are related in each of these bills. In fact, all these bills are issues that are very important to the VA.

For example, we have worked steadily to implement the letter intent of the *Executive Order* improving access to mental health care services for veterans, servicemembers, and military families.

We believe that we have made significant progress towards hiring mental health professionals and many of the other ongoing mental health initiatives demonstrate our strong commitment to ensuring the availability of mental health services to all of our veterans wherever and whenever it is needed.

Likewise, VA understands the needs for a system and organizational processes that support a culture of excellence and one of accountability. And H.R. 241 and your draft Demanding Accountability for Veterans Act both seek to hold VA to high standards. And please know that we share those common values.

And I will take a moment and explain now the position we have on the two bills for which we were able to complete views. There is a more detailed treatment of these in my written statement.

VA generally support bills that expand services to veterans when resources permit us to do so and this would include increasing the

maximum age to 26 for eligibility of young adults covered by our CHAMPVA program.

We are concerned with the bill as it is written because we fear it may not accomplish the objective because it fails to address a technical definition of the term child contained in the current statute. And our written statement provides a more detailed explanation.

I use the term young adults because I have kids that age and they do not like it when I call them children.

Be assured that we are anxious to work with the Committee toward providing the best language to support the intent of the bill. We fully support ensuring that CHAMPVA coverage is consistent with private sector coverage provided under The Affordable Care Act.

The second bill, H.R. 1284, would extend VA's beneficiary travel benefits to certain veterans with vision impairment, spinal cord injury or disorder, and double or multiple amputations.

The eligibility provided in this bill is offered specifically for when this class of veterans is traveling to receive care from the VA's special disabilities rehabilitation program on an inpatient basis or when the trip qualifies for temporary lodging.

And I have been well schooled by Tom Zampieri and Mr. O'Rourke about the complexities of getting particularly blinded veterans back and forth even for their primary care appointments.

We believe the legislation could be improved then by broadening the scope. VA supports extending the beneficiary travel eligibility to all veterans who could most benefit from the program.

VA provides rehabilitation for many injuries and diseases including for veterans who are catastrophically disabled. VA also provides care at numerous specialized centers other than those noted in H.R. 1284.

For example, we have other programs for closed and traumatic brain injury, for post-traumatic stress disorder, military sexual trauma, and other various addiction programs.

Many of these programs provide outpatient care to veterans who might not require lodging, but still travel significant distance or are challenged in traveling to those appointments on a daily basis. And under this proposed legislation, the group of veterans would not be eligible.

For these reasons, VA does not support the legislation as written because it would provide disparate travel eligibility to a limited group of veterans.

However, we do support the idea of travel for a larger group of catastrophically-disabled veterans including veterans who are blind or have SCI and amputees and those with special needs who may not otherwise be eligible for travel benefits.

Once again, VA welcomes the opportunity to work with the Committee to craft appropriate language that is mindful of both resources and especially the needs of these veterans.

So thank you for the opportunity to testify before the Committee and we will be pleased to answer your questions.

[THE PREPARED STATEMENT OF ROBERT L. JESSE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Doctor.

Let me ask you a question. How much time did you have then to prepare for the hearing today? When was the notice given, because you said you did not respond because there was not enough time?

Dr. JESSE. Well, I would defer that to our congressional affairs people because I am not aware exactly when it came in. But I think it was within less than two weeks. So it was a relatively short notice.

Mr. BENISHEK. All right.

Dr. JESSE. We can get the exact timing for you.

Mr. BENISHEK. Well, I am just curious. I think three weeks is probably the standard, I guess, for the hearing notice, and I just feel disappointed when I hear that answer in view of e-mail and that.

Nowadays, it usually happens pretty quickly. So it seems like two weeks would be a pretty good amount of time to figure out a response to some of these legislative ideas.

You understand the purpose of my piece of legislation, Dr. Jesse?

Dr. JESSE. Yes.

Mr. BENISHEK. I am trying to figure out how to get the VA to get some things done that do not seem to be getting done. Some of the comments by the previous panel identified some shortcomings that I do not specifically target what exactly I am looking for.

I just do not like the fact that people, managers of a project, that do not respond to an IG report for over a year and, this incident of, no physician plan for staffing has been going on for 30 years with eight separate IG reports over the past 30 years.

And then when I had them in front of my Committee, a month ago, it was, well, they are going to have a plan in three years. They have agreed that they need a plan for the last 30 years and, yet, nothing is getting done.

So how do I fix that, Dr. Jesse?

Dr. JESSE. So I can, I guess, reflect on that in my experience within the VA. And my job prior to this one was as the director of, well, initially as cardiology and then of medical surgical services.

And I know that there has been work on this, in fact, so I am not sure about the exact date, but it was about the time that I became head of medical surgical services, an office was stood up, the Office of Productivity Evaluation, really looking exactly at this. And it is up in Boston.

And we found that primary care is pretty easy. You can build a panel and we work on a goal of about 1,200 patients per primary care provider. And for specialty care, it is quite a bit harder and——

Mr. BENISHEK. Oh, no, I understand all that for that particular issue. And it is not so much the physicians. The secretary does this kind of stuff all the time. That is just one of the issues that I am getting at. Okay?

Dr. JESSE. Okay. Yeah.

Mr. BENISHEK. I understand that as a physician, you kind of figure this out. You know what I mean? But what I am learning

about there is some manager somewhere whose responsibility it was to get this done and it seems like something could have been done in the last 30 years with eight reports and VA agreeing with the reports, but nothing happening.

And I think that identifying the person in charge of that program is important because when we have these people before us, it is never the actual person that was in charge that actually appears here. And then we have a hard time figuring out who that person actually was.

You understand what I am saying?

Dr. JESSE. Yes. I guess my comment to that would be often it is not a person that gets responsible. So it may not fall under one particular program office at times. And that is part of the problem is—I mean, you are exactly correct—in how one assigns the lines of accountability to get things done. These are often—well, everything is complex in health care.

Mr. BENISHEK. I know. But, I hate when you come up here and you say to me there is no one who is responsible. You said that there. There is not one person responsible, so then how do we hold them accountable because everybody else, they shift that responsibility here and there. It was not my fault. That is not my department.

You know what I mean? We need to have that better defined and I am trying to fix that. And my legislation is an attempt to do that. You know, it may not be perfect. That is why I want input.

Dr. JESSE. No. And I think you are exactly correct in looking at these issues that are open for a long period of time and do not meet their deadlines because clearly there is something wrong if we have committed to do something in a certain amount of time and we are not getting there. Then we owe an explanation as to why.

And sometimes there are very good explanations, but often there are not. And I think when we do not, then we do need to be held accountable for that and to you and with the transparency that we believe we operate under to make that clear.

Mr. BENISHEK. Yeah. Well, I appreciate your comment and the fact that sometimes there is not anyone responsible. That is a really good point that you make there. I think maybe we can try to fix that as we look at, adjusting this bill and actually have it have some teeth. So I appreciate that.

I will allow Ms. Brownley an opportunity to ask questions.

Ms. BROWNLEY. Thank you, Mr. Chair.

And I wanted to follow-up as well on the bill that I am carrying, H.R. 1284. And I certainly appreciate your testimony with regards to expanding these kinds of services to a larger population.

I am just wondering if you have any kind of cost estimate if it were expanded.

Dr. JESSE. I do not have it in my head, but we could certainly get that to you.

Ms. BROWNLEY. So you have looked at it then?

Dr. JESSE. Yeah. I think we have looked into it. I can probably look it up in here, but we can get a rough estimate to you.

I would like to answer that from a different side because it is an important issue and it is not quite as quantitative.

But we know that one of the most costly things in medicine is when people miss appointments and that, in general, making sure that patients get to appointments is in a very broad scope cost effective. And that is not just related to the cost of the travel. It is the cost of the complications of untreated diseases. It is the cost of compliance and all these other things that add in.

And this has been a pretty consistent theme that we have seen, but also in a lot of the other large health systems. And so it is one of the reasons why we are, you know, regardless of the cost, we are very supportive of the ability to get patients to their appointments.

It is also one of the reasons why we are so strongly committed to really moving health care from being about just the appointment to being about the sustained relationships because so many of these issues can be mitigated if patients can just reach into the system and through telehealth, securing messaging, and any other number.

You have all heard a lot about where we are going in those directions. These are important contributors to ensuring good health care, but they are all part of a large package. But that is one of the reasons why we are so strongly committed to that, so that everybody does not have to come in for an appointment, but when they do, we want them there.

And that is why we are very supportive of the transportation and particularly rural transportation. And I know that Mr. Michaud is very committed to this.

Ms. BROWNLEY. Well, just following up with that, and I appreciate your comments relative to that, because I think everybody here really does believe that a bill like this, providing the transportation, making sure that veterans show up for their appointments and so forth in the long term is a cost savings, will be a cost savings to the VA and really a bill like this, I wish it was always presented as a cost savings as opposed to a cost.

And just wondering again whether the VA has done any kind of analysis to demonstrate and quantify, if you will, what the real savings are.

Dr. JESSE. I can get back to you on the record for that. I just cannot tell you right now.

Ms. BROWNLEY. So you actually have all of that information?

Dr. JESSE. Well, I will see what we do have. I know this is an area that we have been very interested in. We have got a lot of interest in looking at this. I just cannot tell you precisely the numbers and data that we have at this time. We will get back to you with where we are on that.

Ms. BROWNLEY. Okay. Great. And I just wanted to follow-up on my colleague's bill, Mr. Michaud's bill and the CHAMPVA, and appreciate your comments vis-a-vis the technical area in the bill and certainly will appreciate your technical assistance so that we can get the bill——

Dr. JESSE. Yeah. We believe this is important. We just want to make sure it is correct.

Ms. BROWNLEY. Okay. Great. Very, very good. And the other thing is that I understand that in terms of identifying the population, the young adults, as you refer to, there were some statistics from the March 31st, 2010 data run.

I am just wondering if there is any updated data on that. I think that the 2010 data run said that the VA estimated a figure of about 59,000 additional young adults would become CHAMPVA eligible and just wondering if you have any updates on that.

Dr. JESSE. I think it is going to be in about that same range.

Ms. BROWNLEY. Okay.

Dr. JESSE. We do know those numbers.

Ms. BROWNLEY. Thank you, sir.

I yield back my time.

Mr. BENISHEK. Well, I have a couple of little follow-up questions.

Dr. JESSE. Sure.

Mr. BENISHEK. I think we are going to end up submitting some written questions to you as well, Dr. Jesse, and I would appreciate your written response to them later.

But one of the comments that Dr. Edney made the urologist that testified talked about the difficulties sometimes coordinating urotrauma care in the VA—when the veteran ends up going to a VA close to his home.

Do you agree that a coordinated centralized effort to treat the long-term urotrauma would be a good idea and how do you see that working within the VA system?

Dr. JESSE. So I was very interested in his testimony. A couple things sort of came to my mind. And one is, as he mentioned, the complexity of moving patients from their active duty into the VA system and it argues very strongly for the work that we are trying to get through at the VLER, the Virtual Lifetime Electronic Record, to make sure that moves across.

VA already has, I think it is about 16 of our VISNs have centers that can deal with complex urinary trauma including the five polytrauma centers. And these are the kind of specialty care that need to go to specialty places.

You know, this is the type of thing that I would normally be thinking about and my thinking on this was changed pretty dramatically about a year ago. I was sitting on a plane and the woman in the middle seat next to me was quite upset. And it turned out why she was upset because her husband was at the front of the plane and she was at the back of the plane. And the guy sitting up front was not willing to change seats with her.

But I got to talking to her. Her husband had complex GU trauma. And I learned an awful lot about—you know, he was getting excellent care for this, but the issue was far beyond the technical surgical care. Really there were just so many complex family issues involved in this.

And that is not the stuff that moves to the specialty centers. Yes, we have expertise in there, but that kind of care needs to go on everywhere when they get back into their communities and it needs to be very much a part of all the rest of the health care that they get.

And that is the coordination piece that I think you talk about. We need to make sure that, you know, our providers are attuned to these issues and can deal with them in more than the technical medical and surgical parts, but also be very attuned to the, you know, the complexities that go on with these.

So, you know, we have done a lot in educating particularly about military sexual trauma. The women's health program in VA is just astounding in the work they have done in the past four or five years and particularly now with work in reproductive health which was part of his testimony.

So all these pieces are, in fact, coming together, but, you know, if it is just about the technical GU surgery piece, I think the specialized centers are really important. But I think we also need to have the windows wide open to see the entire complexity of the situation.

Mr. BENISHEK. Well, I agree with you on that, but I think that the urology specialists provide more than just simply the technical expertise. They provide also a value in understanding some of these social issues sometimes——

Dr. JESSE. Oh, absolutely.

Mr. BENISHEK. —psychosocial issues associated with this trauma sometimes more than the person at the local VA who is taking care of the patient. I agree that the person at the local VA should be in communication with the specialist so they have a familiarity with those things.

But as a general surgeon, I feel a little bit distraught when you say it is simply a technical——

Dr. JESSE. No, I did not mean to imply that.

Mr. BENISHEK. We have more than simply a technical ability. We deal with these issues.

Let me ask you another question if you do not mind. In your written testimony, you stated the VA believes that eligibility for coverage of children under the CHAMPVA would be consistent with certain private sector coverage under The Affordable Care Act. Yet, during the consideration of and the passage of The Affordable Care Act, the Administration did not include in its budget or submit a legislative request to amend the CHAMPVA to extend the coverage for children up to age 26.

Do you know why that happened?

Dr. JESSE. I do not, but we can get that back to you. We are in favor of it. I do not know why it did not come through from us.

Mr. BENISHEK. All right. Ms. Brownley, do you have any other questions?

Ms. BROWNLEY. No.

Mr. BENISHEK. Well, I think that will conclude the hearing today. Please be ready to get the remainder of the questions that we want to have answered to help us formulate this legislation a little better.

But I truly appreciate everyone being here and your comments today and feel free to follow-up with the Subcommittee for any other input you want to provide. And thank you so much for your time this morning.

Dr. JESSE. Thank you, sir.

[Whereupon, at 11:46 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Dan Benishek, Chairman

Good morning. The Subcommittee will come to order.

Thank you all for joining us today as we meet to discuss six legislative proposals aimed at strengthening the health care and services we provide to our honored veterans through the Department of Veterans Affairs (VA).

The six bills on our agenda this morning are:

- draft legislation, the Veterans Integrated Mental Health Care Act of 2013;
- draft legislation, the Demanding Accountability for Veterans Act of 2013;
- H.R. 241, the Veterans Timely Access to Health Care Act;
- H.R. 288, the CHAMPVA Children's Protection Act of 2013;
- H.R. 984, to direct the Secretary of Defense to establish a task force on urotrauma; and,
- H.R. 1284, to provide for coverage under VA's beneficiary travel program for certain disabled veterans for travel for certain special disabilities rehabilitation.

These bills seek to address a number of important issues facing our veterans.

I expect today's hearing to encompass a highly detailed and thorough discussion of the potential merits, challenges, and implications of each proposal before us.

I look forward to working with the Ranking Member, the bill sponsors, and our Subcommittee colleagues to fully evaluate these proposals and ensure that we advance meaningful and appropriate legislation to fulfill the promise we made to our veterans.

My bill - the Demanding Accountability for Veterans Act – is intended to address the pervasive lack of action taken by VA based on their own agreed upon timelines for remediation of issues and recommendations included in VA Inspector General (IG) reports.

Currently, the IG tracks open recommendations on their Web site and in their Semiannual Report to Congress, the latest of which showed that there were 177 total open reports and 1,140 total open recommendations. Of those, 33 reports and 93 recommendations had remained open for more than one year.

My bill would require the IG to make a determination whether VA is making "significant progress" on implementing VA's own agreed upon action plan and timeline to implement the recommendations made by the IG in a report concerning public health or patient safety.

Under the bill, if the IG determines that "significant progress" has not been made, the IG would be required to notify the Committees and the Secretary of the Department's failure to respond appropriately. Following notification, the Secretary, would be given fifteen days to submit the names of each VA manager responsible for taking action to the IG.

In turn, the Secretary would be required to promptly notify each responsible manager of the issue requiring action, direct that manager to resolve the issue, and provide him or her with appropriate counseling and a mitigation plan.

The Secretary would also be required to include in the responsible manager's performance review an evaluation of actions in response to a relevant IG report and prohibit the individual from receiving a bonus or other performance award for failure to take action.

The goal of this legislation is simple – to create a culture within VA where problems that go unresolved are unacceptable.

Far too often, I have seen serious issues that the IG has identified go unaddressed by the Department.

Such inaction is intolerable where the care and services provided to our veterans is concerned and it is well past time for those at VA who are responsible for implementing needed changes to be held accountable for their work.

I am hopeful that the Demanding Accountability for Veterans Act is the first step in ensuring that they are.

I am happy to answer any questions my colleagues may have on this bill and to listen to the views of all of our witnesses.

To that end, I would like to thank all the sponsors for taking the time to speak with us about their proposals today. I am grateful to each for their leadership and advocacy efforts on behalf of our veterans and their families.

I would also like to thank our veteran service organization partners and other stakeholders – both those who will testify here this morning and those who submitted statements for the record – for their valuable input.

I am also grateful to VA for being here to provide the Department's views on these important proposals.

With that, I now yield to Ranking Member Brownley for any opening statement she may have.

Thank you.

Prepared Statement of Hon. Julia Brownley

Thank you Mr. Chairman.

Today, we have a full schedule that includes six bills before us that address some of the unique needs of our Nation's veterans' population. The bills pertain to a variety of areas that affect the lives of veterans every day and this Subcommittee has conducted many oversight hearings to understand the problems and then fix them.

The first two bills on today's agenda, including one of your proposals, Mr. Chairman, are pieces of **draft legislation** to address mental health concerns and increasing accountability at the VA.

The next bill, **H.R. 241, the Veterans Timely Access to Health Care Act,** was introduced by Mr. Ross of Florida and pertains to timely organized and scheduled visits to VA Medical facilities.

H.R. 288, the CHAMPVA Children's Protection Act of 2013 sponsored by Mr. Michaud, Ranking Member of the Full Committee, would amend the maximum age for children to obtain medical care under CHAMPVA from 23 to 26 and effectively reflect the Patient Protection and Affordable Care Act enacted in 2010. I will speak further on this bill during the first panel.

Next, **H.R. 984,** introduced by Mr. Guthrie of Kentucky, would direct the Secretary of Defense to establish a National Taskforce on Urotrauma.

And finally, my bill, **H.R. 1284, the Veterans Medical Access Act,** would provide better access for blind and severely disabled veterans who need to travel long distances to obtain care at a special rehabilitation center. Oftentimes blind and catastrophically disabled veterans choose not to travel to VA medical centers for care because they cannot afford the costs associated with the travel. Currently, the VA is required to cover the cost of transportation for veterans requiring medical care for service-connected injuries. H.R. 1284 would extend these travel benefits to a veteran with vision impairment, a veteran with a spinal cord injury or disorder, or a veteran with double or multiple amputations whose travel is in connection with care provided through a special disabilities rehabilitation program of the VA. Our disabled veterans have already made the greatest of sacrifices and I firmly believe, as I am sure many people in the room here today do, that no veteran should be denied needed medical care.

I thank all of the Members for their thoughtful legislation and I want to thank you, Mr. Chairman, for including my bill here today.

Thank you and I yield back.

Prepared Statement of Hon. Jeff Miller

Thank you, Dan.

It is a pleasure to be here today with you, the Members of the Subcommittee on Health, representatives from our veterans service organizations, and other interested stakeholders and audience members to discuss my draft bill, the Veterans Integrated Mental Health Care Act of 2013.

Two weeks ago yesterday, I spent the day in Atlanta, Georgia, with several Members of the Georgia delegation to discuss inpatient and contract mental health program mismanagement issues at the Atlanta Department of Veterans Affairs Medical Center (VAMC)

This visit occurred after the VA Inspector General (IG) issued two reports, which found that failures in management, leadership, oversight, and care coordination at

the Atlanta VAMC contributed to the suicide deaths of two veteran patients and the overdose deaths of two others.

Alarmingly, the IG found that approximately four-to-five-thousand veteran patients fell through the cracks and were lost in the system, after the Atlanta VAMC failed to adequately coordinate or monitor the care they received under VA's contracts with community mental health providers.

I wish that I could say that the issues in Atlanta are an isolated aberration. Unfortunately, that would be far from the truth.

Rather, the Atlanta story is just the latest in a tragic series of incidents highlighting serious and systemic deficiencies plaguing the provision of mental health care to at-risk veterans through the VA health care system.

Since 2007, VA's mental health care programs, budget, and staff have increased significantly.

Yet, the numbers of veterans taking their own lives has remained stagnant for the past twelve years - with eighteen to twenty-two veteran suicide deaths per day since 1999, according to VA's own numbers.

I could go on but the bottom line is this - the one-size-fits-all path to mental health care that the Department is on is failing the veterans most in need of its services. And, the time to act is now.

I have been and will certainly continue to be a strong and supportive advocate of the VA taking action to hire staff, and address the continued failures of mental health care provided within its own walls.

However, it has become abundantly clear – through the data I have discussed this morning, through Committee oversight, through numerous IG and Government Accountability Office reports, and through the personal accounts of the veteran constituents that call my office and the offices of my colleagues on a daily basis to ask for help – that VA cannot cope with the magnitude of mental health needs our veterans experience in a bureaucratic vacuum with the normal VA business-as-usual approach.

In order to truly maximize mental health care access for today's veterans, VA must embrace an approach to care delivery that treats veterans where and how they want, not just where and how VA wants. Some have said this could undermine VA health care as we know it. Nothing could be further from the truth. This isn't about supplanting the VA health care system, it's about supporting it.

To the contrary, to truly address and resolve the breakdown in the provision of mental health care services to veteran patients, VA must adopt a proactive, integrated, coordinated care delivery model for mental health care.

Most importantly, VA must adopt a mental health care delivery model that is truly veteran-centric – one that meets and cares for veteran patients where they are, treats the entirety of their concerns with supportive and timely wraparound services, and recognizes and respects their unique circumstances, goals, and health care needs throughout their lives as veterans.

That is why I have proposed this draft Veterans Integrated Mental Health Care bill before us. It would take the first important step to help veterans in need, whether those services are provided in or out of VA facilities.

Specifically, the draft bill would:

- require VA to provide mental health care to an eligible veteran who elects to receive such care at a non-VA facility through a care coordination contract with a qualified entity; and,

- require such entity to meet specific performance metrics regarding quality and timeliness of care and exchange relevant clinical information with VA.

It would ensure that existing mental health care resources – both those found within VA facilities and those provided to veterans through fee basis care – are managed effectively.

It would also ensure that the care provided to veteran patients in need of mental health services is timely, convenient, and coordinated from the initial point of contact throughout the recovery process.

I understand that some veterans service organizations (VSOs) have expressed concern about waiting until VA rolls out its own new contract care initiatives.

And – while I appreciate, understand, and respect these views, I look forward to working closely with them to address their concerns – but the time for waiting is over.

Last year, the IG found that more than half of the veterans who go to VA seeking mental health care services wait fifty days on average to receive even an initial evaluation.

This year, the IG found that thousands of Georgia veterans had fallen through giant cracks in VA's mental health care system and may or may not have received the care they so desperately needed.

We cannot wait to see what next year brings.

When a veteran is need of mental health care services, the difference of a day or a week or a month can be the difference between life and death, between contentment and struggle.

The time to act is now.

I look forward to working hand-in-hand with Committee Members, our VSO partners, and other stakeholders to strengthen the language in this draft bill and address any issues that may be raised during the Subcommittee's discussion this morning.

Thank you once again, Dan, for holding this hearing today and for your hard work and steadfast leadership of the Subcommittee on Health. I appreciate the opportunity to be with you all today.

With that, I yield back.

Prepared Statement of Hon. Dennis Ross

Thank you, Chairman Benishek, for holding this hearing today, and for allowing me to testify on behalf of legislation I introduced entitled the Veterans Timely Access to Health Care Act.

America's Veterans are the backbone of the freedom and prosperity this country has enjoyed for over two hundred years. We owe them a debt that we can never truly repay.

Unfortunately, across the country, and across Florida's 15th Congressional District, Veterans continue to encounter unacceptable problems and delays receiving appointments from the Veterans Administration (VA) for essential medical and specialty health care needs.

For instance, the VA has set a goal to provide an initial mental health examination within 14 days from the time a Veteran contacts a VA medical provider to schedule a consultation. They have claimed to meet this goal with a 95% success rate.

However, an Inspector General (IG) 2012 report published greatly contradicts these claims. In fact, this IG report determined the VA only met its goal 49% of the time - with the remaining patients being forced to wait approximately 50 days for the VA to provide this critical mental health evaluation.

To be clear – more than 184,000 Veterans waited approximately 50 days to receive a critical mental health evaluation. Not treatment – just the formal evaluation. This is a disgrace to our Veterans, and something that should not be tolerated.

Additionally, Chairman Mike Coffman of the Subcommittee on Oversight and Investigations held a hearing on March 14, 2013 to examine patient wait times at VA medical facilities. Sadly, the Chairman revealed that according to VA documents, at least two Veterans died last year from diseases while awaiting a medical consultation at the VA.

That is why I am proud to have introduced H.R. 241, the Veterans Timely Access to Health Care Act.

This legislation, supported by the Military Officers Association of America (MOAA) and The Retired Enlisted Association (TREA), will ensure Veterans seeking primary and specialty care from a VA medical facility receive an appointment within 30 days – period.

This legislation also contains a number of detailed reporting requirements, so that Congress may better track the VA's progress. And if the VA discovers they are not meeting their goals and mandated 30-day access to care, it is my hope that they will reach out to Congress before their reports are filed so we can work together to meet the needs of our nation's brave and courageous Veterans.

We are all on the same team, with the same goal of providing timely, high quality care to our Veterans.

However, this legislation will go a long way in ensuring Veteran's critical medical needs, like those needs of more than 184,000 Veterans who waited 50 days for an initial mental health screening, no longer slip through the cracks of the system. It will also prevent the unnecessary loss of life of those Veterans in need of medical care and consultation.

Moving forward, I would like to work with this Subcommittee to strengthen this legislation – potentially including additional access-to-care standards. Today, this legislation is a first step to hold the VA accountable.

Thank you Mr. Chairman, and I yield back the balance of my time.

Prepared Statement of Hon. Brett Guthrie

Good morning and thank you, Chairman Benishek, Ranking Member Brownley, and distinguished colleagues of the House Committee on Veterans' Affairs.

I come before you today as both a Member of Congress and a former Army Officer, to thank you for your past support of a priority issue for wounded warriors, and to ask that you continue to pursue needed work on the subject

As you may know, genitourinary trauma, or simply urotrauma, is a class of wounds that literally hit below the belt. Urotrauma accounts for wounds to the kidneys, reproductive organs, and urinary tract organs. These injuries are some of the most common and debilitating suffered by our veterans from IED detonations and have long-lasting physical and psychological impacts. Urotrauma is one of the signature wounds of the IED and now accounts for one-eighth of all injuries suffered by our troops in Afghanistan. Unfortunately, the most recent available data suggests that this figure is still rising, even after nearly doubling in incidence between 2009 and 2010.

I know that we're in the Veterans' Committee today, but by way of background, let me paraphrase the Department of Defense's report to Congress titled "Genitourinary Trauma in the Military," and the Army Surgeon General's report titled "Dismounted Complex Blast Injury".

According to these papers, urotrauma on today's battlefield exceeds incidence rates of all prior conflicts by at least 350 percent. And yet, the DoD Under Secretary for Personnel and Readiness concedes that "urotrauma injury is not part of the standards of pre-deployment training for U.S. military surgeons and nurses," and that the existing infrastructure for tracking these casualties "is not sufficient to assess the long-term prognosis of GU trauma injuries." This lack of adequate infrastructure is exacerbated by the inherent complications of transitional care from DoD to VA, where most victims will receive treatment for the remainder of their lives.

Now let me say that it is not my view that the VA and DoD are ignoring urotrauma. To the contrary, I believe that many skilled professionals are hard at work on the issue; but as is often the case in government, their efforts are divided, un-integrated, and because of this, less effective.

By my tally, there are six government agencies currently working on urotrauma. And while I'm heartened that this research is occurring, I'm discouraged that there seems to be little dialogue or centralization of information. Put simply, we aren't learning from experience and if we are, we're learning too slowly.

And that's why I introduced H.R. 984, a bill that I have authored with the help of practicing urologists who have cared for wounded warriors in Iraq and Afghanistan. This bill would unite public and private resources to address the growing problem that is urotrauma.

I'd like to highlight two specific opportunities for improved care that are within this committee's jurisdiction.

First, the existing infrastructure to track urotrauma patients is not sufficient. We need the research infrastructure to facilitate urotrauma outcomes research and corresponding follow-up within DoD and, most critically, after transition to the VA. Unfortunately, one thing I have heard time and time again is that the Joint Theater Trauma Registry (JTTR), which tracks approximately 16,000 trauma victims, lacks the specificity of detail needed to accomplish this end. VA, DoD, and health care providers need a better platform to coordinate care across a lifetime for our wounded warriors.

Related to this is the second issue I'd like to focus on – transition of care. Rather than mincing words, I will quote the American Urologists Association's Urotrauma Task Force directly:

"It is clear to those urologists in DoD who care for soldiers with complex urotrauma that the transition to the VA is currently fraught with barriers. These barriers include deficits of communication of the detailed medical and surgical history of injured service members from DoD physicians to VA physicians. Another problem continues to be GU-injured soldiers within the VA system being cared for in locations where access to expertise in GU trauma is lacking."

One solution to this problem would be to designate care coordinators to urotrauma victims. These coordinators would need access to DoD and VA health information and guide our wounded warriors towards existing centers of excellence in polytrauma care.

However, as a Member of Congress, I am not wedded to a single solution to this or any other improvement to urotrauma care. That is why H.R. 984 allows for a "big

tent" solution. As DoD has said in writing, we need "inter-Service and inter-agency relationships to facilitate aggressive, innovative, and relevant translational and outcomes-based clinical research," and that's what H.R. 984 does: bring together VA, DoD, HHS, the Surgeon Generals of each of our Armed Services, and civilian expertise to create a plan to care for these wounded warriors from the point of injury to their final resting place, decades from now.

This is a bipartisan bill with many cosponsors who represent communities like Ft. Knox, in my district, where their constituents are frequently deployed to the front lines. These communities understand the frequency and severity of these wounds at a human level and a professional one. We have all met families who show true courage as they care for their gravely wounded loved ones; and we have met the men who march into harm's way knowing that the next IED could have their name on it.

Let me say in closing that the miracles of modern medicine, combined with the devotion of our military medical corps, have allowed many of these wounded warriors to live long lives rather than dying in the line of duty. However, giving these service men and women the ability to survive is not enough. We have a responsibility to do what we can to ensure that they are allowed to live as full a life as possible. That's the debt we owe to those who defend freedom.

I urge this committee to continue the work it has already done to further our care for these wounded warriors suffering the effects of urotrauma and yield back my time.

Prepared Statement of Mark T. Edney

Chairman Benishek, Ranking Member Brownley, Members of the Committee, honored guests, fellow service members; I thank the Committee on Veterans Affairs, Subcommittee on Heath for inviting me to testify regarding HR 984, a bipartisan bill introduced by Representative Guthrie to direct the Secretary of Defense to establish a task force on urotrauma.

I am a urologist, a surgical specialist who treats genitourinary disease and injury, in private practice in Salisbury, MD. I am also an Army Reservist of 11 years. I have been called to active duty 3 times: first to Walter Reed Army Medical Center in 2004, one tour with the 399th Combat Support Hospital in Mosul, Iraq in the winter of 2006, and finally a tour at Tripler Army Medical Center in 2009. I have treated genitourinary trauma, or urotrauma, in the theater of operations and have participated in its chronic management at our largest military medical centers stateside.

It's an honor to represent the American Urological Association (AUA), the world's premier professional association of urologists, and our urotrauma coalition in support of HR 984 on behalf of this unique class of injured service members. Our urotrauma coalition includes a diverse group of medical societies, veterans' services organizations and industry partners who all support the policy initiatives with respect to genitourinary injury or urotrauma contained in HR 984. Our coalition partners who have pledged their organizational support to our urotrauma initiative include the: American College of Surgeons, American Congress of Obstetrics and Gynecology, American Association of Clinical Urologists, Large Urology Group Practice Association, American Fertility Association, American Society of Andrology, Society for the Study of Male Reproduction, Society of Male Reproduction and Urology, Society for Women's Health Research, Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), AMVETS, Paralyzed Veterans of America, Blinded Veterans Association, Men's Health Network, Zero- The Project to End Prostate Cancer, RESOLVE: The National Infertility Association, Blue Ribbon Advocacy Alliance, Johnson and Johnson, Astellas, and Endo Pharmaceuticals.

There have been approximately 50,000 soldiers wounded in action since 2003 in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Of those, approximately 16,000 injuries are catalogued in the Joint Theater Trauma Registry (JTTR), the inter-service in-theater trauma database that has been in operation since 2003. Recent studies have indicated that 5–10% of battlefield injuries involve injury of the genitourinary (GU) organs for a total of around 1000 GU injuries. Of those, approximately 60% involve the external organs (scrotum, testicles, penis and urethra), and 40% involve other organs including kidneys, bladder, ureters, uterus, fallopian tubes, and ovaries. The DoD's Dismounted Complex Blast Injury Task Force studied and reported on this pattern of injury at the direction of the Army Surgeon General in June, 2011. Because improvised explosive devices (IED) are the enemy's weapon of choice and because soldiers are increasingly required to patrol

on foot or "dismounted" in Afghanistan (as compared to Iraq), the incidence of complex blast injury is up 350% in OEF. Dismounted complex blast injury describes the constellation of catastrophic extremity injury with often bilateral lower limb loss, sometimes together with upper limb loss, traumatic brain injury, and in many cases injury to the genitourinary organs.

Although GU-injured veterans may exhibit no outward signs of their injury, they suffer life-changing loss of proper sexual, bowel, and urinary function and fertility. These deficits have significant social effects on marriages and other relationships and enormous effects on quality of life. The cumulative physical and psychological impact of urotrauma on these soldiers is no less profound than for those recovering from extremity loss and neurocognitive injury. As a complex injury, urotruama has not received the same policy attention and care coordination that has been afforded the more common injury patterns such as extremity loss, traumatic brain injury and eye injury—each with its own DoD center of excellence. Genitourinary injury is increasingly a critical military women's health issue with women now able to serve in direct combat roles. We must do better with the study and care coordination of urotrauma.

In 2009, the AUA convened a working group comprised of AUA members within the Department of Defense (DoD) together with civilian trauma and GU reconstruction experts to formulate policy, craft legislation, and develop a comprehensive legislative strategy. The broad goals of the working group were to: improve the prevention of, improve and educate regarding the initial management of, and better coordinate the chronic care of urotrauma and to enhance urotrauma's research infrastructure to facilitate outcomes research and longitudinal follow-up of urotrauma cases.

As a result of those discussions in 2009, key knowledge gaps were identified, necessitating a broader discussion with respect to the treatment of urotrauma. HR 984 ensures that broader discussions occur by directing the Secretary of Defense to establish a task force on urotrauma. The task force is required to conduct a study of urotrauma among members of the Armed Forces and veterans including: an analysis of the incidence, duration, morbidity rate, and mortality rate of urotrauma; an analysis of the social and economic costs and effects of urotrauma; with respect to the Department of Defense and Department of Veterans Affairs (VA), an evaluation of the facilities, access to private facilities, resources, personnel, and research activities that are related to the diagnosis, prevention, and treatment of urotrauma; an evaluation of the programs (including such biological, behavioral, environmental, and social programs) that improve the prevention or treatment of urotrauma; a long-term plan for the use and organization of the resources of the Federal Government to improve the prevention and treatment of urotrauma; an analysis of the shortfalls in research, expertise, and health care infrastructure for female victims of urotrauma; an analysis of the technical, administrative, and budgetary mechanisms to allow for enhanced reproductive services for members who have been affected by urotruama or who are at high risk of urotrauma; an assessment of opportunities to enhance the coordination of Federal resources used to research, prevent, and continuously improve the management of urotrauma; and inter-agency efforts regarding the chronic physical, behavioral, and emotional care of victims of urotrauma.

With respect to research, I am aware of at least two DoD databases that prospectively collect data on urotrauma injuries for the purpose of longitudinal follow-up and outcomes research: the Walter Reed Army Medical Center (WRAMC)/National Naval Medical Center (NNMC)/ Walter Reed National Military Medical Center (WRNMMC) surgical database that has been in use for 6 years and the Expeditionary Medical Encounter Database (EMED), in operation at the Naval Health Research Center, Medical Modeling, Simulation and Mission Support Division in San Diego, CA. The JTTR, as I mentioned earlier, has catalogued more than 16,000 battlefield traumas since 2003, but lacks specificity for details of urotrauma that would enable longitudinal follow-up and outcomes research. The VA also has a robust repository of patient-level data in its electronic medical record, Vista. The appropriate department should be tasked with coordinating these databases as well as any other similar databases, to ensure that they are collecting appropriate urotrauma measures so that they may facilitate the longitudinal follow-up and outcomes research of urotrauma.

The seamless transition from the DoD to the VA, of the soldier suffering urotrauma with his or her complex care needs, represents an opportunity for improvement. DoD Instruction 1300.24 directs the Assistant Secretary of Defense for Health Affairs under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness to "coordinate with the VA to develop and implement administrative processes, procedures, and standards for transitioning RSMs [recovering service members] from DoD care and treatment to VA care, treatment,

and rehabilitation that are consistent with [language stipulated in the instruction]." A critical element of the transition is that of the transfer of a complete medical and surgical record to accepting providers in the VA. The AUA's working group has heard from a variety of urologists in both the DoD and VA that the record transfer is not happening in many cases.

DoD currently provides a high level of expertise and care coordination for soldiers with urotrauma. However, the difficulty arises when RSMs are transferred to the VA. While the VA has polytrauma centers of excellence with many highly trained surgeons, there are regions of reduced access to the technology and surgical expertise required to care for these complex cases. Therefore, there are opportunities to improve and standardize communication between DoD and VA physicians. There are also opportunities to optimize the placement of GU-injured soldiers in proximity to the expertise and technology that they need and to employ telemedicine and other new information technologies to deliver needed services reducing the impact of geography on access.

Finally, although each of the functional challenges that result from damage to the genitourinary organs is life-altering, perhaps one of the most profound is the loss of fertility. The brave young Americans who are voluntarily putting themselves in harm's way in defense of our country are often doing so prior to their reproductive years. Some are suffering injuries that severely impair or eliminate their natural reproductive capability shattering a dream of many—to begin a family of their own. HR 984 seeks "an analysis of technical, administrative, and budgetary mechanisms to allow for enhanced reproductive services for members who have been affected by urotrauma or who are at high risk of urotrauma". The AUA recognizes that there's much to be done in this area from pre-deployment sperm banking, to cryopreservation of sperm at the initial point of care when testicular loss is inevitable, to providing advanced reproductive services to all military urotrauma victims who are infertile and receiving care in the DoD and VA. We are currently short of that goal and the AUA working group also supports legislation to enhance these policies.

In summary, the rate of genitourinary injury suffered by American soldiers is up 350% in the Afghanistan theater compared to the Iraqi theater as a result of the increased necessity of dismounted patrol. Genitourinary injures are an increasingly common, complex constellation of wounds with devastating long term implications for urinary, bowel, and sexual function and fertility. These sequelae in turn have profound impact on soldiers' mental health, marriages, other social relationships and overall quality of life. HR 984 prescribes the comprehensive study required to address the variety of opportunities for improving the prevention, initial management, care coordination and research of this devastating and increasingly prevalent pattern of injury. We owe these finest of Americans no less for the sacrifices they have made for our great nation. On behalf of the American Urological Association and the urotrauma coalition partners, I urge you to support HR 984 and favorably report it out of the committee.

Again, I want to thank the Veteran's Affairs Committee for their invitation to testify before you and I am available to answer any questions.

Prepared Statement of Mike O'Rourke

INTRODUCTION

On behalf of BVA, thank you for this opportunity to provide testimony today on the current legislation before the Subcommittee on Health. Chairman Benishek, Ranking Member Brownley, and members of the House Committee, thank you for the bringing these bills before the committee. The Blinded Veterans Association (BVA) is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families; BVA has served blinded veterans for over 68 years.

BENEFICIARY TRAVEL FOR BLINDED VETERANS: HR 1284

We appreciate the ranking member Congresswoman Brownley for introducing H.R. 1284 and we would point out that last week the Senate VA Committee held hearing on the companion bill S 633 introduced by Senator Tester that was broadly supported by the witnesses. This legislation would assist disabled spinal cord injured (SCI) and blinded or visually impaired veterans who are currently ineligible for Beneficiary travel benefits. This bill would assist mostly low- income and catastrophically disabled veterans by removing the travel financial burdens to access vital care that improve independence and quality of life. Veterans who must cur-

rently shoulder this hardship, which often involves airfare, can be discouraged by these costs to travel to a Blind Rehabilitation Center (BRC) or Spinal Cord Injury (SCI) VA medical center for either inpatient or residential bed stay while receiving training. The average age of blinded veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group.

It makes little sense to have developed, over the past decades, outstanding blind rehabilitation programs at 13 Blind Centers known for very high quality inpatient specialized services, only to tell low income, non-service connected disabled blinded veterans that they must pay their own travel expenses to access the training they need. To put this dilemma in perspective, a large number of our constituents are living at or below the poverty line while the VA Means threshold for travel assistance sets $14,340 as the income mark for eligibility to receive Means tested travel benefits. VA utilization data revealed that one in three veterans enrolled in VA health care was defined as either a rural resident or a highly rural resident. The data also indicate that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without this financial assistance analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group.[1] In FY 2007, rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400)[2]. The median income of highly rural veterans showed a larger gap at $18,528, adding significant barriers to paying for air travel or other public transportation to enter a BRC or SCI rehabilitation program. More than 70 percent of highly rural veterans must drive more than four hours to receive tertiary care from VA. Private blind outpatient agency services such as Lighthouse for Blind are all located in large urban cities and usually established as outpatient training sites, again barrier for rural veterans traveling long distances every day to get training verses VA rehabilitation centers.

Consider the following facts:

- In a study of new applications for recent vision loss rehabilitation services, 7 percent had current major depression and 26.9 percent met the criteria for subthreshold depression.[3]
- Vision loss is a leading cause of falls in the elderly. One study found that visual field loss was associated with a six-fold risk of falls.[4]
- While only 4.3 percent of the 65 and older population lives in nursing homes, that number rises to 6 percent of those who are visually impaired, and 40 percent of those who are blind and Medicaid direct costs of $11 Billion per year.[5]
- Individuals who are visually impaired are less likely to be employed-44 percent are employed compared to 85 percent of adults with normal vision in working population age 19–64.[6]

If blinded or spinal cord injured veterans are not able to obtain the rehabilitation center training to learn to function at home independently because of travel cost barriers, the alternative—institutional care in nursing homes—may be far more expensive. The average private room charge for nursing home care was $212 daily ($77,380 annually), and for a semi-private room it was $191 ($69,715 annually), according to a MetLife 2008 Survey. Even assisted living center charges of $3,031 per month ($36,372) rose another 2 percent in 2008. BVA would point to these more costly alternatives in describing the advantages of VA Beneficiary Care so that veterans can remain in their homes, functioning safely and independently, and with the rehabilitation training needed to re-enter the workforce. For FY 2014 VA has proposed spending $7,637 Billion in Nursing Home Care program.

We caution that private agencies for the blind are located in large urban cities in New York City, Chicago, Seattle, Orlando, or Boston, so the travel barriers would

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[1] Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics Of Rural Veterans* Issue Brief (Summer 2009).

[2] VSO IB 2013 Beneficiary Travel pg 119–120, 124–125

[3] Horowitz et,.al. 2005, Major and Subthreshold Depression Among Older Adults Seeking Vision Rehabilitation Services The Silver Book 2012, Volume II pg9 *www.silverbook@agingresearch.org*

[4] Ramratten, et.al. 2001 Arch Ophthalmology 119(12) 1788–94. Prevalence and Causes of Visual Field Loss in the Elderly, *www.Silverbook.org/visionloss* Silver Book, Volume II 2012 pg 9

[5] Rein, David B. et.,al. 2006 The Economic Burden of Major Adult Visual Disorders in the U.S. www.Silverbook.org/visionloss Silver Book, Volume II 2012pg 9

[6] Rein, et. al. The Economic Burden of Major Adult Vision Disorders in the U.S. 2006 *www.Silverbook.org/visionloss* Volume II pg. 10

preclude utilization of those sites. VA Centers offer the full specialized nursing, physical therapy, audiology, pharmacy, radiology or laboratory support services that are necessary for the clinical care. BVA requests that private agencies demonstrate peer reviewed quality outcome measurements that VHA Blind Rehabilitative Service have and they must be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

13 Inpatient Blind Rehabilitation Centers (BRCs)

For those members here today we would encourage you to visit one of the 13 VA BRC's and to visit VA SCI locations to better understand the coordinated care being provided at these hub and spoke locations. The BRCs provide the most intense and in-depth rehabilitation to severely disabled blind veterans and servicemembers returning from OIF and OEF. Comprehensive, individualized blind rehabilitation services are provided in an inpatient VA Medical Center environment by a multidisciplinary team of rehabilitation specialists. The management of chronic medical conditions is addressed as part of the training regimen as well. Blind Rehabilitation Specialists guide the individual through a rehabilitation process that leads to adjustment to blindness, new skill development in living skills, orientation and mobility, manual skills, and use of prescribed adaptive technology devices and Computer Access Training (CAT) learning the use of this specialized technology and reorganization of the person's life to enhance their independence. All BRC's use same training approach to maximize the team approach to the needs of each blind veteran. These new skills and attitudes foster new abilities to contribute to family and community life and allow individuals to often regain employment.

BVA supports the change in Beneficiary Travel being proposed in HR 1284 and in our discussions with VA Veterans Travel Program office found support for this legislation that would improve access to rehabilitation care and services for this severely disabled population. Recently VHA however testified before SVAC on S 633 and stated the language currently in this bill was restrictive, and it should include other disabilities like PTSD or TBI veterans. HR 1284 addresses catastrophically disabled veterans going to very specialized rehabilitation centers, and VA operates more than 300 community-based PTSD Vet Center sites, has more than 50 mobile VA centers, and dozens of TBI centers and we would hesitate having the committee broadening this language trying to include many other conditions that are often treated at the 153 VA medical centers.

H.R. 288 CHAMPVA Children's Eligibility Act: BVA fully supports this bill to amend Title 38 USC, to increase the maximum age for children eligible for medical care under the CHAMPVA program that would allow same coverage mandated in other current federal programs. Dependent children who currently turn age 23 have loss of insurance coverage under CHAMPVA and have difficulty finding and being able to afford health insurance. We believe to change this to age 26 is consistent with other mandated coverage for other insurance plans. Often college students or those new graduates who face difficult employment challenges are unable to afford their own health insurance and being covered by CHAMPVA would provide them protection from being uninsured.

Urotrauma Task Force HR 984:

Soldiers who now survive on front line at highest percentages ever however now suffer much more grievous injuries. Bulletproof Kevlar vests protect soldiers' central chest and abdomen, but not their limbs, groin and genitals, and this bill highlight the need for more resources for better care for genito-urinary (GU) wounds. Because there's little research for urologists in the military to draw upon in diagnosing and the surgical initial management and reconstruction of treating these complex cases, plus the social stigma about discussing genitor-urinary problems, this serious life altering injury has received far less attention over past eight years than other combat blast injuries. Most urologists in training and private practices rarely treat civilian patients with these kinds of severe genito-urinary trauma now seen in the military field hospitals or large military trauma centers caused by IED's blasts during dismounted combat patrols.

The Veterans Affairs Office of Public Health tracks veterans who have left active duty in Iraq and Afghanistan and have sought medical treatment in the VA system. From July 2002 through June 2009, 12.5 percent of the 508,000 veterans who sought treatment were diagnosed with diseases or disorders of the genitourinary system, but the report doesn't specify how many of those diagnoses are related to combat injuries and still doesn't report specific GU trauma which we point out high-

lights growing need for joint DOD–VA urological trauma clinical registry for these specific injuries similar to those existing for TBI, amputees, and for vision and hearing.

Again we stress one big challenge is that in the civilian medical world, there is not a high incidence of these kinds of blast urotrauma injuries so development of best practices to treat these kinds of battlefield genitourinary system injuries from this Task Force are urgently needed and DOD and VA must find improved reconstructive approaches for them. Genitor-urinary system mutilation can cause incontinence, infertility, impotence, recurrent infections in these young service members, plus they have emotional and psychological consequences of depression, and psychosocial isolation, and are at higher rates suicide risk in this young mostly male population. It is imperative, therefore, management of this complex pattern of GU injury requires attention paid towards surgical reconstruction and psychological health of these urological injuries with adequate deployment peer reviewed genitor-urinary trauma research funding.

GENITOURINARY (GU) RECONSTRUCTION

GU interventions must be performed in multiple stages starting at front line field surgical sites. If extensive soft tissue is lost, finding adequate tissue to cover these wounds, debridement, immediate wound management, then later in evacuation chain when is best time to perform reconstruction is more challenging. Individuals with Dismounted Combat Battle Injury (DCBI) and genital injury will often require a protracted inpatient/outpatient stay. It is best if these injuries are managed by the same surgical team over time rather than transferring care elsewhere. Because of this, provisions must be made to have adequate staffing, housing, administrative, and medical support at Role V facilities to provide protracted care for these individuals. Currently, there are a limited number of providers (civilian and military) who perform phallic reconstruction surgery—thus indicating the need to train more military urologists and plastic surgeons in these techniques. [7]

GENITAL LOSS AND HORMONAL CONCERNS

While GU injuries present complex surgical and behavioral health challenges, other medical issues must be addressed. Low testosterone levels have been reported after trauma, serum testosterone levels are significantly reduced. Therefore testicular loss will only complicate further hormone deprivation. The role of hormone replacement to promote soft tissue and nervous tissue healing has not yet been determined. It is also unknown when the optimal timing for replacement should begin. Given the long-term needs of hormonal replacement and monitoring, systems should be established to provide life-long care by medical specialists in this area. BVA strongly supports passage of this bill by the HVAC and HASC.

H.R. 241 "Timely Access to Health Care Act"

BVA supports the recommendations made in the Veteran Service Organizations Independent Budget (VSOIB) FY 2014 section on the problems of access to care and waiting times. VHA managers plan budget priorities, measure organizational and individual medical center directors' performance, and determine whether strategic goals are met, in part by reviewing data on waiting times and lists. However, they cannot manage and improve what they cannot measure. Unreliable data compromise meaningful analyses for decision making on the timeliness of access and trends in demand for health care services, treatments, and providers.

The OIG reports of 2005, 2007, and 2012 reiterate the continuing weaknesses causing VA's failure to meet its own access standards. Based on the reports by the OIG and Booz Allen Hamilton137 on the weaknesses in the Department's outpatient scheduling process, the VHA needs to improve data systems that record and manage waiting lists for primary care, and improve the availability of some clinical programs to minimize unnecessary delays in scheduling specialty health care. [8]

BVA appreciates that the committee has investigated the long standing problems over waiting times for clinic appointments and has heard previously in other recent hearings on March 13 about the finding of GAO "Waiting For Care; Examining Patient Wait Times at VA" the testimony by the Director, Health Care Government Accountability Office, Debra Draper provided recommendations. [9] GAO outlined problems found in examining wait times at various VA clinics that despite attempts to solve the problem "VHA report times are unreliable and there was inconsistent

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[7] Surgeon General Army Report Dismounted Combat Battle Injury (DCBI) pg. 45

[8] VSOIB FY 2014 Medical Care Access pg. 89–90.

[9] GAO "Waiting For Care; Examining Patient Wait Times at VA" Testimony Director, Health Care Government Accountability Office, Debra Draper March 13, 2013 pg. 3.

implementation of certain elements of VHA's scheduling policy." [10] BVA supports the intent of HR 241 to address this problem.

DRAFT "Veterans Integrated Mental Health Care Act of 2013":

The problems of mental health care access and wait times in this area are ongoing concern to BVA and the other veteran service organizations as suicides have increased despite numerous programs by both DOD and VA that have been established in the past few years and growing numbers of veterans are being diagnosed with variety of mental health disorders we feel more must be done. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in fiscal year (FY) 2006 to more than 1.3 million in FY 2012 [11]. One major reason for this increase is VA's proactive screening of all Veterans to identify those who may have symptoms of depression, Post Traumatic Stress Disorder (PTSD), problem use of alcohol or who have experienced military sexual trauma (MST).

BVA applauds efforts made by VA and the DOD to improve the safety, consistency, and effectiveness of mental health care programs for servicemembers and veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans with wartime service and post-deployment readjustment needs. [12]

While the VSOs are pleased with VA's progress in implementing its Mental Health Strategic Plan, and veterans who are able to get care from the 300 Vet Centers are very satisfied, we still have concerns that these goals may be frustrated unless proper oversight is provided and VA enforces its own mechanisms to ensure its policies at the top are reflected as results on the ground in VA facilities. As members here know VA announcement from the Secretary of Veterans Affairs Eric K. Shinseki the department would add approximately 1,600 mental health clinicians – to include nurses, psychiatrists, psychologists, and social workers as well as nearly 300 support staff to its existing workforce of 20,590 mental health staff as part of an ongoing review of mental health operations. [13]

While VA has increased the total numbers of full time psychiatrists in 2006 from 1,836 to FY 2012 up to 2,586, and the number of psychologists 1,788 from FY 2006 up to 4,200 in FY 2012, and VA also has 3,498 clinical social workers, and 645 nurse practitioners full time assigned to mental health clinics with additional 244 advanced practice nurses. [14] Still as everyone knows here the wait times grow and so does the OIF OEF enrollment numbers. DOD and VA both continue struggling to hire the same pool of mental health providers and each agency will probably continue to fail to meet the growing demands. We must find alternatives to provide care.

Chairman Miller draft "Veterans Integrated Mental Health Care Act of 2013" would provide mechanisms for medical centers to coordinate necessary clinical services through care-coordination contracts. BVA supports the draft version of this and stresses that ensuring that any veteran that obtains care has their medical records sent to the VA is vital. The VA should exchange clinical best practice guidelines with outside providers on management.

CONCLUSION

Chairman Benishek and Ranking member Brownley, BVA again expresses its support for these proposed changes to VHA programs listed above being considered here today. BVA appreciates the opportunity to provide this testimony today and be glad to answer any questions now.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501c (3) congressionally chartered, nonprofit membership organization.

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[10] Ibid VSOIB FY 2014 pg. 90
[11] VHA Mental Health Care Services March 2013 report.
[12] 12 VSOIB FY 2014 pg. 75–76
[13] VA Press Release April 12, 2012 Mental Health Care Services Expansion
[14] VHA Report Mental Health Providers Full Time 2006–2012 BVA request March 2012

Prepared Statement of Adrian M. Atizado

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

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

Draft Bill, the Demanding Accountability for Veterans Act of 2013

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

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

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

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

This draft bill proposed by the Chairman of the full Committee would establish a new authority for VA to use in contracting for VA mental health care services for eligible veterans. It would place in the hands of a veteran certain mandatory information provided by VA to guide the veteran in making a voluntary decision on whether to receive care in a VA facility, or to receive it in a non-VA facility. The bill would further require VA to contract with qualified entities that administer networks of health care providers, including those experienced in administering the TRICARE networks, to provide coordinated mental health care. The bill would require a series of performance qualifications standards that must be met by such contractors, and would require VA to dispense or pay for prescriptions written for veterans under this program by contractor providers on the same basis as it does for other veterans receiving VA-authorized contract care under section 1703 of title 38, United States Code.

Mr. Chairman, your Subcommittee held a hearing on September 14, 2012, to discuss and consider VA's multiple approaches to providing contract health care services, including specific focus on the upcoming award of VA contracts to regionalized entities that will administer coordination of care through provider networks, including mental health care. I had the privilege of testifying on behalf of DAV at that hearing, and I would call your attention to my complete statement [1] as well as to Dr. Robert Petzel's statement, made on behalf of VA. I quote a small but crucial element of VA's statement for the benefit of the Subcommittee with respect to this bill, as follows:

PCCC [Patient Centered Community Care] will consist of a network of centrally supported standardized health care contracts, available throughout VHA's Veterans Integrated Service Networks (VISN). This initiative will focus on ensuring proper coordination between VA and non-VA providers. PCCC is not intended to increase the purchasing of non-VA care, but rather to improve management and oversight of the care that is currently purchased. This includes improvements in numerous

[1] *http://dav.org/voters/documents/statements/Atizado20120914.pdf*

areas such as consistent clinical quality standards across all contracts, standardized referral processes, and timeliness of receipt of clinical information from non-VA providers. The goal of this program is to ensure Veterans receive care from community providers that is timely, accessible, and courteous, that honors Veterans' preferences, enhances medical documentation sharing, and that is coordinated with VA providers when VA services are not available.

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

In a precedent-setting effort to reform VA contract care, the Department is again receiving bids under PCCC from entities that are qualified and prepared to deliver not only mental health services but a wide range of other specialty health care services, one must question whether Congress, in enacting a new contracting mandate exclusively limited to mental health services would hamper VA's efforts and inject additional uncertainty to those firms that bid for PCCC contracts, and thereby cause disruption and delay in VA's plans to reform all contract and fee-basis health care. For these reasons, DAV recommends this bill be held in abeyance at this time. Our National Resolution No. 210 calls for program improvement and enhanced resources for VA mental health care programs, but we believe this bill, overlayed on the PCCC effort, could have the opposite effect. Therefore, we cannot support this bill in its current form.

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

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

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

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

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

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

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

timely access as a key element in health care delivery, health care quality and health care satisfaction, we would support the bill and urge its enactment.

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

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

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

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

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

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

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

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

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

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

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

[2] *http://www.health.mil/Libraries/110808—TCCC—Course—Materials/0766–DCBI–Task-Force-Report-Final-Redacted-110921.pdf*

[3] *http://tricare.mil/tma/congressionalinformation/downloads/H.Rpt.%20111–491%20Page%20316%20Genitourinary%20Trauma%20in%20the%20Military.pdf*

long-term outcomes. Presumably, the new task force authorized by this bill would address these earlier recommendations.

H.R. 1284

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

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

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

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

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

Prepared Statement of Alexander Nicholson

Bill #	Bill Name	Sponsor	Position
H.R. 241	Veterans Timely Access to Health Care Act	Ross	Support
H.R. 288	CHAMPVA Children's Protection Act of 2013	Michaud	Support
H.R. 984	A bill to direct the Secretary of Defense to establish a task force on urotruama	Guthrie	Support
H.R. 1284	A bill to provide for coverage for certain eligible veterans under the beneficiary travel program	Brownley	Support
DRAFT	Veterans Integrated Mental Health Care Act of 2013	Miller	Support
DRAFT	Demanding Accountability for Veterans Act	Benishek	Support

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

On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding these important pieces of legislation.

IAVA is the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of over 200,000 members

and supporters, we strive to help create a society that honors and supports veterans of all generations.

IAVA believes that all veterans must have access to quality health care and related services. The men and women who volunteer to serve in our nation's military do so with the understanding that they and their families will be cared for during their period of service, and also after their period of service should they sustain injuries or disabilities while serving.

H.R. 241

IAVA supports H.R. 241, the Veterans Timely Access to Health Care Act, which would mandate that an acceptable VA health care appointment wait time is no more than 30 days from the date requested by the veteran. This bill will also help hold VA accountable for meeting this maximum allowable wait time through mandatory quarterly reviews and reporting on timeliness to this Committee. IAVA believes that all veterans should have equal and timely access to VA health care, regardless of where they reside. Furthermore, IAVA believes that a veteran's ability to access timely care plays a vital role in sustaining his or her quality of life. Moreover, from a mental health point of view, the importance of providing timely care becomes even more critical. Timely mental health care can sometimes mean the difference between life and death for veterans in crisis. IAVA believes that every VA medical center and VA health care provider should be held to the same reasonable standards of timeliness when providing care for veterans.

H.R. 288

IAVA supports H.R. 288, the CHAMPVA Children's Protection Act of 2013. With the enactment of the Affordable Care Act, children up to age 26 can now be covered by their parents' health insurance plans. However, these provisions did not extend to recipients of TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). While legislation was subsequently enacted to extend this coverage option to eligible children of TRICARE recipients, no action has been taken on behalf of the same population under CHAMPVA. IAVA believes that we must enact this bill so that CHAMPVA benefits continue to be provided to the children of our nation's wounded warriors and those who paid the ultimate price in service to our country.

H.R.984

IAVA supports H.R. 984, which would direct the Secretary of Defense to establish a task force on urotrauma in order to expand research on and develop new care recommendations for these injuries. Urotrauma, which involves an injury to the genitourinary system and is often seen in service members and veterans who have sustained blast injuries, is becoming more prevalent among today's veteran population, especially among those who served in Iraq and Afghanistan. Additionally, the increased weight of modern body armor and gear worn by today's service members can strain the abdominal muscles over time, which can also damage urinary function and other parts of the genitourinary system. While the number of urotrauma injuries has continued to rise, the body of knowledge on and available treatment options for these injuries have remained relatively stagnant. IAVA believes H.R. 984 is an important step in providing the necessary research and treatment options to address these serious wounds of war.

H.R.1284

IAVA supports H.R. 1284, which would authorize the VA to reimburse the travel costs associated with seeking approved in-patient care at a VA Special Disabilities Rehabilitation Program for additional categories of catastrophically disabled veterans. Under current law, the VA reimburses certain veterans for costs associated with travel to and from approved VA medical facilities. However, there are certain categories of catastrophically disabled veterans who are not entitled to this reimbursement. We believe this legislation would provide critical assistance for more disabled veterans to allow them to receive the specialized in-patient treatment they need.

DRAFT BILL (Rep. Miller)

IAVA supports the Veterans Integrated Mental Health Care Act of 2013, which would assist veterans with accessing quality mental health care through VA-approved providers and TRICARE program networks. The overall shortage of mental health care providers is seriously impacting both VA and DoD. IAVA's 2013 membership survey revealed that 80 percent of our respondents don't think service members and veterans are getting the mental health care they need. IAVA believes that one way to help address the mental health care needs of veterans is through build-

ing the type of community partnerships that are advocated in and facilitated by this bill. These partnerships, which VA can use to help fill in gaps in its ability to deliver care and services, will allow veterans who would have otherwise had very lengthy wait times the opportunity to receive timely mental health care in their local communities. We believe this bill is a step in the right direction toward building such positive and beneficial community partnerships.

DRAFT BILL (Rep. Benishek)

IAVA supports the Demanding Accountability for Veterans Act, which would formalize a system of accountability within VA, give the VA's Office of the Inspector General (OIG) report recommendations more authority, and institute consequences for failing to fix problems clearly identified by the OIG. IAVA believes this bill will strengthen current systems of accountability by narrowing the focus of scrutiny as to who is responsible for producing and correcting OIG-identified public safety issues.

Mr. Chairman, we at IAVA again appreciate the opportunity to offer our views on these important pieces of legislation, and we look forward to continuing to work with each of you, your staff, and the Subcommittee to improve the lives of veterans and their families. Thank you for your time and attention.

Prepared Statement of Alethea Predeoux

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on health care legislation being considered by the Subcommittee. These important bills will help ensure that veterans receive the best health care services available. We are particularly pleased that two bills—H.R. 288 and H.R. 1284 that are very high priorities for PVA—are being considered.

The "Veterans Integrated Mental Health Care Act of 2013"

PVA does not support the, "Veterans Integrated Mental health Care Act of 2013," a bill to amend title 38, U.S.C. to direct the Secretary of Veterans Affairs to provide certain veterans with an integrated delivery model for mental health care through care-coordination contracts. The VA is currently working on multiple initiatives to improve care-coordination with private providers and increase timely access to mental health services. Specifically, the VA is developing mental health contracts with community based providers as required by the President's Executive Order #13625—"Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," and is also in the process of transforming its national non-VA care program in an effort to improve coordination services with non-VA providers, which includes mental health services. PVA believes that the current VA initiatives should be further developed before additional resources are put into another program for non-VA care-coordination.

The "Veterans Timely Access to Health Care Act"

PVA generally supports the intent of the, "Veterans Timely Access to Health Care Act," which proposes to direct the Secretary of the VA to establish standards of access to care for veterans seeking health care from VA medical facilities. If enacted, this bill would establish a standard for access to care that requires the date on which a veteran contacts the VA seeking an appointment and the date on which a visit with an appropriate health care provider is completed to be 30 days. While this legislation may potentially improve the delivery of VA services, the language does not take into account the fact that the standard for access to care may vary depending on the type of care needed. As such, PVA has concerns regarding the use of a 30 day standard for access to care without specifying the type of care that is being provided. While PVA believes that timely access to quality care is vital to VA's core mission of providing primary care and specialized services to veterans, it is also important that factors such as the nature of the services provided and efficient use of VA staff and resources be considered when developing standards for access to care.

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

PVA supports H.R. 288, legislation to amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the Civilian

Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA is a comprehensive health care program in which the VA shares the cost of covered health care services for eligible beneficiaries, including children up to age 23. As a part of health reform, all commercial health insurance coverage increased the age for covered dependents to receive health insurance on their parents plan from 23 years of age to 26 years, in accordance with the provisions of P.L. 111–148, the "Patient Protection and Affordable Care Act." This change also included health care coverage provided to service members and their families through TRICARE.

Today, the only qualified dependents that are not covered under a parent's health insurance policy up to age 26 are those of 100 percent service-connected disabled veterans covered under CHAMPVA. This unfortunate oversight has placed a financial burden on these disabled veterans whose children are still dependent upon the parents for medical coverage, particularly if the child has a preexisting medical condition. PVA strongly supports this legislation because it will make the necessary adjustment in this VA benefit.

H.R. 984, Urotrauma Task Force

PVA supports H.R. 984, legislation that would establish a national Task Force on Urotrauma. Since 2005, the rate of injury to the urogenital organs of service men and women has increased to approximately 10 percent of all war injuries in both Iraq and Afghanistan. The majority of these devastating injuries are the result of exposure to improvised explosive devices (IEDs), with many others from gunshot wounds to the pelvis or abdomen. Similarly, non-urologic injuries such as spinal cord injury affect urologic function. Although less common than extremity injury, trauma to the urogenital organs is no less debilitating both physically and psychologically.

This proposed bill requires the Department of Defense, in conjunction with the VA and the Department of Health & Human Services, to establish a national commission on urotrauma. The commission's objectives are:

1) to conduct a comprehensive study of the present state of knowledge of the incidence and duration of, and morbidity and mortality rates resulting from urotrauma;

2) to study the social and economic impact of such conditions;

3) evaluate the public and private facilities and resources (including trained personnel and research activities) for the prevention, diagnosis, treatment of, and research in such conditions; and

4) to identify programs (including biological, behavioral, environmental, and social) through which improvement in the management of urotrauma can be accomplished.

The nature of the sacrifice that the service men and women who have experienced urogenital injuries have made is beyond measure. It is incumbent upon Congress and the Administration to take every step necessary to help make these men and women as whole as possible. This task force is a necessary first step.

H.R. 1284

PVA strongly supports H.R. 1284, a bill to amend title 38, U.S.C., to provide for coverage under the beneficiary travel program of the VA of certain non-service connected catastrophically disabled veterans for travel in connection with certain special disabilities rehabilitation. This legislation is one of our priorities for the current Congress. If enacted, this legislation would provide reimbursement for travel that is in connection with care provided through a VA special disabilities rehabilitation program to veterans with a spinal cord injury or disorder, double or multiple amputations, or vision impairment. Such care must also be provided on an inpatient basis or during temporary lodging at a VA facility.

For this particular population of veterans, their routine annual examinations often require inpatient stays, and as a result, significant travel costs are incurred by these veterans. Too often, catastrophically disabled veterans, particularly non-service connected veterans who do not have the benefit of travel reimbursement, choose not to travel to VA medical centers for care due to significant costs associated with their travel. When these veterans do not receive the necessary care, the result is often the development of far worse health conditions and higher medical costs for the VA. For veterans who have sustained a catastrophic injury like a spinal cord injury or disorder, timely and appropriate medical care is vital to their overall health and well-being.

PVA believes that expanding VA's beneficiary travel benefit to this population of severely disabled veterans will lead to an increasing number of catastrophically disabled veterans receiving quality, timely comprehensive care, and result in long-term cost savings for the VA. Eliminating the burden of transportation costs as a barrier to receiving health care, will improve veterans' overall health and well being, as well as decrease, if not prevent, future costs associated with exacerbated health conditions due to postponed care.

The "Demanding Accountability for Veterans Act of 2013"

PVA does not have an official position on the, "Demanding Accountability for Veterans Act of 2013." If enacted, this bill would amend title 38 U.S.C. to improve the accountability of the VA secretary to the Inspector General of the VA. PVA supports the overall intent of this legislation to guarantee that systems of checks and balances are in place to help make certain that federal services are effective and provided in a timely manner. PVA believes that it is the responsibility of the VA to provide an action plan in response to VA Inspector General Reports, and carry out such plans as determined appropriate for the successful delivery of veterans' benefits and health care services. Yet, we must question the need for such legislation when Congress already has the authority to conduct oversight.

We would once again like to thank the Subcommittee for the opportunity to submit our views on the legislation considered today. Enactment of much of the proposed legislation will significantly enhance the health care services available to veterans, service members, and their families. We would be happy to answer any questions that you may have for the record.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

No federal grants or contracts received.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $262,787.

Prepared Statement of Robert L. Jesse

Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today is Susan Blauert, Deputy Assistant General Counsel.

Because of the time afforded for preparation of views, we do not yet have cleared views on H.R. 241, H.R. 984, the draft bill "the Veterans Integrated Mental Health Care Act of 2013" and the draft bill "the Demanding Accountability for Veterans Act of 2013".

H.R. 288 Increase of Maximum Age for Children Eligible for Medical Care Under CHAMPVA Program.

The intent of H.R. 288 as expressed in its subtitle is to increase the maximum age for children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). However, VA believes the language in H.R. 288, as written, may not accomplish this intent because it does not address the definition of "child" in 38 U.S.C. § 101 which limits eligibility for children under CHAMPVA in 38 U.S.C. § 1781. VA would be glad to provide technical assistance to the Subcommittee if it does intend to extend eligibility for coverage of children under CHAMPVA until they reach age 26. VA believes that eligibility for coverage of children under CHAMPVA should be consistent with certain private sector coverage under the Affordable Care Act.

Assuming the intent of H.R. 288 is to accord the eligibility for medical care under CHAMPVA to children until they reach the age of 26, VA supports it, contingent upon Congress providing additional funding to support the change in eligibility. Should the bill carry out that intent, VA estimates costs of $51 million in FY 2014; $301 million over 5 years; and $750 million over 10 years.

H.R. 1284 Coverage Under Department of Veterans Affairs Beneficiary Travel Program of Travel in Connection with Certain Special Disabilities Rehabilitation.

H.R. 1284 would amend VA's beneficiary travel statute to ensure beneficiary travel eligibility for Veterans with vision impairment, Veterans with spinal cord injury (SCI) or disorder, and Veterans with double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program (including programs provided by spinal cord injury centers, blind rehabilitation centers, and prosthetics rehabilitation centers), but only when such care is provided on an in-patient basis or during a period in which VA provides the Veteran with temporary lodging at a VA facility to make the care more accessible. VA would be required to report to the Committees on Veterans' Affairs of the Senate and House of Representatives no later than 180 days after enactment on the beneficiary travel program as amended by this legislation, including the cost of the program, the number of Veterans served by the program, and any other matters the Secretary considers appropriate. The amendments made by this legislation would take effect on the first day of the first fiscal year that begins after enactment.

VA supports the intent of broadening beneficiary travel eligibility for those Veterans who could most benefit from the program, contingent on provision of funding, but believes this legislation could be improved by changing its scope. As written, the bill could be construed to apply for travel only in connection with care provided through VA's special rehabilitation program centers and would apply only when such care is being provided to Veterans with specified medical conditions on an in-patient basis or when the Veteran must be lodged. VA provides rehabilitation for many injuries and diseases, including for Veterans who are "Catastrophically Disabled," at numerous specialized centers other than those noted in H.R. 1284, including programs for Closed and Traumatic Brain Injury (CBI+TBI), Post-traumatic Stress Disorder and other mental health issues, Parkinson's Disease, Multiple Sclerosis, Epilepsy, War Related Injury, Military Sexual Trauma, Woman's Programs, Pain Management, and various addiction programs. In addition, many of these programs provide outpatient care to Veterans who might not require lodging but must travel significant distances on a daily basis who would not be eligible under this legislation.

Therefore, VA feels that the legislation as written would provide disparate travel eligibility to a limited group of Veterans. However, VA does support the idea of travel for a larger group of "Catastrophically Disabled" Veterans (including Veterans who are blind or have SCI and amputees) and those with special needs who may not be otherwise eligible for VA travel benefits. VA welcomes the opportunity to work with the Committee to craft appropriate language as well as ensure that resources are available to support any travel eligibility increase that might impact upon provision of VA health care.

VHA estimates costs for this provision as $2.4 million for FY 2014; $13.1 million over 5 years; and $29.8 million over 10 years.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members may have.

Statements For The Record

THE AMERICAN LEGION

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

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide certain veterans with an integrated delivery model for mental health care through care-coordination contracts.

The American Legion believes that veterans should not be denied earned care based on where they choose to live. While we understand that it is not feasible for every community to have a full slate of VA-administered services, every community

has access to medical care in some form. For example, The American Legion conducted a site visit to Martha's Vineyard last year for our report on Rural Health Care. In 2000, a contract was signed between the Providence VA Medical Center and Martha's Vineyard Hospital. Through the contract, veterans living on Martha's Vineyard were able to receive care at Martha's Vineyard Hospital through fee-basis instead of having to travel off of the island. The contract lapsed around 2004, but the VA failed to realize this until 2008, when the hospital acquired new management. Veterans who were being treated under the original contract found out that the contract had lapsed when Martha's Vineyard Hospital sent collection bill notices to those veterans for medical expenses previously covered under the contract. Though a new contract was finally signed in the fall of 2012, it took four years for this to be arranged, with the veteran residents of Martha's Vineyard being forced to commute from their homes to Providence VA Medical Center – a trek involving a ferry ride and a two hour drive – each time they needed care.

Though there are only a few veterans living on the island, these veterans deserve fair treatment, and access to the benefits they have earned through their service. This delay illustrates the frustrations that veterans living in rural and isolated locations or other areas across the country experience in waiting for contracts and receiving assurances from VA that the contract will be resolved. VA should develop and implement a process to ensure all VA and non-VA purchased care contracts are inputted into a tracking system to ensure they remain current and do not lapse. If there are instances with a contract lapsing, such as in Martha's Vineyard, VA should make every effort to hold stakeholder meetings with veterans from those communities to solicit input and keep veterans enrolled in these contracts/services informed.

Exacerbating this problem are mental health issues which many veterans suffer – PTSD and TBI – which at times may require immediate care in order to prevent veterans from harming themselves or others. This legislation would make strides toward addressing this issue by facilitating contracts between VA and non-VA facilities to provide mental health care to veterans who live in areas which do not have VA medical facilities.

The American Legion supports this bill.

Draft Legislation, the Demanding Accountability for Veterans Act of 2013

To amend title 38, United States Code, to improve the accountability of the Secretary of Veterans Affairs to the Inspector General of the Department of Veterans Affairs.

The American Legion's Resolution No. 99, passed at National Convention 2012 states that "bonuses for VA senior executive staff [should] be tied to qualitative and quantitative performance measures developed by VA." While The American Legion refrains from commenting on the specific nature of these qualitative and quantitative performance measures – these decisions are left to the discretion of Congress and the administration – The American Legion believes that the implementation of such measures are a necessary step toward creating a culture of accountability within the VA. This bill, by establishing particular performance standards tied to bonuses received by VA senior executive staff, moves toward addressing this issue.

The American Legion supports this bill.

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

Veterans Timely Access to Health Care Act - Directs the Secretary of Veterans Affairs to ensure that the standard for access to care for a veteran seeking hospital care and medical services from the Department of Veterans Affairs (VA) is 30 days from the date the veteran contacts the VA.

Directs the Secretary to periodically review the performance of VA medical facilities in meeting such standard.

Requires quarterly reports from the Secretary to the congressional veterans' committees on the VA's experience with respect to appointment waiting times.

The American Legion has long been concerned with the inordinate wait times experienced by many veterans when attempting to access VA medical care. In 2002, the inaugural year for The American Legion's System Worth Saving initiative, the resulting report found that over 300,000 veterans were waiting for health care appointments. Of those, over half were waiting more than eight months for primary care appointments. In the intervening decade since then, little has changed, as is demonstrated by the ongoing System Worth Saving reports. While VA medical care

is among the best in the world, access has proven to be a problem for far too many of those who have earned it through their service.

On March 6th of this year, this committee's Subcommittee on Oversight and Investigations held a hearing entitled "Waiting for Care: Examining Patient Wait Times at VA" aimed at examining this issue. The American Legion, in addition to submitting testimony, provided an attachment for the record containing numerous stories from Veteran Integrated Service Networks (VISNs) across the nation, detailing first-hand accounts of the barrier to care that these wait times present – up to eight months, in some cases. This bill would address this issue, and while The American Legion would prefer a standard of less than 30 days – a goal of 14 days would be preferable – this legislation is a step in the right direction.

The American Legion supports this bill.

H.R. 288, the CHAMPA Children's Protection Act

CHAMPVA Children's Protection Act of 2013 - Increases from 23 to 26 the maximum age of eligibility for certain dependent children of veterans for medical care under CHAMPVA (the Civilian Health and Medical Program of the Department of Veterans Affairs [VA]).

The American Legion has no position on this bill.

H.R. 984, To Direct DOD to Establish a Task Force on Urotrauma

Directs the Secretary of Defense (DOD), in order to continue and expand the DOD report submitted in 2011, to establish the Task Force on Urotrauma to: (1) conduct a study on urotrauma (injury to the urinary tract from a penetrating, blunt, blast, thermal, chemical, or biological cause) among members of the Armed Forces and veterans; and (2) provide an interim and final report to the congressional defense and veterans committees on such study.

The American Legion has no position on this bill.

H.R. 1284, To Provide Coverage Under VA's Beneficiary Travel Program of Certain Disabled Veterans for Travel for Certain Special Disabilities Rehabilitation

Authorizes payment under the Department of Veterans Affairs (VA) beneficiary travel program of travel expenses in connection with medical examination, treatment, or care of a veteran with vision impairment, a spinal cord injury or disorder, or double or multiple amputations whose travel is in connection with care provided through a VA special disabilities rehabilitation program, if such care is provided: (1) on an inpatient basis, or (2) while a veteran is provided temporary lodging at a VA facility in order to make such care more accessible.

Requires a report from the Secretary to the congressional veterans committees on the travel program.

The American Legion has no position on this bill.

For additional information regarding this testimony, please contact Mr. Shaun Rieley at The American Legion's Legislative Division, (202) 861–2700 or *srieley@legion.org.*

OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to discuss how the Chairman's draft bill, Demanding Accountability for Veterans Act of 2013, will affect the operations of the Office of Inspector General (OIG).

Timely implementation of OIG recommendations is critical to improvement of VA programs and delivery of services to our Nation's veterans, and we share the Subcommittee's interest in seeing that responsible VA program officials are held accountable for correcting program deficiencies. In considering the proposed legislation, we believe it will be helpful for the Subcommittee to understand the OIG's Follow-Up Program, which is the principal means by which we track VA's progress implementing our recommendations.

OIG FOLLOW–UP PROGRAM

Follow-up is an important component of OIG oversight work. The Office of Management and Budget requires a process to follow up and report on the status of OIG report recommendations. The OIG is also required to report in its Semiannual Report to Congress on the status of report recommendations. Moreover, after the Inspector General testified before this Committee in February 2007, we began providing quarterly updates [1] to Congress and the VA Secretary on the status of open report recommendations, with an emphasis on those recommendations pending over 1 year. In June 2010, the Deputy Inspector General testified before the full Committee about the Department's progress toward implementing recommendations.

Included in each OIG final report is VA's response to the report, a statement whether they concur with each recommendation, and an implementation plan for the recommendations, that includes target dates. Those dates are determined by VA.

OIG staff take great care in developing recommendations to correct identified deficiencies to ensure that they are clear and specific; provide a yardstick to measure improvement; and gauge full implementation. Since 2007, we have worked closely with VA officials to develop recommendations for corrective action that can be realistically implemented within a year. As such, the OIG no longer accepts VA implementation plans that take more than a year to complete, except under the rarest of circumstances and only when measurable timelines are provided. In some instances, based on OIG staff evaluation, VA program offices take corrective action while we are onsite or during the period between the issuance of the draft report and when the final report is published. When this happens, we close out the recommendation as fully implemented and reflect the action in our final report.

However, a majority of the reports we issue contain open recommendations. Once a final report is issued, OIG follow-up staff begin a process of tracking each recommendation until fully implemented. The first OIG follow-up request is sent to the responsible VA program office 90 days after the report is published. (Recommendations in the annual audits related to the Federal Information Security Management Act of 2002 and VA's Consolidated Financial Statements are tracked separately by our independent public accounting firm and the results published annually in separate reports.)

In each follow-up status request we seek a description of what actions have occurred toward implementing the recommendations during the preceding 90 days. We set a 30-day deadline for VA officials to respond in writing. The response must contain documentary evidence such as issued policies, certifications, or other material supporting any request to close recommendations. Our intermediate goal is to obtain evidence that VA is making progress in implementing recommendations. If we do not receive a timely reply, or if we determine VA's efforts appear to be falling behind schedule, we schedule a face-to-face meeting to discuss how to get implementation back on track.

OIG follow-up staff coordinate with OIG line officials who worked on the report. To ensure VA's implementation plans remain on track, they discuss the documentary evidence VA submits with the status reports. If a report recommendation remains unimplemented, OIG staff repeat this follow-up cycle every 90 days. Once a report passes the 6-month mark and we determine implementation is unlikely within the 1-year goal, we increase the frequency of discussions with OIG line staff and VA program officials, and ensure the appropriate senior management officials in the OIG and VA recognize the probability of missing the 1-year target for implementation.

In Appendix B of our Semiannual Report to Congress, we present tables on open reports and recommendations. In the first table, we provide a matrix with totals for both open reports and the associated unimplemented recommendations. The table further breaks the data into those open less than or more than 1 year, and provides the same data by VA Administration or Staff Office. The second table shows only those reports and recommendations that are unimplemented for more than 1 year. In this table, we show the report title, date of issue, responsible VA organization, monetary impact, full text of each recommendation, and an indication of how many recommendations on each report are still open.

NAME CHECK PROCESS

To promote accountability, VA has a process in place to consult with the OIG and certain VA staff offices to assist the Secretary in making his decisions on performance awards and nominations for Presidential Rank Awards for members of the

[1] The update for the 2nd and 4th quarter of the fiscal year is the *Semiannual Report to Congress.*

Senior Executive Service and Title 38 equivalents. The OIG performs name checks where the list of potential award recipients are checked against OIG records to determine whether there are any open criminal or administrative investigations involving the individuals or whether there are any adverse findings in closed cases involving the individuals. These results are provided to VA for consideration by the Secretary when making final decisions on executive awards. We have made it clear to VA that nominating officials are responsible for considering the results of OIG audits and inspections because these results may not be associated with individual executives in our reports or record system.

DRAFT LEGISLATION

We offer the following comments on the draft legislation:

- Page 2, Line 19, Notifying the OIG of responsible managers by the Secretary – It would be helpful when identifying the manager, if there was a requirement to identify which recommendation(s) that manager was responsible for implementing.
- Page 3, Line 3, Notifying the manager – "Promptly notify" should be defined in terms of number of days.
- Page 4, Line 16, Defining responsible managers – Because VA has many positions covered under Title 38 of the United State Code, the section defining managers should include employees covered under Title 38 in addition to employees covered under Title 5 in the competitive service and Senior Executive Service.

CONCLUSION

The OIG appreciates the Subcommittee's interest in our work and ensuring that VA takes the necessary steps to address recommendations that the OIG and VA have agreed will remediate identified problems. We also appreciate the willingness of Subcommittee staff and Chairman Benishek's staff to discuss the draft bill and make clarifying edits.

We will continue to work actively with VA to ensure that OIG recommendations are implemented and to keep Congress advised on the status of those recommendations.

MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

CHAIRMAN BENISHEK, RANKING MEMBER BROWNLEY AND DISTINGUISHED MEMBERS OF THE COMMITTEE, on behalf of the over 380,000 members of The Military Officers Association of America (MOAA), we are pleased to present the Association's views on selected bills that are under consideration at today's hearing.

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

Thank you for the opportunity to submit comments and recommendations on the following pending legislative provisions:

- Draft, Veterans Integrated Mental Health Care Act of 2013
- Draft, Demanding Accountability for Veterans Act of 2013
- H.R. 241, Veterans Timely Access to Health Care Act
- H.R. 288, CHAMPVA Children's Protection Act of 2013
- H.R. 984, Direct the Secretary of Defense to Establish a Task Force on Urotrauma
- H.R. 1284, Amend Title 38 U.S.C. to Provide Coverage Under the Beneficiary Travel Program of the Department of Veterans Affairs (VA) of Certain Disabled Veterans for Travel for Certain Special Disabilities Rehabilitation

MOAA supports all the above provisions with only minor additions as noted below. We believe strongly that such legislation will strengthen existing programs and services under VA's purview, addressing some existing gaps in care, while providing additional tools for oversight and accountability across the medical system.

PENDING PROVISIONS

Draft, Veterans Integrated Mental Health Care Act of 2013. This provision would require the Secretary of VA to furnish mental health care to eligible veterans that is provided by a non-Department facility.

MOAA recognizes that more needs to be done to address the rapidly growing demand for veterans' mental health services. This provision allows more opportunities for care and provides an integrated model for addressing access issues by using network providers outside the VA. Further, greater coordination and oversight of con-

tracts and data sharing between government and non-government entities is supported by this legislation.

We have long supported leveraging existing civilian network providers, such as the TRICARE purchased care network to address the demand. This provision will do just that, as well as help provide necessary data to effectively measure patient outcomes.

MOAA fully supports this provision.

Draft, Demanding Accountability for Veterans Act of 2013. The purpose of this bill is to improve the accountability of the Secretary to the Inspector General (IG) of the VA.

Specifically, the provision requires the IG to notify Congress should the Secretary not appropriately respond with significant progress to a report issued by the IG by the required deadline of the covered report.

MOAA is encouraged by this provision, allowing additional authority to address reporting shortfalls with the Secretary. We see this as a positive way for both the Secretary and Congress to exercise additional oversight capability to improve accountability across the Department.

MOAA fully supports the draft provision.

H.R. 241, Veterans Timely Access to Health Care Act. The bill mandates the Secretary to establish standards of access to care for veterans seeking health care from VA medical facilities.

Our Association believes this legislation provides the forcing mechanism needed for VA to standardize access—an important step in eliminating the significant wait times facing veterans trying to schedule initial and follow-on appointments.

MOAA is also concerned about veterans needing immediate follow-up care after presenting in a VA emergency room (ER). Recently a caregiver took her veteran to a VA ER and was told after discharge to make an appointment for immediate follow-up but was told the earliest appoint available was in 3 months—a common scenario we hear.

MOAA supports the draft provision and would ask the Subcommittee to consider adding language requiring:

- ***Completing appointments within 5–15 days (or some medically-appropriate timeframe) following an urgent care visit to an ER if prescribe by a VA provider.***
- ***Breaking out and tracking of veteran access by Enrollment Priority Groups 1–8.***
- ***Adding a patient satisfaction rate measurement as a metric of effectiveness.***

H.R. 288, CHAMPVA Children's Protection Act of 2013. The provision would amend Title 38, U.S.C. to increase the maximum age for children eligible for medical care under CHAMPVA program from age 23 to 26.

The expansion of eligibility for CHAMPVA for eligible children up to age 26 is in line with provisions in the Patient Protection and Affordable Care Act (ACA) and the TRICARE Young Adult benefit.

According to a new GAO Report on the relationship of TRICARE and VA care to the ACA, "[the] ACA requires that if a health insurance plan provides for dependent coverage of children, the plan must continue to make such coverage available for an adult child until age 26. This requirement relating to coverage of adult children took effect for the plan years beginning on or after September 23, 2010. Under ACA, both married and unmarried children qualify for this coverage. The authorizing statute for CHAMPVA currently does not conform to this ACA requirement."

MOAA fully supports H.R. 288.

H.R. 984, Direct the Secretary of Defense to Establish a Task Force on Urotrauma. Subject to availability of appropriations, H.R. 984 would require the Secretary of Defense, in consultation with VA and the Department of Health and Human Services to establish a Task Force to conduct a study on urotrauma for a four-year period.

Given the severity of wounds and the changing combat environment, MOAA supports the need for more research and analysis, particularly in assessing incidents of urotrauma among our military members.

An important part of national security and readiness of our military force is to have a good understanding of the effects of war. This bill allows an opportunity to study significant injuries as a result of the wars in Iraq and Afghanistan. Timing

is crucial for this provision as the need to capture useful data is essential in order to apply what we learn in these wars and to be able to deploy in future conflicts.

MOAA supports the provision and suggests adding to the Ex Officio members list, military and veteran patient(s)/beneficiaries to ensure the warrior's perspective is considered in task force deliberations.

H.R. 1284, Amend Title 38 U.S.C. to Provide Coverage Under the Beneficiary Travel Program of the Department of Veterans Affairs (VA) of Certain Disabled Veterans for Travel for Certain Special Disabilities Rehabilitation. Under this provision travel would be authorized for a veteran with a vision impairment, a veteran with spinal cord injury or disorder, or a veteran with double or multiple amputations whose travel is in connection with care provided through a special disabilities rehabilitation program of the VA (including spinal cord injury center programs, blind rehabilitation center programs, and prosthetics rehabilitation center programs).

Veterans with catastrophic non-service connected (NSC) disabilities are currently ineligible for travel benefits associated with their visits to one of the 13 Blind Rehabilitation Centers or 29 Spinal Cord Injury locations around the country. These veterans must bear significant financial costs, including air travel which often deters them from getting the necessary training they need to live an independent lifestyle.

Additionally, 32 percent of the NSC blind veterans live at the poverty level and the average age of this population is 67 years old.

This issue is also outline in the Independent Budget, highlighting that, *"When veterans do not meet the eligibility requirement for travel reimbursement, and they do not have the financial means to travel, the chances of their receiving the proper medical attention are significantly decreased . . . For veterans who have sustained a catastrophic injury like spinal cord injury, blindness, or limb amputation, time and appropriate medical care is vital to their overall health and well-being."*

We agree with our VSO colleagues that this provision is a 'preventive medicine' bill.

MOAA fully supports H.R. 1284.

CONCLUSION

The Military Officers Association of America is grateful to the members of the Subcommittee on Health. Thank you for your leadership in keeping these important issues before the Congress and for your commitment to our Nation's heroes and their families.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to offer testimony on today's pending legislation.

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

This legislation would direct the Secretary of Veterans Affairs to ensure that all medical visits to Department of Veterans Affairs (VA) facilities are completed no more than 30 days after the veteran contacts VA to schedule an appointment. Additionally, it would require that VA submit a detailed report to Congress on scheduled wait times no later than 60 days after the end of each quarter.

The VFW understands that unacceptably long appointment wait times present a serious and ongoing problem, especially for new enrollees and those seeking specialty care, and agrees with the intent of this legislation to address that issue. We are concerned, however, that its enactment would remove too much flexibility from the scheduling process. Appointment wait times can be measured either from the date the veteran schedules the appointment or the date that the veteran desires the appointment to take place. The date of contact, or create date, could be several months in advance of the desired date, specifically when the veteran takes the opportunity to schedule a follow-up at the conclusion of his or her current appointment. Many medical conditions require periodic visits with the veteran's health care provider on a less than monthly basis. Legally mandating that all appointments must take place within 30 days of the create date could prevent VA from being able to offer long-term scheduling even when the veteran and the provider agree that it is appropriate. A veteran desiring an appointment 60 days in the future would have until 30 days prior to the desired date to schedule. This would greatly complicate

the VA appointment reminder policy by necessitating reminders for when veterans should be making their appointments in addition to when those appointments occur. For these reasons, we feel that eliminating the ability of VA to schedule appointments based on a distant desired date would inevitably lead to missed appointments, creating unnecessary cost to VA and diminished care for veterans.

The failure of VA scheduling staff to accurately establish veterans' desired dates, however, has led to exceedingly long and inaccurately reported wait times in the past, as highlighted by the December, 2012 Government Accountability Office (GAO) report, Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement. To correct this problem, GAO recommended that VA adopt a scheduling policy which more clearly defines the desired date or adopt new wait time measures that are not subject to interpretation. In response, VA has adopted the use of the create date to determine the appointment wait times for all new enrollees. VA has further stated that it will move to a policy which no longer uses the desired date as determined by the scheduler, and instead begin using an "agreed upon date" which is determined jointly by the provider and the veteran to track appointment wait times for established enrollees. The VFW will be closely monitoring these reforms and encourages Congressional oversight of their progress and effectiveness.

The VFW believes that, if executed properly, this new scheduling policy creates an accurate and reliable method of determining wait times and will increase veteran satisfaction while maintaining the current level of scheduling flexibility. Consequently, we cannot support H.R. 241 in its current form. The VFW would, however, consider supporting similar legislation requiring VA to schedule all appointment requests no more than 30 days after the agreed upon date for established enrollees, and the create date for new enrollees and all those seeking referrals from their current providers to new providers or specialty care.

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

The VFW supports this legislation to extend the age limit for coverage of certain veterans' dependents through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to the level set by the Patient Protection and Affordable Care Act (ACA).

The ACA, passed in early 2010, allowed families with private health insurance coverage to keep their children on their plans until age 26. TRICARE and CHAMPVA recipients were not included in that change. Thanks to responsible leaders in Congress, TRICARE coverage has been guaranteed to this age group. Unfortunately, CHAMPVA beneficiaries have not been afforded the same privileges. This remains an outstanding issue that must be rectified.

The VFW urges, however, that this legislation be strengthened to explicitly provide coverage to all children of CHAMPVA beneficiaries under the age of 26, not just those who are enrolled full-time at an approved educational institution or are unable to do so because of disability. Such a change would provide the standard of coverage offered under the ACA, as amended by the Health Care and Education Reconciliation Act of 2010, which offers coverage to all dependent children until age 26, regardless of educational status. The VFW strongly believes that CHAMPVA, which was established in 1973 and has more than 378,000 unique beneficiaries comprised of dependents and survivors of certain veterans, should in no instance ever receive less than the national standard.

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

The VFW is pleased to offer our support for this legislation which would establish an interagency task force on genitourinary organ injuries (urotrauma) to advise on research and action needed to advance the care and treatment of urotrauma.

The American Urological Association has reported that urotrauma injuries account for 10 percent of battlefield injuries with a 350 percent increase in incidence for those serving in Afghanistan compared to those who served in Iraq. Although less common than other physical injuries, the long-term emotional yet publicly invisible wounds from a genitourinary injury can mean loss of function and fertility for many service members. The psychological outcome of these battlefield injuries for both men and women can be devastating.

The VFW believes that this legislation will begin to address some of those needs by bringing together the Departments of Defense, Veterans Affairs, and Health and Human Services to study current incidence, morbidity and mortality rates, as well as the social and economic impact. It would also task the agencies to evaluate public and private resources for the diagnosis, prevention, treatment and most importantly, research of these injuries. Finally, it would focus on identifying programs

and best practices among stakeholders to improve the coordination and management of urotrauma injuries.

Better coordination and efficient use of resources both public and private will provide the key to improved care, treatment and management of those suffering from the residuals of these injuries. We urge Congress to pass this bill quickly.

H.R. 1284, To amend title 38, United States Code, to provide for coverage under the beneficiary travel program of the Department of Veterans Affairs of certain disabled veterans for travel for certain special disabilities rehabilitation, and for other purposes.

The VFW supports this legislation which would extend beneficiary travel benefits to veterans with certain severe non-service connected disabilities who travel to receive care provided through a VA special disabilities rehabilitation program. Veterans who are catastrophically disabled due to spinal cord injuries, visual impairments, and multiple amputations often require in-patient care in order to achieve full rehabilitation. Not all VA facilities, however, offer the specialized programs of care needed to properly treat these severe disabilities, and many veterans are forced to travel great distances to receive the care they need. Those not eligible for travel reimbursement must do so at great personal cost and, as a result, may be forced to forego essential primary or preventative care for financial reasons. This legislation would alleviate that hardship for this small but vulnerable population of veterans.

Draft Bill, Veterans Integrated Mental Health Care Act of 2013

The VFW does not support this legislation which would require VA to furnish non-VA mental health care to any eligible veteran who elects to receive such care at a non-VA facility that is able to meet certain care-coordination standards. The VFW strongly believes that veterans deserve access to timely and high quality mental health care that is fully integrated and responsive to their needs. However, VA must remain firmly in control of health care delivery. VA is currently moving forward with a major national initiative to revolutionize fee basis care, the Patient Centered Community Care (PCCC) program, which would establish contracts to provide a number of managed care services at non-VA facilities based upon individual need, including mental health services. The VFW believes that mandating new contracting requirements when VA is on the cusp of awarding PCCC contracts could create confusion within VA, halting or disrupting the progress of PCCC reform.

Draft Bill, Demanding Accountability for Veterans Act of 2013

The VFW cannot support this legislation in its current form, which dictates specific disciplinary actions on any responsible manager following a failure by VA to properly respond to the recommendations of a covered report of the Inspector General (IG), as determined by IG. We understand and agree with its intent, but are concerned with the precedent set by placing IG in a personnel management role. Managers must be held responsible for failing to properly perform their duties, but VA must maintain direct control over the accountability of its employees.

Mr. Chairman, this concludes my testimony.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2013, nor has it received any federal grants in the two previous Fiscal Years.

VETSFIRST/UNITED SPINAL ASSOCIATION

Chairman Benishek, Ranking Member Brownley, and other distinguished Members of the Subcommittee, thank you for the opportunity to submit written testimony regarding VetsFirst's views on the CHAMPVA Children's Protection Act of 2013 (H.R. 288) and H.R. 1284.

VetsFirst, a program of United Spinal Association, represents the culmination of over 60 years of service to veterans and their families. We provide representation for veterans, their dependents and survivors in their pursuit of Department of Veterans Affairs (VA) benefits and health care before VA and in the federal courts. Today, we are not only a VA-recognized national veterans service organization, but also a leader in advocacy for all people with disabilities.

CHAMPVA Children's Protection Act of 2013 (H.R. 288)

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program for the spouses and dependent children of veterans who are permanently and totally disabled, died while on active duty, or died due to a service-connected disability. For the families of these veterans, CHAMPVA provides critical physical and mental health care benefits. Children who are CHAMPVA beneficiaries typically lose coverage at age 18 unless they are full-time students, in which case they maintain benefits until age 23.

The Affordable Care Act (ACA) allows a child to remain on a parent's health insurance until age 26. However, TRICARE and CHAMPVA child beneficiaries were not covered by this provision. The National Defense Authorization Act (NDAA) for FY 2011 brought TRICARE into alignment with the ACA provision by extending coverage to age 26 for TRICARE beneficiaries. CHAMPVA child beneficiaries, however, were not included in the NDAA provision.

Thus, CHAMPVA child beneficiaries are prohibited from receiving a benefit similar to that provided to other adult children in our nation. H.R. 288 will correct this injustice by allowing child beneficiaries to continue to receive health care benefits under the CHAMPVA program until age 26. This legislation will ensure parity for the children of permanently and totally disabled veterans and those who died in service to our nation.

VetsFirst supports the CHAMPVA Children's Protection Act of 2013 because it will ensure that the children of men and women who have greatly sacrificed for our nation will be able to finish educational opportunities and begin careers without having to forgo access to critical health care benefits. We urge swift passage of this important legislation.

To provide coverage under VA's beneficiary travel program for the travel of certain disabled veterans for certain special disabilities rehabilitation (H.R. 1284)

Veterans who have spinal cord injuries or disorders, vision impairments, or double or multiple amputations require access to rehabilitation services that allow them to live as independently as possible with their disabilities. For those veterans who need these services but who are not eligible

for travel benefits, the ability to pay for travel to these rehabilitation programs can be very burdensome. In addition, few of these services are available locally, particularly to veterans who live in rural areas.

All disabled veterans who need to travel to receive in-patient care at special disabilities rehabilitation programs should be eligible to receive travel benefits from VA. Every effort must be made to reduce barriers that limit access to these services. The long-term savings of ensuring that these veterans are able to maintain their health and function significantly outweighs the short-term costs associated with this legislation.

VetsFirst supports H.R. 1284 because it will improve access to rehabilitation services for all veterans who have spinal cord injuries or disorders, vision impairments, or double or multiple amputations.

Thank you for the opportunity to submit written testimony concerning VetsFirst's views on H.R. 288 and H.R. 1284. We appreciate your leadership on behalf of our nation's disabled veterans and their families.

Information Required by Clause 2(g) of Rule XI of the House of Representatives

Written testimony submitted by Heather L. Ansley, Vice President of Veterans Policy; VetsFirst, a program of United Spinal Association; 1660 L Street, NW, Suite 504; Washington, D.C. 20036. (202) 556–2076, ext. 7702.

This testimony is being submitted on behalf of VetsFirst, a program of United Spinal Association.

In fiscal year 2012, United Spinal Association served as a subcontractor to Easter Seals for an amount not to exceed $5000 through funding Easter Seals received from the U.S. Department of Transportation. This is the only federal contract or grant, other than the routine use of office space and associated resources in VA Regional Offices for Veterans Service Officers that United Spinal Association has received in the current or previous two fiscal years.

WOUNDED WARRIOR PROJECT

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

Thank you for inviting Wounded Warrior Project (WWP) to provide views on pending health-related legislation. Several of the measures under consideration address issues of keen importance to wounded warriors and their family members.

MENTAL HEALTH CARE

Provision of timely, effective mental health care for warriors is a matter of the greatest concern to Wounded Warrior Project. As such, we appreciate the effort in the draft Veterans Integrated Mental Health Care of 2013 to improve access to such care for those with service-incurred mental health conditions.

The draft bill proposes to give veterans who seek treatment for a service-incurred mental health condition (or who have a total and permanent disability resulting from service-connected disability) a choice between VA care and care provided under contract with an entity that administers a provider-network. Under the draft bill, VA would be required to inform those veterans when, where and who would provide such needed VA treatment, and the veteran could choose to receive that care from VA or instead from a contract provider. The measure would permit VA to award a contract only if an entity demonstrates that it can meet certain capabilities, including the ability to provide nonurgent mental health care with access to a care-coordinator; the ability to ensure an acceptable no-show rate and to exchange relevant clinical information with VA within 30 days after an appointment; and the ability to meet performance metrics regarding the quality of care provided, patient satisfaction, timely access, and cost-effectiveness.

We welcome consideration of the principle of offering a warrior choice regarding treatment for a service-connected condition. At the same time, the draft bill raises a number of questions. It is not clear, for example, how informed a veteran's choice would be under the proposed framework and whether the treatment modalities available to the veteran through a contract provider would be as extensive as they might from VA. More specifically, the bill does not make clear whether the veteran would have the same information regarding the contract-care option as regarding the VA option (who would provide treatment and when). And would the veteran have access to the same treatment modalities under the contractor option as through VA? We infer not. For example, the contractor would be responsible for providing "nonurgent mental health care or medical services." That suggests that a veteran whose care needs become urgent or critical would be referred back to the care-option he or she had earlier rejected, the VA. The reference to "or medical services" (in the phrase "the term'covered mental health care' means nonurgent mental health care or medical services ... ") raises the question, what kind of providers could furnish the required services and whether those services could simply be provided by primary care physicians rather than behavioral health specialists. The measure also raises the question, what would be the scope of care provided under contract arrangements? Would psychotherapy be routinely available, or would the first-choice (or only) treatment modality be limited to prescribing and managing medications? Real choice surely calls for a patient to have full information regarding the options, particularly if they do not involve an "apples to apples" choice. There are certain reasons why a veteran might elect to receive treatment from a contract provider, but a veteran would likely also want to understand the implications of first electing the contractor option and subsequently seeking to opt-out. Could that veteran return to the VA under those circumstances? And, if so, would VA still be responsible for payment for a full course of treatment?

The principle of choice is an important one, but the goal, in our view, should not be simply to afford a choice, but to provide timely, effective mental health care. The draft bill reflects concern for issues of quality, but its language sets no specific expectation as to patient outcomes or effectiveness of treatment. Yet a relatively recent study by the Institute of Medicine on the quality of behavioral health care in this country stated that "despite what is known about effective care for M/SU [mental health and substance use] conditions, numerous studies have documented a discrepancy between M/SU care that is known to be effective and care that is actually delivered. [1]

At its most basic, for care to be effective, there must be a relationship of trust between provider and patient. [2] We know from many of our warriors, however, that

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[1] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, "Improving the Quality and Health Care for Mental and Substance-Use Conditions," (The National Academies Press 2006), 5.

[2] Lambert, Michael J.; Barley, Dean E. "Research summary on the therapeutic relationship and psychotherapy outcome," *Psychotherapy: Theory, Research, Practice, Training,* Vol 38(4), 2001, 357–361.

one critical element of that trust, particularly as it relates to a highly sensitive subject like mental health, is the provider's understanding of the warrior experience and ability to relate, accordingly. Comments we have received from our field staff regarding warriors' experience with mental health care are illuminating in that regard. The following are typical:

"The biggest [warrior] complaint seems to be . . . [that providers have] no military background and they don't 'get it' or understand what I am going through and struggling with . . . .[It's] hard to connect with someone when they haven't been in your shoes."

*"I ask warriors how they are coming along in their recovery; in more cases than not, warriors do not want to talk about their war time experiences with non-vets."*1A[3]

"Cultural competence" is an important component of building a therapeutic alliance, but the draft bill does not specify that the contract entity meet any cultural training requirements. So there is little reason to believe that contract providers under the proposed framework would have the training and experience to address military and veteran-specific "cultural" issues.

These questions and concerns cited above argue, in our view, not only for addressing the kinds of issues we have raised, but for proceeding cautiously. Rather than directing VA to offer contract care to all veterans who need treatment for service-connected mental health conditions (as the draft bill appears to do), we urge consideration of developing a limited pilot program. Such a pilot could test the underlying principle of providing service-connected veterans choice. But that choice should not only be fully informed, but should optimally offer the veteran a similar range of covered services under a framework that provides reasonable assurance that they would receive both timely and effective mental health care.

UROTRAUMA

H.R. 984 would direct the Secretary of Defense, subject to the availability of funds for such purpose, to establish a "Task Force on Urotrauma" to conduct a broad study of that subject that includes analyzing data on incidence, morbidity and mortality; social and economic costs and effects; evaluation of pertinent capabilities and programs; and analyses, including an analysis of mechanisms to allow for enhanced reproductive services for servicemembers.

We note that several of these topics were the subject of relatively recent study by an Army task force;[4] as such, we are not clear on the rationale for establishing the proposed entity. Since that Army task force completed its report, DoD has developed new policy relating to advanced reproductive services, and broad legislation has been introduced in the House that would authorize VA to provide reproductive services to assist in helping severely wounded veterans who have service-incurred infertility conditions to have children.[5]

In WWP's view, the experience of our operations in Iraq and Afghanistan has heightened the importance of grappling with the issue of reproductive services. Blasts from widespread use of improvised explosive devices (IED's) in Iraq and Afghanistan, particularly in the case of warriors on foot patrols, have increasingly resulted not only in traumatic amputations of at least one leg, but also in pelvic, abdominal or urogenital wounds.[6] While not widely recognized, the number and severity of genitourinary injuries has increased over the course of the war, with more than 12% of all admissions in 2010 involving associated genitourinary injuries.[7] With that increase has come not only DoD acknowledgement of the impact of genitourinary injuries on warriors' psychological and reproductive health,[8] but recent adoption of a policy authorizing and providing implementation guidance on assisted reproductive services for severely or seriously injured active duty servicemembers.[9]

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[3] Conference call with WWP alumni managers; May 1, 2013.

[4] Dismounted Complex Injury Task Force, "Dismounted Complex Blast Injury: Report of the Army Dismounted Complex Injury Task Force," I (June 18, 2011) available at: *http://www.armymedicine.army.mil/reports/DCBI%20Task%20Force%20Report%20%28Redacted%20Final%29.pdf.*

[5] See H.R. 958, accessed at *http://thomas.loc.gov/cgi-bin/query/z?c113:H.R.958:*

[6] Dismounted Complex Injury Task Force, supra.

[7] Id. at 16.

[8] Id.

[9] Asst. Secretary of Defense (Health Affairs) & Director of TRICARE Management Activity, Memorandum on Policy for Assisted Reproductive Services for the Benefit of Seriously or Seriously Ill/Injured (Category II or III) Active Duty Service Members (April 3, 2012) available at: *http://www.veterans.senate.gov/upload/DOD—reproductive—letter.pdf.*

DoD's policy, set forth in recent revisions to its TRICARE Operations Manual, applies to servicemembers of either gender who have lost the natural ability to procreate as a result of neurological, anatomical or physiological injury. The policy covers assistive reproductive technologies (including sperm and egg retrieval, artificial insemination and in vitro fertilization) to help reduce the disabling effects of the servicemember's condition to permit procreation with the servicemember's spouse. [10]

For veterans, however, VA coverage is very limited in scope. The regulation describing the scope of VA's "medical benefits package" states explicitly that in vitro fertilization is excluded [11] and that "[c]are will be provided only . . . [as] needed to promote, preserve, or restore the health of the individual . . . ." [12] Consistent with that limiting language, the VA's benefits handbook advises women veterans with regard to health coverage that " . . . infertility evaluations and limited treatments are also available." [13]

In a departure from longstanding policy, VA stated last year that "[t]he provision of Assisted Reproductive Services (including any existing or future reproductive technology that involves the handling of eggs or sperm) is in keeping with VA's goal to restore the capabilities of Veterans with disabilities to the greatest extent possible and to improve the quality of Veterans' lives." [14] In its statement, VA also expressed support in principle for legislation authorizing VA to provide assistive reproductive services to help a severely wounded veteran with an infertility condition incurred in service and that veteran's spouse or partner have children. It conditioned that support, however, on "assurance of the additional resources that would be required." [15]

Certainly the administration of a VA program that would assist wounded warriors and their spouses to conceive children would require careful attention to ethical [16] and regulatory [17] issues associated with providing advanced reproductive services. Economic considerations certainly can arise in that regard. [18] But while these advanced interventions can be quite costly, cost should not be a barrier as it relates to this country's obligation to young warriors who sustained horrific battlefield injuries that impair their ability to father or bear children.

WWP urges the Subcommittee to take up legislation to enable couples unable to conceive because of the warrior's severe service-incurred injury or illness to receive fertility counseling and treatment, including assisted reproductive services, subject to reasonable regulations.

CHAMPVA

Under current law CHAMPVA coverage expires at age 18 except in the case of a full-time student when it may be extended until age 23 if the student incurs a disabling illness or injury while pursuing a course of study). H.R. 288 would extend that student coverage until age 26. We support this legislation, which brings CHAMPVA into closer alignment with the Affordable Care Act, which allows children to remain on a parent's health plan until age 26.

Timeliness of Care

H.R. 241 would direct VA to establish a 30-day timeliness standard with respect to the numbers of days between the date on which a veteran seeks care until the date on which a visit with an appropriate health care provider is completed. The measure would also require the Department to provide a detailed semi-annual re-

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[10] Dept. of Defense, TRICARE Operations Manual 6010.56–M, Chapter 17, Section 3, para. 2.6 (Sept. 19, 2012).

[11] 38 C.F.R. § 17(c)(2).

[12] 38 C.F.R. § 17(b) (Emphasis added).

[13] Dept.of Veterans Affairs, "Federal Benefits for Veterans, Dependents and Survivors" available at *http://www.va.gov/opa/publications/benefits—book/benefits—chap01.asp*

[14] *Health and Benefits Legislation Hearing Before the S. Comm. on Veterans Affairs,* 112th Cong. (2012).

[15] Id.

[16] See Meena Lal, "The Role of the Federal Government in Assisted Reproductive Technologies, 13 Santa Clara Computer and High Tech. L. J. 517 (1997).

[17] See Michelle Goodwin "A Few Thoughts on Assisted Reproductive Technology," 27 L. & Ineq. 465 (2009). Among these regulatory issues, VA would have to address the need for physicians providing advanced reproductive technologies to fully inform couples as to their risks, including greater health risks in children born through these technologies. See N.Y. State Dept. of Health Task Force on Life and the Law, Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy, available at: *http://www.health.ny.gov/regulations/task—force/reports—publications/execsum.htm*

[18] Id.

port to the Veterans Affairs Committees of Congress with respect to the waiting times veterans experience.

We applaud the focus on timeliness of care, but would caution against establishing in law any single measure of timeliness. Thirty-days would be an unacceptably long wait in the event of a medical or psychiatric emergency. Yet it might be an unnecessarily strict standard with respect to VA's performing a truly elective procedure or providing health-promotion services, for example.

It is also important that there be rigor and integrity with respect to any VA methodology for reporting and determining timeliness. The Subcommittee would surely find instructive the experience associated with VA's establishment of timeliness standards for mental health care and the Inspector General's finding wide disparity between VA-reported timeliness-performance data and its own data analysis. [19]

BENEFICIARY TRAVEL

H.R. 1284 would amend current law governing VA's "beneficiary travel" program to cover certain severely disabled veterans' travel in connection with care provided on an inpatient (or lodger-basis) through a special VA disability-rehabilitation program.

WWP works extensively across the country with wounded warriors, specifically veterans and servicemembers who were injured, wounded or developed an illness or disorder of any kind in line of duty during military service on or after September 11, 2001. Our warriors certainly encounter barriers to receiving needed VA services – barriers that include sometimes-rigid VA appointment-scheduling, long-distance travel, and instances of inflexible program requirements. We are not aware, however, of problems that warriors have encountered regarding receipt of beneficiary travel generally or with respect to travel to special disability-rehabilitation programs. As such, we have no position on H.R. 1284.

Thank you for your consideration of WWP's views on these measures.

Questions For The Record

July 11, 2013

The Honorable Dan Benishek, Chairman
Subcommittee on Health
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Benishek:

Thank you for giving PVA the opportunity to testify during the May 21, 2013 hearing on pending health care legislation being reviewed by the Subcommittee. As requested, enclosed you will find the responses to your follow-up questions from that hearing. Paralyzed Veterans of America thanks the Subcommittee's for their attention to these important issues. Please do not hesitate to contact me with any questions that you may have regarding the responses, or involving veterans' health care issues.

Again, thank you and we look forward to working with you and the Subcommittee on these issues.

Sincerely,

Douglas K. Vollmer
Associate Executive Director, Government Relations

Questions for the Record from the Honorable Dan Benishek M.D., Subcommittee Chairman and PVA Responses

Draft Legislation, "The Veterans Integrated Mental Health Care Act of 2013"

1. In a statement for the record, the Wounded Warrior Project urged consideration of a limited pilot program to test the underlying principles of the "Veterans Integrated Mental Health Care Act."

[19] VA Inspector General, "Review of Veterans Access to Mental Health Care" (April 23, 2012) accessed at *http://www.va.gov/oig/pubs/VAOIG–12-00900-168.pdf*

-Would you be supportive of such an arrangement? Please explain?

PVA believes that timely and quality care, as well as care coordination are the top priorities when providing veterans with mental health care services. During the hearing on May 21, 2013, PVA's written statement to the Subcommittee stated that the Department of Veterans Affairs (VA) is in the process of transforming its national non-VA care program in an effort to improve coordination services with non-VA providers, which includes mental health services. As a result of such efforts, it is our position that these initiatives should be further developed before additional resources are put into another program for non-VA care-coordination. However, we would not be opposed to incorporating specific provisions from this legislation into one of the mental health pilots that the VA is currently developing under the President's Executive Order #13625—"Improving Access to Mental Health Services for Veterans, Service Members, and Military Families." If such action is possible, we believe that these mental health pilots serve as a good starting point to test the underlying principles of the "Veterans Integrated Mental Health Care Act."

Additionally, we urge the Subcommittee and the VA to consider incorporating some of the underlying principles from this legislation into its non-VA care coordination program. As the VA is currently developing the Patient Centered Care Coordination (PCCC) initiative, which will manage non-VA mental health services, aspects of this bill may help improve coordination of such care.

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

1. Given Concerns raised during the hearing regarding establishing a single Department-wide timeliness measure in law, please provide your views as to how to facilitate timeliness standards that take into account the need for separate standards depending on the type of care that is being provided – i.e. primary, specialty, and mental health care services for both new and established veteran patients.

The establishment of timeliness standards for primary, specialty, and mental health care services must include, to some degree, clinical expertise and input. Therefore, PVA first recommends that the Subcommittee and the VA work together to better develop timeliness standards for VA services. Second, we suggest defining an "acceptable" time frame during which a veteran should be able to schedule an appointment and have a visit with a medical professional. As discussed in previous hearings held by the Subcommittee, the VA defines access standards in many different ways, which leads to patient confusion and can also be misleading when evaluating timely access, particularly in the area of mental health.

Lastly, when reviewing H.R. 241, the Subcommittee may want to consider requiring the VA to make a distinction between the types of appointments being scheduled. The types of appointments can be divided into categories that include first time appointments, follow-up visits, and emergency visits. Each category may or may not have different timeliness standards. Additionally, as the VA has multiple ways to provide care, timeliness standards should take into consideration how and where the care will be provided. Methods to provide care include telehealth via the telephone and using the computer, or peer counseling.

H.R. 1284, to amend title 38, United States Code, to provide for coverage under the beneficiary travel program of the Department of Veterans Affairs (VA) of certain disabled veterans for travel for certain special disabilities rehabilitation, and for other purposes

1. In their written testimony, VA states that, " . . . VA feels that the legislation as written would provide disparate travel eligibility to a limited group of veterans."

-Do you agree with the Department's assessment?

PVA does not fully agree with VA's statement that the H.R. 1284 as written would provide disparate travel eligibility to a limited group of veterans. Ultimately, PVA advocates the VA providing travel reimbursement to all catastrophically disabled veterans [as defined by the Secretary] whose travel is in connection with receipt of VA medical services. However, we believe that providing the veteran populations described in H.R. 1284 with VA travel reimbursement is a good first step to eliminating the burden of transportation costs as a barrier to care for severely disabled veterans, and improving access to VA care.

H.R. 1284 provides travel benefits to specific groups of veterans that require chronic, expert care from designated VA specialized systems of care, the Spinal Cord Injury/Disorder System of Care, the Amputation System of Care, and the Blind Rehabilitation Service. These groups of veterans can only receive their primary health

care services from a limited number of health care centers that are sparsely located across the United States. Receiving services from primary care providers that are not a part of their VA system of care, or from providers who do not have the specialized expertise will jeopardize the health and well being of these veterans. For instance, SCI/D annual exams average two to three days because of the comprehensive testing that takes place, such as image testing and physical examinations. Often, our members drive to such visits and return home at the end of the first day, and return each day until the exams and all required procedures are complete. Driving to these appointments can be very costly to the veteran when paying for gas of trips that can range up to 6 hours or more round trip. PVA members choose to drive because they need accessible transportation and lodging that is safe and comfortable. Driving is also a much cheaper option than admitting them into an SCI/D unit for two to three days, and allows them to maintain their personal independence.

2. In a statement for the record, the Wounded Warrior Project states that, "[w]e are not aware ... of problems that warriors have encountered regarding receipt of beneficiary travel generally or with respect to travel to special disability-rehabilitation programs."

-Please respond to that statement.

At this time, PVA does not purport to have knowledge of problems that service-connected veterans have encountered regarding receipt of beneficiary travel reimbursements. However, we do have PVA members who are non-service connected, catastrophically disabled veterans, who are not eligible for VA beneficiary travel benefits and have difficulty affording the costs associated with traveling for medical visits. It is for this reason, we strongly support H.R. 1284.

3. Do you see other avenues – such as through non-profit entities or community groups – to provide transport to those certain non-service connected individuals – that cannot defray the cost of air-fare and other travel needs themselves?

PVA recognizes that other avenues of transportation are available, and very much necessary. However, it is our position that many veterans who have a catastrophic injury or disability, particularly, the three populations identified in H.R. 1284, require adaptive equipment and automobiles when traveling. It is not always the case that the transportation provided by non-profit entities or community groups meet the accessibility needs of catastrophically disabled veterans. Further, arranging for accessible transportation can be very arduous and time consuming, and as a result, it is common for disabled veterans who are not able to drive themselves to medical appointments to delay health care until transportation can be arranged, or forgo medical attention completely. Many PVA members prefer to use personal transportation options for reasons involving their comfort and safety; H.R. 1284 will allow severely disabled veterans this option.

Inquiry from: Representative Julia Brownley

Context of Inquiry:

During the May 21, 2013 HVAC Health Subcommittee Legislative Hearing, Representative Brownley requested updated CHAMPVA data. We last sent her data on the program in 2010.

Response:

Analysis of the Child Population in the CHAMPVA Program Enrollment File.

The current program-wide eligible count for CHAMPVA is 378,277 as of 30 April 2013. This includes all persons that are eligible to file a claim for healthcare services received during FY13. About 8,942 of these individuals have already been declared ineligible for further benefits this year, due mainly to divorce, death, or children that have lost eligibility due to reaching one of the age restrictions.

The remainder of the analysis will deal with the child population, and will be based on data that is current as of 5/1/2013. All age groupings presented below are as of 5/1/2013 and based on the individual's DOB in the enrollment file.

The number of covered children and students currently eligible for benefits on 5/1/2013 was 52,975. The current population is slightly smaller than the population review in FY 2009 that we were asked to update (55,037). These children can be broken down into the following groups

Birth -18th Birthday	Children	45,573
Age 18 – 23rd Birthday	Students	7,362
23 – 25th Birthday	Extended Benefit	40

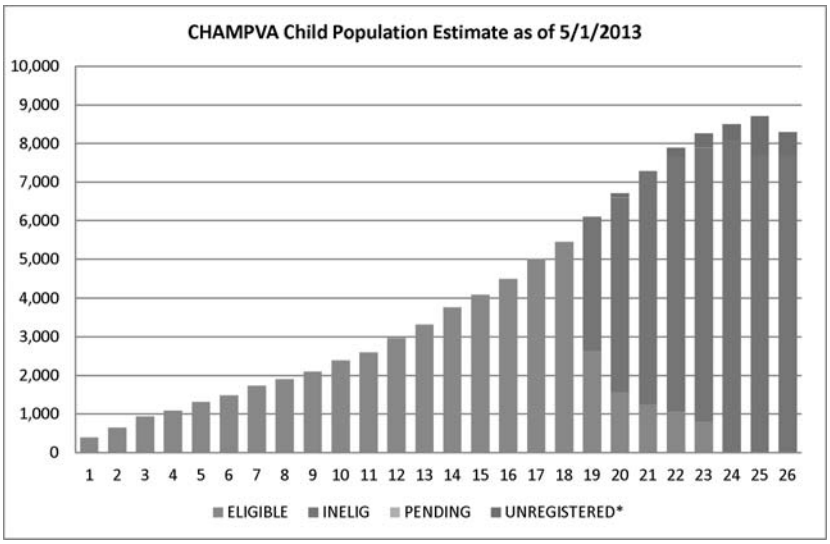
CHAMPVA coverage can be extended when a covered child over age 18 suffers and injury, accident or other medical condition that makes them unable to maintain their full-time student status. By regulation, these individuals continue to receive coverage for up to two years from the date of the event.

Based on the current enrollment file, there are 51,599 children that have lost eligibility under the current CHAMPVA regulations, but are still under the age of 26. The "Ineligible" counts provided on the table and chart below only include children that have lost coverage specifically due to age considerations. Other losses of eligibility, such as marriage, death, or step-children that have left the qualifying sponsor's household are not included in the ineligible child population. This ineligible group can be identified by name, SSN and last known address/phone number in our enrollment file.

Additionally, there is a cohort of children that have never applied for benefits because their parent became a CHAMPVA eligible sponsor after the child was no longer eligible due to current age restrictions. We do not have any way to specifically count these individuals, but we are providing a best estimate of this group under the category of "Unregistered".

AGE	TOTAL	0–17	18	19	20	21	22	23	24	25
ELIGIBLE	52,975	45,573	2,648	1,571	1,260	1,070	813	24	12	4
PENDING	163	115	12	9	9	8	6	3	1	
INELIGIBLE	51,599	0	3,445	5,033	6,023	6,583	7,077	8,082	7,675	7,681
UNREGISTERED*	2,699	0		92	0	231	365	387	1,021	603

The following chart provides a graphical representation of the data in the table.



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